Medical-State Collaboration:

Regulating Substance Using Pregnant Women

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THESIS

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This dissertation is dedicated to my mother, *Ellen*, and my granny *Ada*, two unbelievable forces, the memories of whom move me in everything.

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LIST OF ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecology
AFCARS	Adoption and Foster Care Analysis and Reporting System
ASAM	American Society of Addiction Medicine
CAPTA	Child Abuse Prevention and Treatment Act
CDC	Centers for Disease Control
DCFS	Department of Children and Family Services
ILPQC	Illinois Perinatal Quality Collaborative
KFT	Keeping Families Together
MAT	Medication Assisted Treatment
NAS	Neonatal Abstinence Syndrome
NICU	Neonatal Intensive Care Unit
OUD	Opioid Use Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SEI	Substance Exposed Infant
SUD	Substance Use Disorder

SUMMARY

This study examines local responses to perinatal substance use in the city of Chicago. I explore the ways that policy makers, medical professionals, and state actors collaborate to regulate substance using pregnant women. The findings of this research contribute to our understanding of the relationship between medicalization and criminalization and documents the emergence of a hybrid form of governance by which medical-state collaborations fundamentally empower and transform each other.

Drawing from qualitative interviews (N = 86) with experts, professionals, medical actors, and women who have used substances while pregnant, this study reveals the complementary logics that bring disparate institutions together. The findings reveal that in response to perinatal substance use, medical and carceral logics comingle and pervade medical practices; treatment and diagnostic norms are scaled back while forensic methods used to surveil, monitor, and collect evidence are promoted. This research shows that medical providers play an active role in initiating state interventions in women's lives for their behavior during pregnancy. This research also documents women's experiences once they have been referred to child protective services and reveals that on the other side of medical-state handoffs women must contend with precarity within the privatized social service sector. Finally, this dissertation explores how substance using women experience motherhood when maternity status and childrearing are targets for punishment and discipline by multiple experts and institutions.

CHAPTER ONE: INTRODUCTION

In November 2018, I attended the annual Illinois Perinatal Quality Collaborative conference. The topic of this year's conference was maternal opioid use, which was also the selected issue that the perinatal network was undertaking for their statewide quality improvement initiative. For the two previous years, I had been collecting data and conducting interviews for my study examining local responses to substance use during pregnancy. I had interviewed doctors, nurses, maternal addiction experts, hospital social workers, child welfare actors, drug treatment providers, and women who had used drugs while they were pregnant. I had learned that responses to substance use during pregnancy were largely unstandardized and varied dramatically not only across hospitals but across individual providers. I was struck by how much responses seemed to be centered around punishing women for their substance use, rather than providing them with medical care and other forms of support. At the same time, in the broader culture, I was confronted with messages that responses to addiction were changing, becoming more medical, evidence-based, and compassionate, unlike the draconian days of the "crack era" during which incarceration and child removal were the go-to reactions. Contemporary drug policy and media representations emphasize that addiction is a disease, which, like other diseases, could be medically managed and treated. I was cautiously optimistic to learn of the state-wide initiative centering the very population I was studying and was hopeful that the conference represented a sea-change in responses to substance use. I was encouraged by what I had seen of the initiative up to that point which was a commitment to developing a more standardized and evidenced-based approach to responding to perinatal substance use. Yet, as I sat in the audience at the day-long event, I grew increasingly aware of the troubling ways that the speakers and organizers talked about substance using pregnant women.

I was expecting the speakers to discuss what *medical care* for substance using women looked like. For instance, how should providers treat and refer women who needed Medication-Assisted Treatment (the gold standard for treating opioid addiction which involves providing opioid agonist therapy to dependent patients)? How might physicians employ harm reduction methods with their patients including providing patients with life-saving medications like Naloxone (an opioid antagonist that rapidly reverses an opioid overdose)? How do clinicians treat medically complex conditions that arise from intravenous opioid use like bacterial blood infections or endocarditis (also known as heart vegetation in which blood infections spread to the valves of the heart)? Unfortunately, the medical care and needs of this population of patients was not the central concern of the speakers at this event. Rather, the topics covered framed substance using pregnant patients as *a problematic population* not as *a population with a medical problem.*

One speaker discussed the importance of counseling drug-using women about immediate post-partum LARC insertion (Long Acting Reversible Contraception usually an intrauterine device or hormonal implant). Immediate postpartum LARC insertion has been critiqued by feminists of color and reproductive justice advocates as a modern-day form of population control targeting marginalized populations (Hindrixson 2018, NWHN & SisterSong n.d.). Another speaker who worked for the Department of Children and Family Services (DCFS) instructed the room of medical providers on how to work with child protective agencies to report that a woman had given birth to a substance-exposed infant (which is considered child neglect in the state of Illinois). Another speaker explained to the audience the importance of avoiding stigmatizing language when interacting with drug using populations and emphasized that words like “clean and dirty” in reference to drug test results should be avoided while terms like “substance use disorder” should be used in place of older terminology like substance abuse. Finally, a woman

who had experienced a child welfare intervention after giving birth shared her experience with the audience. Unlike the other presenters, she did not have a polished PowerPoint presentation with stats and research and instead shared her testimonial of medical neglect with the audience of hundreds of medical providers. She explained how she had been the victim of sexual abuse and later intimate partner violence. She explained how drugs were a way to cope with her traumatic past. She had gone to treatment, was in recovery, and was on a methadone maintenance program. Then she became pregnant. She described how the hospital staff made her feel like a "horrible" person for being on methadone. How the neonatal nurses told her she couldn't hold or breastfeed her baby. She detailed how she was made to feel disconnected from her newborn "I felt like she wasn't mine, like she belonged to the staff, not me…" Her testimonial was a powerful disruption in the tone and flow of the conference. Here was a woman speaking truth to power, forcing the audience to contend with her humanity and bear witness to her story. She ended with a succinct diagnosis of what was at the root of these sorts of power dynamics in medical interactions, she explained: "I felt like I was a horrible person by just having children, like I shouldn't be having children." When the speaker finished, the audience stood from their seats and gave her a standing ovation (it was the only standing ovation of the event).

What I had witnessed at the conference had unnerved me. As I drove home from the conference, I thought about how confused the messaging of the event had been. If I were a medical provider, and not a sociologist critically examining medical responses to perinatal substance use, what would I have walked away from that conference having learned? That I should avoid calling my patients substance abusers, while I report them to child protective services for child abuse? That my patients were people, just like me, and that I should not other them, while I compel them to agree to long-acting contraception? Something about the event felt

incongruous, like the standing ovation for the speaker, the content of the conference seemed to be centered around *appearing* to support patients with substance use issues without meaningfully addressing their needs as patients. I was bothered that there had been no discussion of how opioid addiction may affect women's health or that detoxing cold turkey during pregnancy threatens the health of both the fetus and mother. I was bothered that there had been no mention of the state law that classifies substance use during pregnancy as child abuse and how such a law interferes with the provision of basic medical care during pregnancy. It seemed to me that the organizers and the attendees of the conference (obstetricians, neonatologists, maternal fetal medicine providers, midwives, neonatal nurses, labor and delivery nurses, among others) hadn't quite figured out how they felt about patients who use drugs while they are pregnant. Were their patients offenders, recklessly harming their fetuses who deserved to have their children removed at birth so they could inflict no more harm? Or, were they *patients*, suffering from a treatable medical condition that could cause complications during pregnancy (like other complications during pregnancy such as hypertension or gestational diabetes)?

The conference and the entire initiative reflect the shifts occurring in American culture writ large. Attitudes towards illicit drug use have evolved over the past 20 years. Pew data reveals that the majority of Americans support policy approaches that emphasize medical treatment as opposed to criminalization. For instance, 63% of Americans support moving away from mandatory prison terms for non-violent drug offenses, while two-thirds (67%) support treatment over prosecution, 54% support the legalization of marijuana, and only 22% believe that those convicted of minor marijuana possession should serve jail time (Pew 2014). In addition to changing attitudes around illicit substance use, the opioid crisis has brought the realities of addiction to the fore of public awareness. By 2017, overdose deaths had exceeded 70,000 deaths,

with opioid-related overdoses accounting for nearly 50,000 deaths (CDC WONDER 2018). As rates of opioid dependency and overdose deaths increase so does the push to recognize and treat the condition as a medical problem. Yet, despite these positive changes in attitudes in recent years, there is still no uniform response in place to respond to substance use during pregnancy. Across the country, punitive state laws and policies target pregnant and postpartum substance users while federal and national initiatives promote policies that emphasize a medical and treatment-focused approach (SAMHSA 2018).

In 23 states and the District of Columbia, substance use during pregnancy is considered child abuse under state statutes. In some parts of the country, states have sought to criminalize pregnancy among drug users (Paltrow & Flavin 2013). In Alabama, laws used to prosecute methamphetamine manufacturing around children have been distorted to prosecute pregnant women who use drugs while pregnant, legally equating their wombs to meth labs (Martin 2015). In Mississippi women who use drugs while pregnant are being charged with felony child abuse and being forced to plead guilty to poisoning their fetuses (Hensley & Liu 2019). In 2014, Tennessee was the first state to make drug use during pregnancy illegal calling the offense "fetal abuse," and offering women who birthed substance-exposed neonates an ultimatum of entering drug treatment or serving up to 15 years in prison. The state's lawmakers let the bill expire in 2016 due to the disastrous unintended effects it had on maternal-fetal health, which included more women seeking prenatal care late into their pregnancies or avoiding it altogether, women birthing unassisted at home, women attempting to self-detox without the supervision of a physician (which is associated with fetal demise) and perhaps unsurprisingly, the law had no effect on reducing the actual number infants born with a drug in their system (Burke 2016).

A study carried out by attorney Lynn Paltrow and criminologist Jeanne Flavin (2013) reveals that since the passage of *Roe v. Wade* in 1973, there has been an upward trend of criminalizing pregnant women for their behavior during pregnancy. The authors argue that the strategy is a part of a larger attempt to curtail women's reproductive autonomy by granting personhood rights to fetuses. They document 413 cases of pregnancy-related criminalization (arrests, detentions, and forced interventions) from 1973 to 2005, even as they acknowledge this is an underestimation based on limited access to data[1]. Their findings reveal that race, class, and drug-use significantly predict who ends up in contact with the law. For example, most of the women legally sanctioned were economically vulnerable (71% were eligible for indigent defense) (311). Furthermore, of the 363 women for whom race demographics were available, 52% were African American (311). Finally, the use of substances was highly associated with criminalization (84% of the cases involved alleged drug use) (316). This cursory overview of the demographic trends in state interventions reveals that the most socially and economically vulnerable women are at the highest risk of having their liberties infringed upon during pregnancy. The researchers also reveal that medical providers play a pivotal part in initiating state actions against pregnant women; 40% of cases were initially reported by medical providers (i.e., doctors, nurses, midwives, hospital social workers, hospital administrators, drug treatment counselors) (327). The patient's race appears to play a deciding factor in whether or not medical providers initiate extra-clinical interventions (interventions which are not related to treatment and do not fall within the clinical scope, such as collaborating with state actors to regulate pregnant women). Illustrating this, nearly half of all interventions on black women were initiated in medical settings compared to only 27% for white women (Paltrow & Flavin 2013:327).

[1] Recent data collection efforts by the team suggest that an additional 800 arrests have been documented since 2005, putting the total number of legal interventions at over 1200 since 1973 (*see* Burke 2016).

The increasing prevalence rates of pregnancy-related criminalization are certainly troubling and suggest that the post-Roe strategy for regulating pregnancy involves an increasingly penal approach aimed at women themselves, in contrast to pre-*Roe* strategies which primarily targeted providers (Solinger 1998, 2005). Yet, arrests, detentions, and forced interventions, are perhaps the most extreme and least common state-regulatory response to pregnancy "offenses." A much more common and less remarkable approach is the use of child welfare interventions- e.g., removing children from their parents and placing them in foster care, terminating parental rights, or mandating participation in various behavior modification programs like drug treatment, counseling, and parenting classes as a condition of parental custody. The exact rate at which child welfare interventions occur in response to pregnancy "offenses" is unknown. Although data collected by the Adoption and Foster Care Analysis and Reporting System (AFCARS) estimates that over 35% of children living in out-of-home care were removed due to parental substance use (AFCARS 2016).

Despite the lack of data on child welfare interventions due to substance use during pregnancy, one may gain a general sense of the culture of intervention from federal and state laws. The Child Abuse Prevention and Treatment Act (CAPTA, 2003) federally mandates that child welfare services be contacted if a newborn infant appears to be affected by substance withdrawal symptoms. Yet, the interpretation of this federal mandate and what it means for medical providers in terms of their responsibilities to intervene on pregnant women varies widely from state to state. For example, Illinois considers drug use during pregnancy child neglect but does not specify guidelines by which to determine substance use or guidelines for reporting, leaving much room for discretion by individual providers. Mandates like these complicate the role that doctors feel they play in treating pregnant women. One study which surveyed 847

physicians (obstetricians, pediatricians, and family practitioners) found that a majority of doctors were in favor of punitive measures against substance using pregnant women, including redefining child abuse laws to include alcohol and drug use during pregnancy for the purposes of removing children from their maternal care provider (61%) (Abel & Kruger 2001). A systematic review of 28 studies exploring provider bias against substance using patients revealed that providers overwhelmingly view substance users negatively and uphold stigmatizing beliefs such as: substance users are violent, manipulative, and lack motivation (van Boekel et al. 2013).

Stigma against substance using pregnant populations promotes the belief that parental substance use poses an inherent and immanent threat to offspring. Some policy makers and scholars argue that post-birth removals are essential to preventing later abuse and maltreatment (Bartholet 2014, 1999). However, studies which have investigated the relationship between substance use during pregnancy and future maltreatment find no evidence of a direct causal relationship (De Bortoli et al. 2014). In fact, evidence suggests that it is the mere reporting of substance use during pregnancy to child welfare agencies that results in increased odds of child welfare agencies opening subsequent maltreatment cases regardless of actual physical abuse or neglect (Smith & Testa 2002). Other researchers note that prenatal drug-use is just one manifestation of the effects of poverty and typically co-occurs with other social problems such as domestic violence, unstable housing, and lack of access to quality healthcare (Marsh et al. 2006). These authors argue that substance use cannot be singled out as the primary predictor of child maltreatment when various other facets of social disadvantage are in play. Despite the lack of rigorous research indicating a clear causal connection between substance use and child abuse, the effects of child removal based on the premise of future abuse may be long-enduring. A study conducted in Illinois found that substance-exposed infants had a very low re-unification rate with

their families, only 14% of removed infants were re-united with their families within 7 years (Budde & Harden 2003).

Research on the use of child welfare interventions to respond to maternal drug use not only suggests that intervention might not be the most appropriate response to the problem but also that interventions are racially disproportionate and uneven. Several studies reveal sharp racial disparities in responses made by child protective services (Roberts 2002, Hines et al. 2004, Hill 2004, Roberts 2011). For example, studies conducted in the 1990s showed that while black women were no less likely to test positive for substances than white women, they were 10 times more likely to be reported to government agencies for their drug use (Chasnoff, Landress, & Barrett 1990). More recent studies reveal that black newborns were drug tested more often than their white counterparts; 1.5 times more likely (Kunins et al. 2007) to 2.2 times more likely (Ellsworth et al. 2010) despite the fact, that there was no racial disparity in positive results. Another early study that examined response rates across New York City hospitals, found that among women whose newborns tested positive for substances, black women were 72% more likely than white women and twice as likely as Latina women to have their newborns removed by child protective services (Neuspeil & Zingman 1993). Other studies have documented that racial disparities plague the child welfare system at every significant decision point in the intervention process (Harris & Hackett 2008, Hill 2004, Wulczyn 2003).

This dissertation tackles the question of how multiple systems and institutions respond to perinatal substance use. Reproduction and reproductive practices are at the center of the analysis. I contend that if these populations were not reproducing and bearing children they would be of little interest to the state or medical domain. Even though substance use is often presented as the problem under intervention, it is this population's reproduction that qualifies them for state

intervention and intrusion. Much like the speaker at the ILPQC conference, I argue that responses by institutional actors are intended to discourage the reproduction of this subset of marginalized women. I develop a eugenic analytic informed by biopolitics to analyze and interpret the findings that follow focusing on the ways in which power operates through reproduction and harnesses the potentiality of reproduction to create entire fields of social, legal, and economic action and intervention.

I also consider the logics and disqualifying discourses that position some substance using women as risky subjects who require carceral forms of intervention because they are deemed to be unable to adequately self-govern. While reproductive health frameworks and obstetric medicine generally treat *all* aspects of pregnancy and birth as involving some uncertainty and risk (Lupton 2012), these forms of risk are deemed to be manageable within the normative scope of medical intervention. Substance using women, on the other hand, are viewed as risky *because* they are reproducing, which challenges the notion that reproductive risk has become increasingly "universal" in a standardized way and suggests that some women are positioned as risky in ways that are socially implicated and morally contextual.

In this dissertation, I argue that the securitization and risk-management strategies used to manage substance using women are rooted in anxieties about gender and race that frame understandings of responsible reproduction and self-governance in a neoliberal era. Historian Nancy Campbell argues that women's substance use threatens gendered expectations regarding social reproduction, self-responsibility, and responsibility to dependent others (2002, 1999). The construction of women's substance use as more harmful and dangerous relative to men's, is grounded in a cultural and essentialized view of "maternal instinct" and "ideal motherhood" (Campbell 1999). Sanctions aimed at pregnant substance users are partly aimed at reforming

their behavior as gender deviance and their "failure to absorb the cost of social reproduction" (Campbell 1999: 909). However, gender and race operate together to shape representations of "ideal motherhood" and the reproduction of women of color is policed and in ways that are distinct from techniques used to police white women's reproduction. This research explores the ways that racist forms of maternal disqualification inform constructions of substance use as a threat to feminized responsibility and "maternal instinct" (Bridges 2011, Roberts 1997).

These findings also reveal that substance use and addiction are actionable but unstable categories. Is addiction a medical condition, a criminal activity, or some hybrid of the two? This study suggests that the partial medicalization of addiction has enabled a fluid, multi-institutional hybrid form of governance that is at once medical and carceral. The fusion of medical and legal systems of governance creates fissures and loopholes in which the norms, standards, and safeguards of neither system applies, leaving substance using women exposed to multiple forms of violence and violation. Several social theorists have posited that "addiction" is better understood as an historical and discursive accomplishment, rather than a scientific fact or discovery (Campbell 2007, Reinarman 2005, Tiger 2013). These findings support that interpretation and examine how the hybridity of addiction allows multiple jurisdictions to expand and collaborate in innovative ways. In the proceeding sections, I outline the theoretical frame I use to analyze this hybrid carceral form of health governance and provide a brief overview of the chapters that follow.

The Biopolitics of Reproduction

Foucault introduces biopower as a political development that emerged in the 18th and 19th centuries in response to the population explosion of the era. Consequently, it is implicitly

concerned with regulating biological reproduction (1978). Although Foucault does not explicitly name "reproduction" as a target of biopower in and of itself, reproduction is certainly the regenerative sexual process on which much of his theory of biopower rests. Biopower's task of "administering life" is achieved by targeting "sex" which sits at the "juncture of the body and population" (1978:147). This sort of power is "situated and exercised at the level of life, the species, the race, and the large-scale phenomena of population" (1978:137). Biological reproduction is the sub-textual access point to a massifying power, a power targeting population and species. And yet, reproduction is also an effective means by which to regulate and discipline individual bodies, particularly women's bodies. Therefore, biopower is the diffusion of power at two scales. One aimed at regulating population-level phenomena e.g., tracking demographic changes, birth rates, mortality rates, epidemics, etc., the other aimed at disciplining the individual body or *anatomo-politics.* Thus, as biopower expands at two poles to "invest life through in through" (1978:139), the fundamental operation of power changes as well. Biopower emerges to expand power's scope which was limited by the relation that a sovereign could have with his subjects- a power made apparent only in the act of killing, a power to "take life or let live" (1976:241). Biopower, vested in the population, is concerned with life and its regenerations, its daily activity, its health and vitality, its productivity, its capacities and resources, as well as the threats to those vital resources, threats posed by disease, illness, random accidents, death, and other energy sapping endemics. In this maneuver, biopower takes over biological life and life's environment, biopower is power vested in "making live" and "letting die" (1976:241).

In Foucault's lectures on biopolitics (1976), he outlines biopower as an assemblage of mechanisms concerned with life, death, sexuality and race. However, multiple critics have noted that Foucault's (and Foucault's interlocutors) analysis of race and death are far less developed

and integrated into his theory of biopolitics. Critics have rightfully taken Foucault to task for his lack of attention to colonialism and slavery as biopolitical regimes that predated the 18th century, his narrow focus on Western bourgeoisie cultural formations, his limited conception of genocide as particularly modern and European, and his too narrowly conceived notion of race as defined by the nation-state form (Mbembe 2003, Stoler 1995, Weheliye 2014). In order to use biopolitics as an analytic that illuminates the eugenic operation of power over the population, it is necessary to specify how reproduction as life and life's regenerations comingles with death, killing, and death-making processes. Foucault makes a distinction between two types of death, 1) death as a part of the life process, as "letting die," it is calculated via mortality rates, it is the spread of illness and disease, and the slow "sapping of the population's strength" (1976:244), and 2) death which marks the boundary of biopolitical regimes, death as killing. It is this "war-like" death which Foucault associates with State racism. For Foucault, racism is the dovetailing of biopolitical and sovereign power, it provides a dividing line between life that must be preserved and life that must die, "it is a way of fragmenting the field of the biological that power controls" (1976:255). Racialized killing has what Foucault calls a "positive relation" (or life-enhancing effects) by which the killing of racially marked groups results in more life and vitality to groups not marked for death. This breakage in the biopolitical field creates two kinds of subjects- those racialized and therefore marked for death, and the benefactors of racialized killing. Thus, the state's death function is fundamentally eugenic, according to Foucault's own formulation:

> The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species and the more – as species rather than individual- I can live, the stronger I will be. I will be able to proliferate. The fact that the other dies does not mean simply that I live in the sense that his death guarantees my safety; the death of the other, the "bad" race, the degenerate, the abnormal, is something that will make life in general healthier- healthier and purer (1976:255).

In sum, Foucault outlines two types of death, dying as "letting die" which may reflect processes of social neglect and structural violence and "killing" which is warlike, racially motivated, but also "positive" (i.e., vitality-enhancing for one group) and distinctly biological, making it a power that is eugenic at its core.

This dissertation explores the ways in which reproduction and life's regenerations comingle with death, social death[2], and exposure to death-making processes as racialized killing. Agamben refers to this blurring between "letting die" and political killing as a "zone of indistinction" (1998). Modern racism implicates many forms of bio-regulation and "letting die" from poverty and its effects, to exposure to toxic environments, to numerous other forms of political and social abandonment. Letting die as social abandonment is analytically indistinguishable from what Foucault calls "indirect murder" (1976:256) which includes exposure to death, political death, expulsion, rejection and disqualification. More explicit though, eugenic death clearly links race and death to life processes, shaping life's regenerations, letting die, and state killings. How is this zone of indistinction productive for an analysis of the regulation of reproduction? For one, it allows us to consider indirect eugenic processes, for example, how do the conditions of contemporary racism, like poverty, welfare dependency, segregation, environmental racism, unemployment, police violence, criminalization and so on, differentially affect and operate through biological reproduction? Monica Casper's biopolitical analysis of infant mortality (2014*)* speaks to this "zone of indistinction" where everyday stresses associated with surviving in a state of perpetual deprivation and navigating numerous forms of

[2] Social death has been used in a number of research contexts to describe various forms of rightlessness and exclusion, from slavery (Patterson 1982) to systems of normative valuation that reward personhood rights to groups based on their fealty to and positionality within heteropatriarchal capitalist systems (Cacho 2012). Jana Králová (2018) has defined social death as involving "the loss of social identity, a loss of social connectedness and losses associated with disintegration of the body."

domination affect lifestyle and health as well as the biological capacity to reproduce. Racial disparities in infant mortality rates in the US reflect the cumulative effects of what Elizabeth Povinelli calls "the cruddy life" (2011) or the everyday dying of biopolitics.

Reproductive justice scholars (Briggs 2002, Luna & Luker 2013, Murphy 2013, Richie 2012, Roberts 1997, Solinger 2005) and activists have argued that we must expand our understanding of reproduction to consider the myriad and nuanced ways that the death-function is deployed to control the reproduction of disadvantaged women. In the US, women of color activists spearheaded the "reproductive justice movement" (Smith 2005, Ross 2006). Reproductive justice seeks to push back against mainstream reproductive rights discourses that emphasize privacy, individualism, and rights over and above other forms of domination that can impact reproductive outcomes and health. Reproductive justice advocates recognize the narrow political pathway that an individualized rights discourse offers and the various systemic injustices that a body-focused rights agenda cannot address. These scholars have noted the ways that the prison-industrial-complex (Richie 2012), the child welfare system (Roberts 2002), poverty, unemployment, and segregation (Sillman 2004), environmental racism (Gurr 2011), government surveillance (Luna & Luker 2013), punitive and exploitative "welfare" programs (Solinger 2010), and police violence (McClain 2014, Richie 2012), disproportionately effect communities of color and especially these communities' ability to reproduce healthfully and safely. If biopower is a securitizing apparatus that ensures the health and vitality of one racially privileged group through creating pervasive forms of insecurity for non-privileged race groups, then we can understand repro-justice advocates as fundamentally concerned with the death-function of biopower. When reproductive justice scholars critique the shackling of pregnant prisoners (Davis & Shaylor 2001), the effect of police killings on the reproductive futurity of

communities of color (McClain 2014), the effects of toxic facilities siting on indigenous lands (Murphy 2013, Gurr 2011), or the effects of coercive forms of welfare provision that directly impinge on the reproductive lives of recipients (Roberts 1997), they are pointing to contemporary eugenic deployments of biopower and they are pointing to the "zone of indistinction" between letting die and political killing (Agamben 1998).

This dissertation takes a page from the work of reproductive justice scholarship and explores the operation of biopower in the investment of life and the racially motivated cuts in those investments. What marks the threshold between investment and abandonment, between security and insecurity for this population of substance using pregnant women? The War on Drugs is a powerful technology of state racism that both reinforces the securitization of the boundaries of the nation (keeping harmful drugs and the racialized importers of harmful drugs outside) while simultaneously creating an internal racialized bloc that poses a threat to national security and requires neutralization, containment, and incarceration. While the War on Drugs originally targeted urban, men of color for policing and incarceration it morphed over time to reflect anxieties concerning race and sexuality and the "pathological" reproduction of poor black women.

The crack cocaine epidemic and moral panic concerning the birth of a generation of "crack babies" demonstrates how sexuality is deployed to expand the carceral and punitive response to the War on Drugs into new domains such as the welfare system and onto new bodies (black women). Paul Amar argues that "sexuality infuses and animates the essential logics of securitized domination" (2013:20) and defines sexuality politics as "security sector struggles to discipline dangers and desires that mark the controlled boundary of the human ... rendering

overly visible race, gender, classed bodies as sources of danger and desire, [while] rendering invisible the political nature of hierarchy and the identity of powerful agents" (2013:17).

The response to substance using women illustrates this obfuscation well. As peripheral institutions of social control (e.g., the child welfare apparatus, medicine, and the therapeutic state) are enrolled to manage "high-risk" populations the line between investment and racialized killing, or exposure to death, becomes less apparent. It is this "sexualized biopolitics" by which "governance through medicine, health, and protective policing regimes meets necropolitics (the exterminatory governance of populations through war, colonialism, racism) (Amar 2013: 20-21). This research seeks to explore the operation of "sexualized biopolitics" by tracing the experiences of drug using reproductive populations through the healthcare system and penal welfare system to document how various modes of power operate on and through their reproductive capacities.

In chapter two, I contextualize this research within the contemporary post-crack era, in which responses to illicit drug use and drug crises have shifted in several ways. This chapter unpacks how the growing marijuana decriminalization effort and increased calls to medicalize addiction, in large part due to national attention on the opioid crisis, have transformed discourses and policy approaches toward illicit substance use. While there has been a cultural shift in attitudes and approaches since the crack cocaine era, this study reveals that localized responses still target substance use among low-resourced and racialized populations in ways that are mostly carceral and punitive. In this context, racism is muted (Davis 2009) and difficult to pinpoint as state actors distance themselves from the destructive and violent legacy of the crack cocaine era. Therefore, racial targeting for carceral interventions goes relatively unchecked as new discourses

that emphasize compassionate and humanizing treatment modalities predominate and shape public perceptions of responses.

Chapter three examines the relationship between medicalization and criminalization processes in the provision of care to substance using patients. Physicians report selectively drug screening and surveilling their patient populations through making "risk" assessments that are rooted in racial stereotypes about drug use and poverty. These findings demonstrate that physicians were able to fluidly toggle between medical and forensic language, logics, and assessments when making determinations about "at-risk" patients. As physicians use surveillance technologies to sort their patient populations, they reveal a dividing line, or *threshold of care*, in reproductive healthcare wherein "problem" patients are marked for intensive intervention within semi-carceral institutions that will administer their riskiness.

Chapter four explores the dynamics on the other side of the clinical handoff. What happens to patients who have been deemed a threat to their offspring by the medical establishment? These findings document local responses to substance using pregnant women and reveal some of the inner workings of privatized poverty management programs. State child protective programs and private social service agencies work collaboratively and in mutually beneficial ways to manage at-risk substance using women. The findings reveal that these semi-carceral programs function to *sustain* the dependency and immobility of the women within them while providing little in the way of life-enhancing or mobility-enhancing resources. I argue that reproductive and maternal status becomes the primary means by which these institutions coerce compliance from their clientele and in so doing reflects a form of eugenic biopower in which the control over life and regeneration processes operates alongside technologies that administer "slow death" [defined by Lauren Berlant variously as "the condition of being worn out by the

activity of reproducing life" (2007: 759), "populations marked out for wearing out" (2007: 761), and "the physical wearing out of a population" (2007: 754)]. This work demonstrates that processes of wearing out become competitive and profitable techniques fostered and deployed by private institutions.

Finally, this research considers the ways in which substance using women experience the institution of motherhood – particularly when multiple institutions and forces are acting upon and disciplining women through their reproduction and maternal status. Chapter five explores how motherhood is embodied by marginalized women and documents the complex feelings and ambivalence this group of women has toward reproduction and motherhood. How is motherhood experienced among a population whose oppression and social subordination is linked to their reproductive activity? This chapter uses women's own accounts of pregnancy, birth, and raising children to explore the ways in which women who are unable to gain entry to "ideal motherhood" through "respectable reproduction" build relationships with their children and create maternal identities.

This study engages with and seeks to contribute to a field of critical scholarship which examines the ways in which reproduction is inherently political, racialized, classed, and paramount to state interests (Bridges 2011, Briggs 2002, Roberts 1997). The particular form of power I hope to elucidate acts upon reproducing women in particular and acts differentially and selectively based upon class, race, and other social and cultural factors. This study will contribute to our understanding of what has been referred to as processes of "exclusionary inclusion" (Decoteau 2013), "bioinequalities" (Fassin 2009), and "biological sub-citizenship" (Sparke 2017) or the unequal distribution of essential and life-sustaining rights. The following chapters underscore that "the reproductive body is a key element of any theory on the limits of

citizenship" (Latimer 2011) and documents the rise of a form of carceral health governance that employs securitization techniques aimed at protecting offspring in order to make marginalized populations less secure.

Methods

Analytic Approach

I use a grounded qualitative approach informed by feminist situated knowledges epistemology. Donna Haraway outlines its core features as an epistemology (1988): 1) that it is local, contextual, and always partial, 2) that it is an approach that makes claims on and through bodies and lives and that these claims are always contested, complex, contradictory, structured and structuring, and 3) that the object of knowledge should be pictured as an actor and agent not a screen or a ground or a resource. Adele Clarke has sought to expand the epistemological foundations into a methodological approach, integrating it with grounded theory approaches and aligning it with post-modern thought (2003). For Clarke, a situational analysis builds upon the interpretivist, perspectival, and constructivist traditions of grounded theory (Charmaz 2007) but expands them in significant ways to allow for researchers to contend with the differences and complexities of social life. Clarke suggests that the social process/action metaphor in traditional grounded theory must be supplemented with an "ecological root metaphor of social worlds/arenas/negotiations" that "allows situational analysis at the meso-level, institutional level, as well as individual-level" (558). Specifically, Clarke's framework builds upon grounded approaches by extending the analytic frame beyond "social processes" and seeks instead to make the "situation" the unit of analysis, incorporating both human and non-human actors, discourses and other elements. In addition, situational analysis expands traditional grounded approaches by

considering the social worlds and arenas that the situation is in. Meso-level maps of the situation allows for an analysis of institutional-level discourses and collective actions, without bounding action or creating directional hypothesis regarding which way actions flow. Clarke's situational analysis which promotes an unbounded interrogation of specific "situations" lends itself to the multi-sited ethnographic approach.

I conducted a multi-sited ethnography to understand responses to perinatal substance use. Multi-sited ethnography allows the researcher to pursue the "situation" under investigation by following people, narratives, and objects as they move across place and time and between levels of analysis (Marcus 1995). Multi-sited ethnography enables engagement with both discursive objects such as "addiction," meso-level analyses of institutional processes, and the portrayal of the intimate details of people's lives. This multi-sited ethnography examines the situation (responses to perinatal substance use) at three distinct scales; the systems-level which enables an analysis of the organizing structures and discourses that frame the situation, the institutional level which provides insight into the local and spatial arrangements that constrict and define women's mobility as well as the institutional logics that shape their subjectivities, and the individual level which allows an understanding of the ways in which the situation becomes embodied and articulated as lived experience.

Field site

I conducted this study in the city of Chicago. The child welfare system in Chicago is noted for its long, troubled history for disproportionately separating black families. Dorothy Roberts carried out fieldwork in Chicago over 15 years ago for her investigation of the child welfare system (2002). Along with interviews and ethnographic fieldwork she compiled statistics from a number of reports and found troubling trends: not only had child welfare caseloads

increased since the 1980s, tripling in size, but over 95% of the children placed in foster care in Chicago were black. The storied past in Chicago lays a rich historical backdrop of all sorts of activity and institutional configurations actively involved in responding to substance using pregnant women and mothers. This project takes that historical backdrop and considers the ways in which responses have evolved and adapted since the crack cocaine era of the 1980s and 1990s.

The legal landscape is also unique to Chicago. The state of Illinois classifies giving birth to a substance-exposed infant (SEI) as prima facie evidence of child neglect (Abused and Neglected Child Act of 1975). While this rule certainly expands the scope of state intervention it is tempered somewhat in Chicago by a program that manages cases of reported SEIs. DCFS fields SEI hotline calls and diverts a proportion of reported cases to a DCFS-funded program, Keeping Families Together[3] (KFT) is administered by private agencies which offer long-term case management and drug surveillance to women in the program. The Keeping Families Together program illustrates an innovative public-private collaboration that targets women based on their reproductive status and offloads some of the intervention activity of DCFS. I examine this program in-depth in chapter four and consider how programs like Keeping Families Together may represent the future of welfare provision in the US, by which welfare becomes increasingly privatized and punitive.

Methods

I rely on a range of varying sorts of data sources in pursuit of understanding how and in what ways systems come together to punish and discipline women for reproducing (while poor, while black, while on drugs). I conducted qualitative interviews to draw conclusions at each level of analysis and conducted a total of N= 86 interviews (N= 63 formal and N= 23 informal

[3] The names of the programs and organizations presented in this dissertation have been changed to protect the identities of the individuals who participated in this study.

interviews). I also relied upon various other documents including policy statements, state statutes, DCFS reports, and organizational products like educational PowerPoints in order to analyze how institutions respond to substance use during pregnancy.

System-level analysis

I conducted qualitative interviews with experts from around the country in order to gain insights into systemic and historical responses to substance using women. I employed a purposive sampling approach wherein I personally reached out to (via email correspondence) individuals who are publicly recognizable experts in the field of maternal addiction medicine or figures who held leadership positions at organizations that address drug policy and maternal health or drug policy and child welfare. In addition, I reached out to local authorities who were directly involved in administering programs that targeted substance using women. Oftentimes I would request, or participants would offer, referrals to other experts in the field that I could interview for this project, consequently, several of the subjects in the expert sample were contacted through snowball methods. Very early in the interview process I learned that the field of maternal addiction experts was small and insular, despite being over 30 years old, as I was frequently referred to the same experts. Nonetheless, the national and local experts I spoke to represent a diverse set of actors, with varying degrees of expertise on the population under study. I conducted a total of 21 "formal" interviews with experts in which interviews were semi-structured, recorded, and transcribed and a total of 23 "informal" interviews in which interviews were carried out to glean supplemental information about particular processes, laws or statutes, or the intricacies of a system I was examining. When participants were local, I arranged to meet in person if possible, however, many interviews in this subsample were conducted over the phone.

The expert sample is eclectic and heterogenous. It includes experts in maternal addiction medicine- often these were medical doctors who became interested in the population through their practices. These experts were invaluable as they provided insights into the history of the field of maternal addiction medicine and the various shifts that have occurred over time in drug policy and medical approaches to the population. The sample also included researchers, drug policy experts, child welfare policy experts, lawyers, state legislators, DCFS staff, child welfare supervisors, substance treatment providers, addiction recovery peer advocates, journalists, local public health officials, and parents' rights advocates. The heterogeneity of the sample is a strength and weakness of this study. Although I am not able to generalize about my sample of experts, the diversity does enable a more representative lay-of-the-land, essential for carrying out a system-level analysis. The data provided by my sample of experts directed my attention to the mosaic texture of the situation at hand and the various actors, places, ideologies, and debates that frame responses to perinatal substance use.

In addition, I contextualized many of the findings reported here with additional data gleaned from policy reports [reports published by the state and city departments of public health, federal drug policy guidelines and reports produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), programmatic and promotional material published by national organizations that work at the intersections of child welfare and drug policy (e.g., National Center of Substance Abuse and Child Welfare), and policy statements published by addiction medicine organizations (e.g., American Society of Addiction Medicine], state statutes and child welfare procedures and allegations rules and DCFS assessment materials, and numerous reports, white papers, and meeting notes from working groups published about responses to the opioid crisis and drug use patterns at the local level.

Interviews with medical experts

I also conducted interviews with medical actors directly involved in the provision of care to substance using pregnant women. I selected 5 hospitals in the Chicagoland area as recruitment sites. These sites were selected because they serve distinct patient populations (in terms of race-ethnicity and class) and included: 1 safety net hospital, 1 teaching hospital, 2 private hospitals, and one small community hospital. Each of these hospitals had publicly available contact information for their obstetric and neonatal physicians. I sent emails to all of the providers whose contact information was accessible (N=116) to invite them to participate in an interview about their "observations and experiences managing" substance using patients. The cold-call email recruitment resulted in a total of 12 participants confirming and scheduling a time to meet with me in-person for an interview. An additional 9 participants were subsequently recruited via snowball sampling, for a total of 21 interviews. The final sample consisted of ob-gyns, neonatologists, neonatal nurses, hospital social workers, and pediatricians.

I conducted in-person, semi-structured interviews with participants which lasted on average 45 minutes to an hour, with the longest interview spanning over 3 hours. The interview schedule centered around the provision of care for substance using patients including questions regarding how substance use was determined, drug screening and testing practices, hospital procedures and protocol for treating the population (and their infants), and providers attitudes towards child welfare involvement.

Interviews with women

For the sample of women who had experienced child welfare interventions during pregnancy, birth, or postpartum I used a targeted sampling technique and isolated my recruitment efforts to two local sites, the Downtown Recovery Center and Community Treatment First. The

Downtown Recovery Center was a site I learned about from DCFS supervisors who explained that it specifically housed women who had been reported to the state for giving birth to a substance-exposed infant. Community Treatment First is one of the few treatment providers in the city that offers residential inpatient and residential recovery for women with small children. At both sites, I provided recruitment flyers seeking the participation of women who had given birth in the last five years and were willing to speak about their experiences giving birth, interacting with medical providers, and parenting. I offered a $45 gift card to participants for their time. Twenty-one women participated in interviews.

The sample (N = 21) was racially and ethnically diverse; 10 women were black, 6 women were white, 4 women were Latina, and 1 woman was Arab. The respondents skewed slightly older, the youngest was 26 at the time of the interview and the oldest was 43. There were three women in their early 40s at the time of interview, each of whom had their last child in their 40s. Although I did not ask for women's income or SES information, over the course of an interview almost of all of the participants had expressed that they were financially dependent, several had experienced homelessness recently and most were unemployed at the time of the interview. The sample was also somewhat sexually diverse, as 3 women identified as bi-sexual and/or otherwise expressed that they had engaged in intimate romantic partnerships with women as well as men.

Interviews were conducted at the site where the participant resided, either Downtown Recovery or Community Treatment First (with the exception of one interview which was conducted at a public library), and generally lasted one hour in duration, although a few were considerably longer (2-3 hours in length). The interviews were loosely structured in order to allow women to tell their stories as they saw fit. As a result, interviews organically assumed the structure of a life history interview. For example, I might start the interview with the statement:

"tell me about your childhood" or "tell me about where you grew up" which would frequently result in respondents describing their life narrative in a somewhat linear fashion starting with family dynamics, early traumatic experiences, social networks, intimate relationships, introduction to substance use and experiences parenting. Since I was interested in their experiences interacting with medical providers and institutions of social control and their experiences of pregnancy and parenting, I would often probe and follow-up when respondents touched on those topics in order to gain greater clarity into the details surrounding those areas of their lives.

Limitations and considerations

My interest and background in this population (substance using pregnant populations) emerged while I was working for a legal reproductive justice non-profit organization, National Advocates for Pregnant Women (NAPW). Through the work being carried out at NAPW, I learned about the multitude of back channels that reproductive rights foes wield to punish women for their reproduction including the criminalization of drug use during pregnancy. I became interested in child welfare interventions as a form of state interventions on pregnancy-related behaviors partly because they are a form of intervention that is legally opaque and generally less visible to the public than criminalization. When I returned to grad school, I wedded this interest with my interest in medical sociology to devise a study that examines how medical care providers and state actors within child protection agencies come together to manage and discipline the reproduction of this population. There is no doubt that my personal background and political stance towards this topic shaped the research design, interview questions, and ways in which I conducted interviews for this project. For example, with medical actors I would often approach interviews in a value-neutral manner, however, I would interject

questions that were designed to challenge the taken-for-granted nature of child welfare interventions in medical practice; for instance, “do you think the statute designating substance use during pregnancy as child neglect is an appropriate use of the law” or “do you find child welfare interventions to be appropriate in the context of pregnancy and post-natal care practices?” While it is likely that such questions revealed some of the underlining positions I hold as a researcher (by implying that such interventions could be anything but appropriate), these proved to be revealing moments in interviews because they positioned state interventions in medical care as political and disrupted normative narratives around medical care as neutral or solely clinical.

In contrast, before I sat down to conduct interviews with women who had experienced interventions during pregnancy, I would inform them of my background in advocacy work and express an understanding of the ways in which women who use substances are often stigmatized as mothers. These gestures were intended to facilitate communication and open-up areas of conversation that may otherwise have been avoided for fear of judgment. In addition, interviews with mothers presented several challenges that I had to approach with some flexibility and openness. For example, because I conducted interviews at the facilities where participants resided there was often very little control over the conditions of the interview setting. Lacking temporary childcare options, several women had to bring their young and sometimes restless children with them to the interview. From time to time this proved to be difficult as interviews were disrupted multiple times to address their needs. On days when the weather was permitting, I got into the habit of offering to conduct interviews outside (one facility had a playground area), this allowed children to play while I interviewed their mothers. This also allowed women to

speak more freely about the living conditions of the facilities as they were fully out of earshot of staff and other residents.

Although I was initially concerned about my positionality as a researcher (privileged, educated, white cis-woman) and the ability to gain the trust of marginalized women as I asked about the intimate and vulnerable details of their lives, I believe I had multiple factors working in my favor that reduced some of those social tensions and initial concerns. First, I soon realized that the women in these facilities fluidly and comfortably recounted their life stories and past traumas. I began to notice similar narrative arcs across interviewees such as "initiation into drug use" "past traumas" and "turning points." Upon reflection, this is likely due to the fact that residents in treatment and recovery programs spend a considerable amount of time in therapeutic "groups" in which they repeatedly recount their biographies. As a result, for the most part, respondents seemed relatively comfortable being interviewed despite the fact that I was an outsider with a notebook and tape recorder.

Due to time-related constraints the size of my sample of medical actors is relatively small (N=21), particularly given its diversity (across multiple institutions and sub-specialties). As a result, the claims I am able to make are constrained to the level of individual actors and are not intended to be generalized to all medical practices [particularly since responses to perinatal substance use varies widely at every level of analysis (Drescher-Burke & Price 2005)]. Regardless of this limitation, these findings, though reflective of a limited and heterogeneous sample of medical actors, reveal a pattern of extra-clinical evaluations (evaluations beyond the medical scope) being used to incriminate and mark high risk patient populations for state interventions and such activity is occurring across institutions. In the future, I expect to conduct more interviews with medical actors to fully round out this dataset and am planning on

expanding this study and collecting data in another Midwest city to compare approaches towards perinatal substance use (as I note in chapter two, the opioid crisis has not affected the city of Chicago to the same extent as it has other Midwest areas. Thus, I hope to document some of those regional variations in a future study). Finally, this research is a study of local responses to perinatal substance use. Many of the programs I analyze are specific to Chicago and cannot be generalized to other large urban areas. While specificity allows a rich understanding of local systems and groups it does limit generalizability. This analysis and findings presented in the chapters that follow generalize to theory and broader patterns of inequality and exclusion and are not intended to describe the experiences of any one group or system beyond the local parameters of this study.

CHAPTER TWO: HISTORICAL DISTANCING AND RACIAL DENIAL: MEDICALIZING OPIOID DEPENDENCE, NORMALIZING MARIJUANA, AND FORGETTING ABOUT CRACK

When I started collecting data for this project, it seemed that everywhere I turned to gain some understanding of institutional responses to perinatal substance use in Chicago left me with more questions than answers. Taking the national conversation and daily news coverage about the opioid crisis as my cue, I was certain that health and state officials in Chicago would be brimming with stories from the frontlines of the new, highly publicized drug crisis and the ways in which pregnant persons were specifically affected. Yet, my initial meetings and interviews with experts did little to shine light on the situation. Conversations with researchers in social work, medical providers who worked with DCFS, and epidemiologists at the Department of Public Health all took on a similar theme- a shared lack of knowledge about *current* responses to substance use during pregnancy and the emergence of a common refrain that whatever was happening now was an improvement upon "the old response." *The old response*, of course, was a reference to the crack cocaine epidemic of the 1980s -1990s during which low-income pregnant women, overwhelmingly black women, were systematically and aggressively targeted by medical and state actors and often non-consensually drug-tested during labor. If drug use was suspected, the state swiftly removed newborns at birth.

Ms. Sellers, a grassroots activist in Chicago advocating for parents navigating the child welfare system, was inspired by her own experience during the height of the crack cocaine crisis to help women like herself. In 1995, Ms. Sellers went into labor with her son. She arrived at the hospital with contractions and was kept on strict bedrest for 2 days while she labored. The hospital staff informed her that she would not be able to leave the bed even to go to the bathroom

and made her use a bed pan during the two-day period of forced bed rest. Unbeknownst to her, the medical staff had been collecting her urine from the bed pan and testing it without her consent or knowledge. After she delivered her son, she held him briefly before he was taken to the nursery and put under observation. When Ms. Sellers asked to see her baby the nursing staff informed her that she could not because she had tested positive for cocaine and if she wanted to see her baby before DCFS came to take him, she would need to visit him in the nursery under the supervision of hospital security. She spent her last moments with him under the watchful gaze of an armed security guard. Harrowing stories like, Ms. Sellers' were what my respondents referred to when they mentioned what happened "years ago" and "the old response".

During the "crack craze" doctors and the state alike had been mobilized and emboldened by "bad" science. The findings of Dr. Ira Chasnoff claimed that crack cocaine use during pregnancy would have life-long, detrimental developmental effects on offspring (Chasnoff et al. 1985). Today, Dr. Chasnoff's research is often skewered in introductory research methods courses as a cautionary tale about poor research designs and the limits of small sample sizes. However, at the time, his findings provided a scientific permission structure for medical practitioners to treat perinatal substance use as a form of abuse and neglect. One of my respondents, a physician who had worked closely with DCFS for over 25 years, explained that in Chicago in the 1990s, they were so impacted by research like Chasnoff's that they were removing infants at birth and placing them in long-term care facilities and other "centers" where they would remain connected to monitors for months on end before being placed in foster homes (Expert A, Interview, 5/3/2017). The aggressive response was in part a result of Chasnoff's over-blown and much-hyped findings suggesting irreparable damage, yet when researchers sought to replicate his findings and track the developmental outcomes of crack-exposed infants they found

little evidence to support his initial claims. One longitudinal study followed the outcomes of crack-exposed infants for 23 years and found that they were not significantly different from their non-exposed peers cognitively, developmentally, or emotionally (Hurt et al. 2009, 2005, 1997).

Images and stories of babies warehoused in long term care facilities, hooked up to monitors, and of women being secretly drug-tested, align with the findings that emerge from Dorothy Roberts' examination of the Chicago child welfare system during the crack-cocaine era. In *Shattered Bonds,* Roberts reveals that large urban cities like Chicago and New York became social laboratories for the expansion of child welfare systems' power to intervene in the lives of low-income families of color. *Shattered Bonds* depicts the chaos caused by racist removals at birth, which not only wreaked havoc on black communities, but resulted in such extreme bloat in the state foster care system that it was nearly brought to the brink of collapse. In Chicago in the 1990s, "9,164 parents lost permanent custody of their children between 1993 and 1997…. Terminations grew from 958 to 3,743 in that period, meaning that three out of every five cases ended with parents losing custody" (Chicago Reporter, 1997). Of these, 95% of the children in DCFS custody were black (Roberts, 2009). The explicitly racist practice of removals at birth for cocaine exposure has had lasting effects on DCFS's public image. Individuals who work with and within the agency that I spoke with for this study expressed a desire to rehab the agency's reputation by promoting a new ethos of "keeping families together and intact" and seemed to internalize some of the language of their critics who have pointed to their racially disproportionate policies.

The traumatic, not so distant, past of the crack response became background texture in my interviews with long-time experts. For people who had worked in Chicago during that violent period, the response to crack cocaine functioned as a kind of aberration to be disavowed, a

system failure frozen safely in the past, a repository of overreaction and racially-charged bad instincts that could be mined to demonstrate progress in the present tense. Medical providers', experts', and child welfare workers' historical distancing from the crack cocaine panic presented an illusion of resolution. In addition, my attempts to understand current responses to perinatal substance use were thwarted both by a lack of public data and a lack of interest among public officials. As I searched for data and information regarding current responses to substance use during pregnancy in Chicago, I encountered numerous dead-ends. A search for data on the number of child removals due to parental substance use – data reported bi-annually by each state to the national Adoption and Foster Care Analysis and Reporting System (AFCARS)- revealed that the state of Illinois stood out as an outlier, reporting a total of *zero* removals for substance related issues. A search for data collected at the state level turned up similar results. A state official shared with me that data pertaining to substance-exposed infants was not shared with the public because it did not represent the "real numbers" of substance exposure at birth but was instead an indicator of drug testing practices of providers which, she added, were racially-biased (Expert B, Fieldnotes, 3/1/2017). I spoke with officials at the Department of Public Health who, while sympathetic to the barriers that pregnant populations might face seeking treatment and care, explained that they were not aware of current responses to perinatal substance use and that their primary population of concern was homeless men. Even my search for grassroots activists organizing around this issue turned up few results, just a few Facebook groups with names like "Stop DCFS corruption" and Ms. Sellers' small organization, Families Organizing for Child Welfare Justice. I asked Ms. Sellers why she thought that there was a lack of grassroots organizing for parents experiencing this issue and she explained that grassroots organizations, like her own, were simply out-funded by DCFS which contracted with or ran most of the parent

advocacy groups in Chicago. From the state, to the institutional, to the grassroots-levels it appeared that the "problem" of substance use during pregnancy had been muted, if not resolved, disappeared. Yet, as I continued my search and began speaking with people on the ground, not just state officials and experts, but neonatologists, obstetricians, hospitalists, social workers, case managers, and substance treatment providers, I learned that the silence around responses to substance using pregnant women was not evidence of resolution but rather was the quiet lull that accompanies a shift, a re-organization in ideologies, practices, institutions, and knowledge production.

I found that responses to substance use during pregnancy in Chicago had two faces, a public and a private face. The public face was one that had evolved from the "crack craze" of the 1980s and 1990s. It was concerned with stigma and education around addiction as a "brain disease." The language of addiction needed to be closely managed- "substance abuser", "junkie", and "withdrawal baby"- were words to be avoided. The public face was concerned with solving the BIG problem before it- the opioid crisis- the problem required harm reduction strategies, public education initiatives, NARCAN administration, Medication-Assisted Treatment (MAT) programs, multi-institutional collaborations, evidenced-based approaches. Yet, under this public face the private response was one of continuity, black and brown, low-income women were still indexed for state interventions through coercive and differential drug testing practices within medical settings. In my interviews with medical providers the shift was apparent in the ways they discussed how responses varied by substance type. Substance type became a stand in for race. In what were typically highly, racially-coded conversations, I learned to place certain drugs in racial categories (despite research that demonstrates that white and black drug use patterns are similar (Rothwell 2014)). Cocaine and PCP, for instance, were described as more illicit,

associated with criminality, poverty, and blackness. Marijuana, on the other hand, had become confounding from the clinical perspective. Clinicians noted that marijuana use was ubiquitous and transcended racial lines, more women were openly admitting to using marijuana during prenatal visits and given the culture of decriminalization and growing acceptance of the drug, doctors and medical staff struggled to shape their responses to perinatal marijuana use. Opioids assumed a kind of duality – heroin was often parsed from other opioids and described as more identifiable, problematic, and "urban", while prescription narcotics and "pain pills" were often framed as difficult to detect and hidden in plain sight among privileged, white, suburban populations. Oddly, heroin users were rarely figured as part of the "opioid crisis" that medical providers were recently called upon to attend to. As one physician who practiced at a public teaching hospital explained:

> I mean we keep talking about this "opioid crisis," but we just um…I don't think we really believed it. I don't know…I just don't think people really believed it. The other thing is that in the city, people have this thought of: "oh, these people are gonna…it's gonna be *these* people on heroin." But I mean it's a lot of patients who are taking prescription drugs. And I think we're kind of underestimating that for those patients. I think it's really easy to say: "oh, this patient's on heroin, you know, this is a problem." But I think we're under…I think we're normalizing people being on prescription medication.

I was struck by the repeated claim by providers that "the opioid epidemic" did not exist in Chicago. Some physicians described the situation as you might a storm on a weather radar- as something that was deadly, and for which one ought to be prepared, but had yet to arrive. Others thought that "the opioid crisis" was happening on someone else's turf. Providers in private institutions thought that it was affecting low-income communities in segregated parts of the city while providers at public hospitals that serve low-income populations thought it must be happening at private hospitals where white, affluent patients went for care. The uncertainty surrounding the "opioid epidemic," the demographic traits of the groups believed to be most

affected, and the discordance between the ways it was discussed at the national level and its localized dimensions created an overwhelming sense of confusion regarding opioid use patterns in Chicago. Accounts like the one above, in which heroin use is described as somehow distinct from "the opioid crisis," reveal the classed and raced parameters of the crisis in the medical imagination. The opioid crisis is made visible or invisible in racialized ways. The "pharmaceuticalization" of the opioid crisis situates the crisis as particularly medically-implicated and seemingly race-neutral, yet the race-neutral face of "the epidemic" obscures the ways that drug policy implements a racially segregated response for white users (Netherland & Hansen). A recent report published by the Chicago Urban League entitled "*Whitewashed: The African American Opioid Epidemic"* demonstrates that despite national media coverage and policy initiatives that typically portray the opioid epidemic as overwhelmingly affecting white, suburban populations, the opioid epidemic (including heroin use) disproportionately affects impoverished black communities in Illinois and has resulted in a 132% increase in overdose deaths among African Americans in the state over a three-year span (2013-2016). On the surface, it appears that the national discourse which has coded the opioid epidemic as white helps to elide the way the crisis manifests across different localities and among non-white populations. In other words, the search for the great white opioid crisis has left low-income communities of color in the lurch.

The use of drug type as a proxy for race and class is by no means novel, US drug policy is rooted in the racial tensions and the history of the country. Critical drug policy scholars have noted that the racialization and criminalization of drugs are co-constitutive processes (Campbell 2002, Netherland & Hansen 2017). Racial anxieties about miscegenation have been deployed to shape drug policy since the passage of the Harrison Act in 1914, which used racially-charged

claims against Chinese immigrants and Southern black populations to promote a program of prohibition (Campbell 2002). While racial animus sustains efforts to criminalize substance use among populations of color, drug policy and regulation simultaneously function to carve out a protected, decriminalized space for white drug consumers (Netherland & Hansen 2017). The opioid epidemic bares the contours of this dynamic in high relief – markets, technologies, and policies are systematically rolled-out to protect white drug users from punitive action and to ensure that their substance use behaviors are medicalized. As Netherland and Hansen note: "[w]hen addiction is framed as a brain disorder, rather than a crime, its cultural work to racially recode prescription opioid addiction as White is unrecognized. This ultimately leads to a bifurcated discourse of White addicts as having a 'brain disease' and needing 'treatment', and of non-White addicts as 'criminals' that require incarceration to protect the public" (2017: 7).

The use of racially-coded language to describe substance using populations demonstrates the potency of racial labelling. Dana-Ain Davis describes how neoliberal, color-blind ideologies rely on racially-coded language to maintain racial hierarchies while simultaneously making racial inequality incoherent (2007). Davis' work illustrates that culturally manufactured terms can carry over into multiple contexts to denote racial devaluation. Certainly, racialized labels pervade drug discourses and drug policy. For example, news and media outlets attempted to brand the methamphetamine and opioid crises by way of indexing the racialized language of "crack babies"- referring to affected infants as "meth babies," "oxy tots," and "opioid orphans." Critics have called out such labeling as problematic and stigmatizing (Copeland 2014) yet, these linguistic heuristics have been limited in their capacity to mobilize the kind of moral panic and carceral response witnessed during the height of the crack cocaine epidemic. This non-transferability of racially-coded labels speaks to the unidirectionality of racial-indexing projects.

Racially demeaning labels lose their stickiness when applied to predominantly white populations who are otherwise socially inoculated from the meanings associated with the labels. "Crack baby" was a signifier for a much larger, pervasive racial project taking place during the 1980s and 1990s which intended to problematize black women's reproduction as "heterodegenerate" (Davis 2007) and associated black reproduction with various forms of social disorganization, community-level violence, family disintegration, and criminality (Roberts 1999).

The incommensurate response to the opioid crisis was not lost on some of the medical providers that I spoke with. In particular, black practitioners were most likely to point to the stark contrasts between the crack and opioid epidemics. Dr. S, a black obstetrician who worked at a public hospital explains how the aggressive response to the crack epidemic aligned with malignant representations of black communities while the opioid epidemic does the work of deracinating opioid use by locating it within the medical purview:

> [In the 80s], it was incarcerate them. They were superpredators. They're…you know. It wasn't seen as an addiction. It was seen as a criminal act. And now, you know, we need to spend money…oh, prescription…prescription. Oh, we need to help them; it's an addiction. We need to have all this support and da-da-da. We don't need to jail them. And I'm like crack cocaine is no different than…Just because the doctor's writing it on a script, it's the same addiction.

The frustration expressed by some black physicians with the current response toward the opioid epidemic did not appear to be rooted in an underlying stigma toward drug use writ large but rather was an acknowledgement that current attempts to humanize addiction are dependent on the race of the user. The adage that "addiction does not discriminate" rings hollow for those with personal and institutional memories of the response to the crack cocaine crisis. Dr. A, a young black maternal fetal medicine physician, shared that she struggled to adjust to the "new response" toward treating opioid use as an addiction rather than a criminal behavior. For her, the

new response papered over the unresolved racial violence imposed upon black communities during the crack cocaine epidemic:

> I just feel very…sometimes very incensed by this…the notion of an opioid crisis. And I feel…on one hand, I feel like that's really horrible for me because I think it's terrible that I…I…maybe lack a little bit of empathy towards this…this addiction. And I think, I don't like that part of me. But on the same token, I get very upset when I think about just when I was growing up—and also it's from the perspective of a child—of seeing the crack epidemic, and how many people that affected, and how many children that affected, how many families were basically torn apart. And I feel like with this epidemic, we're doing a lot more to try to keep families together, and like restore the home that was broken up by this terrible medication, when before we were tearing families apart. And it just…it just bothers me to my soul.

The response to crack cocaine haunts contemporary responses to the opioid crisis whether it's in the form of distancing and denouncing former responses as the legacy of a racist past or whether it took the form of reckoning with the ways in which the former system of racial reproductive disinheritance was never fully resolved. For these physicians, "the opioid epidemic" is clearly a response to *white, middle class* struggles. Therefore, although heroin is an opioid, and despite the fact that heroin use rates are nearly identical among whites, blacks, and Latinos (Martins et al. 2015), the vestiges of the War on Drugs have effectively associated heroin use with low-resourced, "Black urban dwellers" (Bechteler & Kane-Wallis 2017, Netherland & Hansen 2017). Thus, when I encountered the language of the "opioid crisis" in my research, it was coded as a "white" object and extricated of racialized associations including heroin. This research updates contemporary knowledge about responses to perinatal substance use in a post-crack era, in a city that was particularly impacted by the institutional response to the "crack epidemic" and still reverberates with traces of its destructive legacy.

There have been two major localized system-level changes in response to perinatal substance use in Chicago. The first is the very recent emergence of a medical quality improvement initiative that seeks to equip providers to respond to perinatal opioid use. The

second is the creation of a DCFS-funded program called Keeping Families Together program which enlists private agencies to monitor families that have been indicated for child neglect due to substance exposure in utero. These two programs represent the two sides of the shift in responses to perinatal substance use. The first, represents an attempt to medicalize certain addictions and protect privileged substance using populations from poor treatment in the medical system and the second, is the continued, but less visible, involvement of semi-carceral, surveillance systems for less-privileged substance using populations.

In early 2018, I learned of the state-wide Illinois Perinatal Quality Collaborative initiative focusing on Mothers and Newborns Affected by Opioid Use Disorders (ILPQC MNO). The initiative seeks to develop protocol for physicians treating pregnant people with opioid use disorders and their infants. There is much to laud about the ambitious initiative as it tackles many fronts of perinatal opioid addiction including: the roll-out of recommended protocol for treating pregnant opioid users, the promotion of validated screening tools to assess the risk of opioid use disorders, referral resources that point providers to MAT programs in the state, and updated non-pharmacologic approaches to treating neonatal abstinence symptoms (NAS) in newborns withdrawing from narcotics. Yet, by singling out *opioid use disorders* (OUD) as the targeted intervention the initiative excludes other substances and thus, other substance using populations from this medicalized approach. This exclusion may seem irrelevant as one might expect that institutionalizing and standardizing responses to opioid use will naturally, positively impact responses to other substances in a trickledown fashion. Yet, as I found in my conversations with providers and experts, the highly-racialized nature of substance use (even within the opioids family) portends a two-tiered system for responding to perinatal substance use, in which opioid use- narrowly defined as prescription pain pill dependence that affects predominantly white,

resourced populations- has a greater likelihood of being managed medically with an emphasis on treatment and therapeutic recovery while other forms of substance use will continue to be managed by punitive, semi-carceral systems.[4]

The Keeping Families Together (KFT) program launched in Chicago in 1998 and was intentionally designed to act as a catchment for women identified by medical providers as having substance-exposed newborns. Rather than automatically removing substance-exposed infants at birth via the child protection arm of the state this program offered a solution for reducing DCFS caseloads and addressing the unsustainable crisis plaguing the foster care system. The program allows parents to keep custody of their children while they are enrolled in a long-term drug surveillance program. While the program is technically "voluntary" women are often coerced into enrolling in the program as an alternative to traditional DCFS involvement, court involvement, and the possibility of losing custody of their children. KFT is administered by several private agencies throughout the city and provides women with case managers who conduct spontaneous and unannounced home visits and regular urinary toxicology screens or "drops." Once women have demonstrated that they can produce "clean drops" for up to one year, they are discharged from the program. The Keeping Families Together program allows DCFS to claim that they are "keeping families intact and out of courts" while also reducing their own caseload numbers. In addition, because the program is administered by private agencies that sub-contract with DCFS it obscures the ways in which poor, substance using women are treated within an increasingly privatized sphere of poverty management services. I interviewed both individuals who administered the Keeping Families Together program and women who were

[4] It should be noted that this assessment of the quality initiative is an optimistic forecast. As I note in the introduction, when I attended the annual conference for the perinatal network, I was struck by the mixed messages that were presented regarding medically treating addiction versus policing pregnant substance users.

currently or had previously been enrolled in the program. The findings presented in chapter three unpack the ways in which the War on Drugs is still silently being waged on low-income communities of color within the private social services sector. The Janus-faced response to perinatal substance use, the medicalized approach of the ILPQC initiative and the discipling approach of the Keeping Families Together program represent two very different approaches toward the same problem.

This study attempts to contextualize current responses to substance use during pregnancy by bringing these local and historical dimensions into view. One could argue that new approaches to perinatal substance use, medicalization in the case of opioids, normalization in the case of marijuana, and privatization in the case of the re-scaled drug war on poorer, darker populations of substance users, are all still improvements upon the previous response to crack cocaine and indicate social progress. However, my findings suggest that it is the contradictory, racialized, and highly differential treatment of substance use during pregnancy that belies a pattern of *continuity* in responses. While responses are certainly more complex and multi-faceted, race and class *still* largely determine whether women will be punished and have their lives, autonomy, and human rights violated for their behavior during pregnancy.

By targeting behaviors in pregnancy both state and medical actors expand their jurisdiction over the lives and autonomy of low-resourced women of color, institutionalizing a multi-system catchment that has proven difficult to dismantle even *after* a Supreme Court case declaring non-consensual drug testing unconstitutional (*See e.g.*, Ferguson v. City of Charleston 532 U.S. 67 (2001)), *after* the research findings of Ira Chasnoff were debunked, and *despite* the marijuana decriminalization movement and growing cultural acceptance of a disease model of addiction. This study documents how in the face of social and institutional change some things

remain the same. The findings that follow highlight that *hyper-fragmented care* and sub-contracted systems obscure a clear view of responses to perinatal substance use. The opacity regarding current responses allows professionals to dispel that current practices are differential by race and class. In addition, this research considers the effects of mandated collaborative relationships between the state and medicine and unpacks the *complementary logics* that keep these two seemingly disparate systems aligned in their shared goal of determining the best way to manage substance using pregnant women. In the following chapter, I will discuss how surveillance technologies and risk frameworks in maternal-fetal medicine significantly overlap with those in child protection systems and create similar expectations regarding social intervention and the limits of clinical care for "problem" patients. Research on biomedical stratification (Clarke et al. 2010) tends to focus on the ways in which high-tech, advanced biomedical technologies create steep chasms in healthcare between the "haves" and the "have-nots." This research contributes to the literature on biomedical stratification by considering the low-tech surveillance technologies that are used to manage those at the bottom echelons of the health system. Providers scale back medical and diagnostic clinical standards when interacting with low-income substance users and instead engage in a process of "social diagnosis" (Brown et al. 2011) whereby patients' social status and the perceived social risk factors that accompany racialized poverty are used to make forensic rather than clinical diagnoses. I argue that what emerges from these data is a pattern of *fragmented violence,* in which the medical care and the social services that low-resourced substance using women receive amount to a series of inter and intra-institutional handoffs, each fissure in care enacting violence to the lives and well-being of substance using women.

CHAPTER THREE: CARCERAL MEDICINE: DISTINGUISHING BETWEEN PATIENTS AND PROBLEMS

> Without a doubt, physicians should care about what happens to their patients. Physicians should not be backstabbing their patients. I feel that physicians should honor their oath…and I feel that we should follow the Constitution, and that we should care about our patients. I'm often at a loss for words when people say "no, I don't think that's what we should do." I often don't know what to say to those people. Like no, we shouldn't protect our patients? I think there's something inherently wrong about violating your fiduciary duty, you know? You should not go to a defense attorney, spill the beans, and then have him rip his shirt open and be like "aha, I'm the County Sheriff, and I got you now." And you should not go to your accountant and—it turns out it's an IRS agent. Like that's illegal. You should not go to your doctor and it turns out he's a policeman (Dr. M).

Medicalization is a process by which biological experiences and individual behaviors come to be medically defined and managed. Medical sociologists characterize medicalization as an inclusionary and assimilative process that incorporates and civilizes bodies, behaviors, and practices that were previously excluded as deviant or immoral (Conrad 1980, 1992, 2005, Clarke et al. 2010). This transformation, from "badness to sickness," has been recognized as a more humane and value-neutral response to non-normative bodies and behaviors (Conrad 1980). Medicalization is often critiqued and examined by sociologists studying the ways in which the medical domain expands its power to define what is normal and abnormal, healthy and pathological. This body of research highlights how medicine, and the ways in which the medical domain constructs reality has detrimental iatrogenic ("doctor-made") effects on the population, e.g., making the population dependent on medicine for solving problems which are essentially socio-political and largely explained by factors such as poverty, occupational exploitation, and environment toxicity (Illich 1979, Zola 1972). Early theories of medical social control were essential to pointing to the ways in which medicine had gained significant legitimacy and power

over not only the bodies it sought to transform but over cultural understandings and values associated with "health" and individuals' responsibility over it.

Relative to the criminal system, medicine is generally viewed as a gentler mode of social control for containing, reforming, and correcting individuals who are deemed to be abnormal, pathological, or dangerous (Conrad 1980). Medicine and the criminal legal system are often constructed as existing on opposite poles in which there is very little overlap between the two. Researchers have explored how, over time, criminalization has given way to medicalization (for example, our contemporary view of mental health issues contrasts starkly with the historical view of insanity as proof of sinfulness, immorality, or possession). Recent scholarship explores how medicalization has given way to criminalization (Hoppe 2017). For example, Trevor Hoppe's study of HIV-related non-disclosure convictions details how a medical condition and set of risks (HIV positivity) became reclassified as a criminal condition and set of risks. This chapter explores the ways in which medicalization and criminalization processes overlap and co-constitute one another by examining how medical actors describe the ways they respond to substance use during pregnancy.

Although medicalization is generally viewed as an assimilative process by which an ever-expanding range of processes and behaviors comes under the jurisdiction of medicine, substance dependence or addiction has remained only partially medicalized since 1956 when alcoholism was first declared an addiction by the American Medical Association. Nancy Campbell's historical account of responses to addiction (2012) reveals that despite numerous campaigns and efforts from many in the scientific and medical community to medicalize addiction, the disease model of addiction has never fully taken hold. At best, the medicalization of addiction can be described as fragmented and partial, seen variously as a disease, a criminal behavior, and an

individual moral failing. Examples of failed medicalization, like the disease model of addiction, reveal the social and moral underpinnings of medicalization and suggests that some conditions, behaviors, and bodies are morally unassimilable. This research takes the paradoxical relationship between pregnancy and reproduction (processes that have been exhaustively medicalized) and substance use (which is both medicalized and criminalized) and considers how substance using pregnant women are constituted at the crossroads of the "medico-legal borderland" of reproductive healthcare (Timmermans & Gabe 2002). I argue that medicalization and criminalization are not distinct processes but that they overlap in meaningful ways, in doing so I take up the call by medical sociologists to examine the intersection of medicalization and criminalization by unpacking how "alliances are created that link medical knowledge with knowledge about criminal deviance for the purpose of social control" (Timmermans & Gabe 2002:507).

Irving Zola's (1972) influential essay *Medicine as an Institution of Social Control* lays out how medical power acts upon dis-empowered populations in two primary ways. *De facto medical control* describes how medicine is a resource for the privileged and a liability for the vulnerable whereby impoverished populations' problems are neglected or made worse by the medical establishment. *De jure medical control* described the direct linkages between medicine and the state in which medical actors report on the conduct of the poor, the racialized, the morally abject, and the socially disadvantaged (e.g., drug users, HIV positive patients, child abusers). This early portrayal of medicalization captures how medicine is stratified and stratifying segments of the population based on their social worth. Medicine plays the dual role of protecting those deemed worthy of therapeutic healing and abandoning or otherwise discarding those deemed undeserving.

Foucault's work traces the rise of medical experts as entrusted moral authorities on all matter of human behavior. Medicine, specifically psychiatry, emerges in the 18th and 19th centuries as a form of expertise that targets individual conduct and desires, sexuality, and the family and significantly expands institutional power over those domains. In his *Abnormal Lectures, 1975-1975* (2003), Foucault outlines the relationship that emerges between medicine and law in the 17th century. Examining expert witness testimony of criminal psychiatrists, Foucault illustrates the rise of a form of grotesque and absurd expertise that is given the full weight of juridical influence. Foucault paints criminal psychiatric legal testimony as a kind of pseudo-expertise that is "consistent with neither law nor medicine" (pp. 42) and violates both the rules of legal proofs and "the internal norms of medical knowledge" (pp. 42). Instead he argues that criminal expert testimony is enrolled in juridical decision-making in the service of describing the moral character of the accused, the criminal psychiatrist provides a personal biography of the accused which consists of a history of their conduct, desires, and irregularities. The vivid portrait allows the law to judge the accused not just for the offense at hand but the underlying "cause, origin, motivation, and starting point of the offense" which constitutes the "material to be punished" (pp. 15). The aim of this maneuver is "to show how the individual already resembles his crime before he has committed it" (pp. 19) and allows criminality to be assessed beyond the temporal limits of the criminal act or event. Criminal psychiatrists allow the law to judge an offense based upon the existence of a "constant criminal desire" (pp. 21) or corrupt *instinct* that resides within the individual and makes their desires "fundamentally bad" (pp. 21). In addition, the enrollment of psychiatrists as experts in criminal cases marks a shift in institutional power and allows for the fusion of what previously had been constructed as two mutually exclusive institutions:

> Expert opinion must make it possible, or at least should make it possible, to distinguish clearly between the dichotomies of illness and responsibility, between pathological causality and the freedom of the legal subject, between therapy and punishment, medicine and penalty, hospital and prison…Madness cannot be crime, just as crime cannot be, in itself, an act rooted in madness. In terms of the law, when pathology comes in, criminality must go out. In the event of madness, the medical institution must take over from the judicial institution (pp. 31-32).

However, the psychiatric assessment of individual conduct, desires, and motivations, allows the two institutions to judge together; one can qualify for both medical and judicial intervention – or legal intervention via medical assessments and vice versa. Thus, the relationship between medicine and law, the "seam" that fuses the two institutions together emerges in response to danger, the "dangerous individual" (pp. 34). *Medico-legal power* is the power to name, define, and expound upon what constitutes the "abnormal" which must be contained, surveilled, or reformed. The institutions of medicine and law work in tandem at the intersection of registering *abnormality*, *perversion*, and *danger*. The legal testimony of psychiatrists created a "seam" between medicine and law by narrating the perverse and abnormal conduct and desires of a subject who was irredeemably and intractably corrupt.

Although Foucault's periodization locates these shifts in the formation of power within a particular era, these insights into the historical formation of medical-legal power provide useful historical context for this analysis. For example, the contemporary construction of "the drug addict" demonstrates that the ungovernable, perverse, and dangerous individual is alive and well today. In *Judging Addicts* (2013), Rebecca Tiger explores how the seemingly contradictory approaches to drug use - therapeutic and punitive- are merged in the concept of drug courts. Her research reveals that the logics of drug courts and drug treatment are not contradictory but rather have been made compatible as both aim to coerce normality in the "offender" (pp. 39). In both the treatment model and legal approaches, drug users are constructed as intractability deviant.

Addiction, as a medical diagnosis- conceived as a chronic, recurring condition- appears to justify punishment and invasive surveillance as a logical response because drug users are deemed to be always at risk of relapsing and ultimately incurable. Therefore, drug courts function not to identify when drug users are cured but to establish a never-ending line of inquiry into the life world of the user, becoming enmeshed in ever-expanding aspects of the user's life to assess the risk of relapse. Similar to the ways that Foucault describes medico-legal power as a power that merges medicine and law to contain the "constant criminal desire" of the "dangerous individual" drug courts and drug treatment finds in the "addict" a risky subject who can be neither cured via medical treatment nor reformed via criminal punishment, but rather is managed by both systems via pervasive and intrusive forms of surveillance and risk assessment.

If the "drug addict" is deemed incorrigible, then the *pregnant* "drug addict" is especially morally reprehensible. Nancy Campbell suggests that women drug users experience a kind of compounded social stigma regarding their drug use (2002). Drug use signifies failed self-governance and immaturity, but for women- who historically have been "enmeshed in complex relations of dependency on and responsibility for others" (pp. 4: 2002) drug use poses a threat to the institution of the family and women's role in social reproduction more broadly. Thus, women's drug use poses a crisis in self-governance in which various institutions, medical, carceral and semi-carceral; punitive and therapeutic; private and public are all enrolled to manage, discipline, and rehabilitate the patient-offender.

This chapter explores the complementary logics that fuse medical and state domains and examines the ways that medical knowledge and practices, diagnostic tools, and medical decision-making co-mingle with and are informed by carceral state logics of legal-forensic investigation, risk containment, and surveillance. I argue that these complementary logics are deployed

selectively in the clinic setting to distinguish normative patients from "problematic" ones. The first section explores the ways that drug-testing straddles the line between clinical diagnostic tool and forensic investigation technique. Rather than a neutral clinical assessment, drug testing is a classed and racialized mode of surveillance and sorting. The following section considers how harm is constructed by medical actors and asks: how does substance use during pregnancy get constructed as child neglect by medical providers? The final findings section elaborates on the limits of clinical surveillance and details the ways in which medical actors delimit their own authority and sovereignty over substance using patients by handing them off to state authorities who are differently empowered to monitor, discipline, and "civilize" them (Rose 1992).

What a Drug Test Does: Drug Testing as a Surveillance Technology

The following findings explore drug testing practices as a part of medical surveillance culture and considers the work that drug testing does in maternal-fetal healthcare. This section provides an overview of the ways that medical actors, neonatologists, obstetricians, and hospital social workers describe the surveillance culture within their institutions. I use the term surveillance culture because rather than official or standardized protocol guiding clinical decision-making, physicians were often guided by their own values and calculations of social risk, danger, and safety when determining who to drug test and report to DCFS. Other research has demonstrated that the clinical culture plays a crucial role in shaping care provision for patients who are deemed to carry some unknown social risk. For example, in *Fertile Grounds* Elena Gutierrez demonstrates that biased and racially resentful views of Latina women's reproduction as a social threat created a culture that enabled uninformed and non-consensual sterilization of hundreds of Latina women at the Los Angeles County Hospital during the 1970s.

Similarly, Stefan Timmerman's ethnography of resuscitation practices revealed that medical staff worked less diligently to revive patients for whom they saw little social value such as drug users, alcoholics, and the homeless and openly expressed disdain toward patients who had overdosed from a drug misuse (1999). These studies remind us that systemization and standardization of practices need not be determined by explicit, official protocol, rather clinical cultures foster and promote differential treatment among patient populations and can create the appearance of a uniform clinical response to treating patients for whom there is collective disregard or prejudice.

Drug testing patients during pregnancy is a controversial practice. There has been some significant debate in the obstetrical world regarding if, and under what circumstances, it is appropriate to drug test pregnant patients. In 2001, the Supreme Court ruled that non-consensual drug testing of pregnant women for the purposes of reporting them to law enforcement was an unconstitutional breech of their 4th amendment protection from unreasonable search and seizure (Ferguson v. City of Charleston 532 U.S. 67 (2001)). The American College of Obstetricians and Gynecology (ACOG) has come out against universal drug testing of pregnant patients arguing that a universal program of testing will deter patients from care and create a culture of animosity and distrust between patients and providers. Yet, despite these developments drug testing pregnant patients is a common practice across the nation. Federal law complicates the clinician's role in determining when to drug test, as it mandates that hospitals report instances of substance-exposed infants to state child protection agencies. The federal reporting mandate is vague and offers no guidance to physicians on the best way to determine that an infant is substance-exposed. As a result, drug testing and reporting practices vary dramatically not only by state but within states, municipalities, and hospitals (Drescher-Burke & Price 2005). The legal and policy

landscape offer contradictory and competing messaging regarding how to respond to perinatal substance use but even among clinicians there is contestation around drug-testing practices.

The argument for drug testing is that it can be a useful clinical diagnostic tool that allows physicians to "rule-in" certain diagnoses – for example, if a patient comes into the hospital with vaginal bleeding the physician may order a urine toxicology screen in order to rule in placental abruption[5]. Drug testing is also often used when the neonate is showing signs of neonatal abstinence syndrome (NAS) or withdrawal symptoms and is used to guide the care of the newborn who may need to ween-off of narcotics with methadone or morphine. Despite some useful clinical applications, maternal health advocates argue that drug testing should be used sparingly, if at all, because of the potential legal and social ramifications of the results outweigh the potential diagnostic benefits (ACOG 2012, ASAM 2017). One reproductive public health researcher explained the argument against testing in the following way:

> I'd be really skeptical of the use of the urine test for like what the purpose of urine tox actually are. In relation to drug use, I don't know either that we have enough protections in place, or that there's enough evidence of effectiveness to warrant screening everyone. I would also say that from a public health perspective, I was always trained that if you're gonna do a screening for something, you need to be able to get people treatment. And I would say we're sort of bad in serving—you know—and adequately caring for those who are identified…I would say you need to improve the systems to care for the people you're already identifying first (Expert C, Interview, 5/26/2017).

Currently in 23 states and the District of Columbia, giving birth to a drug-exposed infant is considered evidence of child abuse or neglect and medical providers are mandated to report positive results to state child protective agencies (Guttmacher 2019). This poses a conflict of interest for providers who, if they drug test for the purposes of adequate diagnosis or treatment

[5] Placental abruption is a relatively rare medical condition in which the placenta separates from the wall of the uterus disrupting the flow of oxygen and nutrients to the fetus. It usually occurs in the last trimester of pregnancy and can be accompanied by vaginal bleeding.

are also simultaneously legally exposing their patients to incrimination or intervention by state actors. When clinical procedures are used for the purposes of providing evidence to the state then they are no longer solely clinical in nature. However, the physicians that I spoke to rarely acknowledged role strain, duality, or a conflict of interest in their responsibilities as healthcare providers, forensic investigators, and witnesses for the state. Moreover, as the above respondent suggests, screening and drug testing practices are often divorced from adequate, accessible, and comprehensive medical treatment options. For example, in Chicago, there is only one maternal health clinic that provides integrated-MAT (medication-assisted treatment) to pregnant and post-partum patients (IDPH 2018). Therefore, the vast majority of providers are not able to directly initiate treatment with patients who have a substance dependence issue and choose a treatment course. This creates a barrier for patients who must then navigate finding treatment in a referral-based system with a limited treatment capacity. Chicago's treatment capacity ranks lower than several other large cities, including Philadelphia, New York, San Diego, Phoenix, Los Angeles and Houston – and also ranks lower than several mid-sized midwestern cities such as Columbus, Indianapolis, Milwaukee, Cleveland, and Detroit (Bechteler & Kane-Wallis 2017). The situation in Chicago poses a unique threat to women with substance use issues. On the one hand, physicians are incentivized by state statutes to conduct forensic investigations that may dramatically impact their patients' lives and infringe on their rights, on the other hand, there are significant infrastructural barriers to adequately treating women who have substance use disorders and seek treatment options. Therefore, a system that strongly prioritizes identifying substance users without having the means to adequately treat them; becomes by definition a punitive surveillance system.

These findings demonstrate that drug testing was anything but neutral, clinical, or therapeutic, rather drug testing was often conducted in a contradictory way- as both a clinical and forensic tool for the purposes of sorting patient populations and determining thresholds for clinical care and medical norms. I spoke with 21 medical actors who collectively practiced at a total of N=8 hospitals in the city.[6] From these conversations I was able to gain some insights into the surveillance cultures in which drug testing decisions are made. I found that decisions to test were variable and largely up to the discretion of the physician. None of the providers that I spoke with indicated that they worked at an institution with explicit drug testing protocol. While it is possible that such protocol may exist within these institutions, if the medical staff working within them were not aware of the protocol, it is not likely that they were meaningfully guiding responses. Rather what emerges in the data below are patterns in response that demonstrate that the markers for testing typically hinged on signs of social precarity and poverty which were sometimes explicitly racial but were mostly associated to race via the proxy of substance type.

The decision to test was meaningful for numerous reasons. First, the state child abuse and neglect statute states that evidence of substance exposure at birth (including withdrawal symptoms in the newborn, or evidence of substances in the blood, urine, or meconium (first stool) of the infant) is prima facie evidence of child neglect when detected by a physician (Abused and Neglected Child Reporting Act of 1975, 325 ILCS 5/4.4)

Although the statute states evidence of substance exposure constitutes neglect, it does not direct providers to go *look for such evidence.* Therefore, physicians' decisions to initiate testing could not be solely explained by guidance from legal mandates or protocol. Furthermore, decisions to test were not always followed by reports to DCFS- rather, test results were the

[6] I sampled providers from 5 hospitals, however, a number of providers practiced at more than hospital.

beginning of a process in which medical staff made other assessments of the patients to determine if DCFS should be called. So, although the law mandates reporting to child welfare, it appeared that there was some variation in whether medical staff followed through with a hotline call to child protection. The findings suggest many points in the decision-making process are determined by the individual discretion of the physician.

Deciding to Test: Fusing Forensic and Clinical Logics

Forensic and clinical rationales were often used interchangeably to describe decision-making processes for drug testing patients. Dr. A, who practiced at a community hospital on the Southwest Side of Chicago that serves a public patient population that is predominantly black and Latino, interweaved both medical and non-medical justifications to explain the circumstances under which she initiates drug testing:

> We always ask. Any patient is screened verbally. It's part of the medical history. You know, smoke? Drink? Do you use any drugs? Especially in this demographic. We know that the um substance abuse usage rate is very high. So we screen all of our patients. We ask every single patient. We see a lot of marijuana. A lot of marijuana. Patients will sometimes admit to marijuana usage and sometimes they won't. We use the circumstances of the admission sometimes to drive whether or not we are going to do urine screening for drug use. If a patient comes in with a clinical picture that suggests substance abuse, uterine abruption…uh placental abruption or… Then we'll go ahead.
>
> A lack of prenatal care in and of itself—during the whole course of the pregnancy—kind of raises our index of suspicion for substance abuse. So we use different pieces of our medical history, and sometimes just our eyes and ears to determine whether or not we're going to really focus on having the patient admit drug use. And if they don't, in the interest of the baby, then we'll just go ahead and do a urine drug screen (Dr. A, Interview, 8/20/2018).

Dr. A uses the language of forensic investigation in the account above – the emphasis on attaining "admissions" from the patient, an "index of suspicion," and using "our eyes and ears" all point to a clinical culture in which an ethos of surveillance guides decisions regarding

potential drug use. *Index of suspicion* is terminology that is regularly used in the medical world and medical training to describe the extent to which a disease or condition is being weighed as a likely diagnosis. However, in this context, "index of suspicion" takes on non-clinical connotations. "Substance abuse" is suspected not as a medical condition that the physician is intending to treat or as a piece of a larger diagnosis, rather substance abuse in this context is a dangerous behavior that the physician is indexing or marking "in the interest of the baby." Medical lingo and the language of diagnostic discovery overlaps seamlessly with the terminology one might expect in forensic investigations, criminal proceedings, and court hearings. For instance, Dr. A's insistent interest in acquiring "admissions" from patients presents a kind of medico-legal hybridity. In law, an "admission" is a piece of evidence that can be entered in the adjudication of a legal case. In healthcare encounters, an admission is a part of standard medical history-taking and screening and is often conducted under the auspices of a private and confidential interview for diagnostic or therapeutic purposes. Healthcare providers do not read the equivalent of a Miranda warning to their patients before taking a verbal history or conducting a screening, therefore, patients are not "put on notice" or otherwise informed that the information that they share can be used as evidence against them by the state or other non-clinical actors.

In fact, the extent to which patients were informed about drug testing and in exchange provided voluntary consent was often discussed in ambiguous terms by medical staff that I interviewed. For example, Dr. A never explicitly states that she attains consent from her patients when she's making drug testing decisions rather her repeated claim that the medical staff will "go ahead" and test under certain circumstances creates the impression that informed consent is

not carried out. Sometimes physicians referred to moments when they *told* their patients that they were going to drug test them:

> So, for my patients that use…like if a patient tells me that she's using marijuana, I usually don't do a urinary tox screen. But if they admit to anything more than that, then I'll tell them that we just need to do a tox screen just to…just to check. And then most of them are like, "okay, that's…that's fine" (Dr. J, Interview, 8/21/2019).

As with all clinical procedures, informed consent should be obtained prior to collecting urine specimens from the patient or their infant. The most alarming finding from my interviews with doctors was the lack of clarity regarding informed consent and testing practices. Some providers mentioned "telling" their patients when they were going to test them, others appeared to avoid informed consent by testing the infant rather than communicate with the mother. Informed consent for drug testing should involve informing parents of the potential risks of testing- including the risk of false positives, DCFS involvement, and the potential loss of custody of their infant and any other children. Testing should only be conducted if the mother, having full knowledge of the risks, agrees to the test or provides permission for the infant to be tested (ACOG 2009). Informed consent is not the process of informing a patient that a procedure will be carried out on their bodies. The provider-patient interaction presented above, suggests considerable coercion and dissembling on the part of the provider- who does not inform the patient of the justification for testing or the risks associated with testing and instead states that testing is done "just to check" which leaves aside questions of clinical utility and does not adequately pre-empt the many negative consequences associated with a positive test result instead presenting drug testing as a relatively benign and routine practice. Another surprising theme that emerged from the data, was the practice of drug testing patients *after* doctors had received an admission that they had used substances during pregnancy. If a clinician has been informed by the patient that they have recently used substances, why would a drug test need to

be carried out if not primarily for the purposes of collecting forensic evidence to be handed over to the state?

Dr. M was the only provider I spoke to who seemed alarmed by testing practices being carried out on substance using patients. He was critical of the practices and actively trying to counter the culture and practice within his institution. He explained that informed consent was not practiced in a way that adhered to clinical ethical norms and that he was trying to actively challenge the culture of drug testing within his institution, first and foremost, by ensuring that he personally informed patients of testing practices. In the account below, he explains why informed consent for drug testing is unlike attaining consent for a medical procedure:

> We gotta consent them. Ask, is this okay that I do this? We would like to drug test your baby for amphetamines because well, there's no medical reason but we just kinda wanna know because, somehow, we think it'll make a difference. We can't tell you how it'll make a difference, but we do know we'd like to kick it over to DCFS and have them investigate it. Would that be okay? Oh…there's a 20 to 30 percent chance that we'll get a false positive and you'll be investigated based on this false positive. And things could happen after that. Like you could lose your child. Would you like to do this? And they're gonna say no. How do I know they're gonna say no? Because I've asked when there's a mother in the newborn nursery, not so tongue in cheek, like I've laid it on to them in a more sober manner, and 100 percent of them have been like, "hell no" (Dr. M, Interview, 11/8/2018).

Urine toxicology screens have a 5-10% false positive rate (Smith et al. 2010) with some studies reporting a false-positive rate as high as 20-50% depending on the substance being tested for (Saitman et al. 2014, Moeller et al. 2017)[7]. These rates may be higher for people with compromised health who are taking medications to treat a condition. Although the false positive rate is substantial, few of the providers that I spoke with discussed the potential risks of false

[7] A false positive is a testing error that indicates that a condition is present, when it is not. Some drug tests are more prone to testing error, for example, urine drug screens are less reliable than hair or blood tests. False positives are most commonly caused by cross-reactivity of chemical compounds structurally related to the illicit substance being tested for (e.g., chemicals that can be found in certain foods and over the counter medications).

positives to their patients including the considerable legal and social risks. More often than not, providers tended to focus on their frustrations with potential false negatives and the inability to attain results that aligned with their suspicions regarding a patient's possible drug use. While conservative estimates for urine toxicology tests' false positive rate is similar to other clinical screening devices such as mammography screening [which has a 7-12% false positive rate for one time screening (Nelson et al. 2016)], the implications of a false positive in the case of a drug test on pregnant patients carries a significant threat of social and legal harm to patients relative to screening tools that are used in solely therapeutic contexts. Dr. M's account reveals in a somewhat "tongue in cheek" manner, the absurdity of asking for patients' consent to perform what is essentially a forensic investigation on them. Certainly, if patients were informed of the far-reaching social ramifications of a test that has a relatively frequent failure rate, they would likely be reluctant to agree to it. However, I learned through my interviews with medical staff that there were other ways that providers circumvented the consent process. One way was by drug testing the infant in lieu of the mother.

The maternal-newborn dynamic creates a unique gray zone in which clinicians act upon the newborn infant as a means of implicating the mother's behavior during pregnancy. By testing the infant's biological material, meconium, chord segments, or urine, clinical staff were able to avoid directly interacting with the mother, informing her of their desire to test, or gaining her consent. Reproductive sociologists have explored maternal-fetal conflict in the realms of prenatal genetic screening (Rapp 2004, Markens et al. 1997), fetal surgery and patienthood (Williams 2005, Casper 1999), prenatal diet and other pregnancy-related behaviors (Markens et al. 1997, Mackendrick 2014) but the relationship between the postpartum mother and *newborn* patient is underexamined in this area of scholarship. The ethical dilemmas posed by maternal-fetal conflict

revolve around the tendency of medicine to treat the mother and fetus developing in her womb as separate patients with competing interests. The situation described by physicians regarding drug testing infants was one in which the newborn and mother were treated as separate yet still biologically fused and fatefully tethered. What other medical procedures or diagnostic decisions, barring perhaps transfusions and transplants, allow for the medical information, biological material, and medical history of one patient to be used to make decisions about another patient?

In the case of maternal-newborn care, the recent biological dependence and the current independence or separateness of the infant and mother provide a unique and time-sensitive clinical-forensic opportunity in which the infant's body can be used as an investigation site to narrate the mother's unlawful behavior. In addition, the spatial and physical organization of the medical setting is siloed in such a way that the newborn clinic and NICU side do not operate in a coordinated way with the labor and delivery or antepartum side of the clinic. Therefore, the isolation of the newborn in neonatal care further alienates the mother from her offspring and reinforces that neonatal staff assume the role of interim guardians of the infant who have a stake in its well-being and make decisions on its behalf. These care silos situate postpartum patients as particularly vulnerable to medical abuse as the neonatologists and pediatricians caring for the newborn likely have no relationship or interaction with the mother and therefore are not inclined to consider her as they do things to the infant. Consent disappears between the cracks of fragmented and siloed care systems.

Nurse N, who worked as a neonatal nurse at a public teaching hospital explained how the medical history of the mother was flexible and transparent, moving between care contexts and guiding decisions about drug testing *the infant* without any particular concern for safeguarding the postpartum patient's medical information or privacy:

> We tend to…to test you know the baby, let's say, do a meth test to look for that. And you know with babies…we say well, if the mom had an abruption…but do we do it for all moms who have an abruption? Or we do it for a certain type of mom that looks to us like she might be a druggie, right? I mean I shouldn't say it like that, but I'm being honest. (Nurse N, Interview, 8/23/2018)

In this case, a placental abruption is selectively used in a post-hoc manner to determine if an infant should be tested based on traits and characteristics of the mother. In stark contrast to what some physicians claim is the diagnostic value of drug testing- to rule in conditions like placental abruption- Nurse N explains that an abruption is sometimes used as criteria to test for substances in the neonate. In this way, placental abruption is a clinical diagnostic that moves fluidly between patients and care settings as a label that flags suspicion of drug use. Nurse N confirms that placental abruption is not always used in the calculus to test the infant but may be used to single out "a certain type of mom" who looks like a "druggie." When stated in such starkly candid terms, the neutral and clinical basis for drug testing based on placental abruption is de-mystified. The social status and presentation of the patient drives when and for whom drug testing is carried out and how their medical history will be enrolled by the clinician.

At times race and class were clearly articulated in physician's decisions to drug test. I spoke with Dr. F, a neonatologist who worked at a private hospital in the city, about the circumstances under which providers were testing patients and she mentioned that among their largely, middle and upper-class patient populations the race and class status of their patients often clouded their ability to determine when to test:

> I mean the [patients] that strike out are um like multiple substances. You know? And in a population like this you wouldn't suspect it. Like oh my god, this mom was doing everything under the sun, but [we] just never—you know—thought about it. And they tell the teaching fellows like: "oh my god, you have to…you have to suspect it." And it was like a yoga instructor and they're like: "yeah, but she's not doing drugs. No, she couldn't be doing drugs." But she was like an alcoholic, just doing everything. And her baby's urine tested positive for everything (Dr. F, Interview, 8/29/18).

Drug tests are an example of what Simone Browne refers to as "white surveillance technologies" (2015) used to sort populations into different segments of the economy, institutions of social control, or, in this case, clinical tracks of care. The class and race status of patients are used superficially to determine who should or should not be drug tested. Upper middle-class lifestyle markers protected some patients from suspicion and testing. That a "yoga instructor" "couldn't be doing drugs" reveals the normal operation of drug testing as a racialized and classed sorting apparatus. Drug testing is a tool used to confirm physicians pre-existing notions about who is engaging in behavior that is believed to be risky, illicit, or immoral. The presence of non-racialized patients in this sorting apparatus is deemed unbelievable and a remarkable disruption of providers expectations of who is a "problem" patient. The same physician later reflected on her own history of testing patients and explained that suspicion rests on racial categories: "It's based on the clinician's discretion…You know, if I hear you know African-American teenage mom is kinda loopy, I'll say send it (the drug test). It…it's terrible" (Dr. F, Interview, 8/29/18).

Racialized suspicion is presented as a kind inevitability, an unfortunate fact of clinical care over which providers have little control or power over shaping. It was notable that physicians seemed to both recognize the inherent bias in testing decisions yet also ascribe a lack of agency over biased practices which appear to originate in their own assumptions. These data reflect the predominance of "implicit racial bias" in medical approaches to understanding racial inequality in healthcare interactions (Feagin & Bennfield 2014, Metzl et al. 2018). The implicit racial bias paradigm encourages providers to understand racial inequality as individualized and interactional, leaving aside the ways in which social structures, history, and institutions reproduce racism and create the conditions for individual racism, while simultaneously promoting the idea that racial animus is largely unconscious, unintended, and intractable. Thus,

the implicit racial bias framework allows medical actors to acknowledge their own racism, without having to contextualize it within larger systems of racial disqualification or remediate it.

Dr. M shared that in response to the non-consensual drug testing at his institution he had begun to collect data on the hospital's testing practices. He explained that although the white and black patient population were roughly detected and reported at the same rates, the black population was being tested at significantly higher rates:

> M: The big numbers [disparities] are coming from over-surveillance of the blacks. If you get 50 blacks and 50 whites that are testing positive about that ratio will be reported. However, maybe you had to test you know…maybe you tested 2,000 blacks and 100 whites to get that 50/50.
> K: So, you're saying there's way more testing of the black patient population?
> K: Yes. At the hospital surveillance level. Yeah…no, they're disproportionately screened. However—and this is more of a personal anecdotal kind of thing—when they come…when there's a White woman that looks to be middle or upper class that's here, and we're like where did you get prenatal care? and she's like pushin' a watermelon out, she'll be like I don't know…some…some group, I don't know. And we're like okay, okay…we'll get your records later. Right? And if it's the…if it's the black teenager, and she's like I don't know. Then it's like hmm…get the test (Dr. M, Interview, 11/8/2018).

These accounts by providers support a picture of racial bias in drug testing decisions in perinatal care. Research exploring racial bias in drug testing practices confirms that black infants are more likely to be tested than white infants (Ellsworth et al. 2010, Kunins et al. 2007), even within institutions in which protocol and guidelines were in place to reduce bias in testing decisions (Ellsworth et al. 2010). These findings illustrate that drug testing is a racialized sorting apparatus revealed in moments of explicit racial profiling, but also in moments when the sorting apparatus captures patients who are not the intended targets of surveillance. In these cases, medical actors contend with upsetting privileged patients by subjecting them to racialized forms of surveillance as depicted by an obstetrician below:

> I remember once in my old institution they had a policy that anyone with under a certain number of prenatal visits would get a urine drug screen. And I remember

> having a patient who was actually an employee of the hospital, who had been seen maybe the whole pregnancy, and for whatever reason, peds just hadn't counted the encounters correctly. And so, she…her baby's being bagged for a urine drug screen…you know a drug screen. And it was very—you know— [the patient] was good natured about it, but…but they were kind of also upset at the same time (Dr. K, Interview, 9/14/2018).

There is some debate regarding the value of universal drug testing i.e., testing every person who seeks prenatal or pregnancy related care. Professional organizations like ACOG have come out against universal testing arguing that it poses too many risks to mothers in a patchwork system where some states incarcerate women for a positive result. However, many providers, public health, and maternal health advocates support universal drug testing as a racial "fix" for discriminatory testing practices. While universal testing would ensure that everyone is tested and perhaps reduce some of the discriminatory effects of physician discretion; some of the providers I spoke with seemed uncertain and apprehensive about an approach that would include everyone on a level playing field of surveillance and suspicion:

> [I]f you start picking and choosing, that creates problems and you're gonna miss people…It would be better off if everybody got the drug screening. Now it creates a whole set of problems, like mom gets a dose of Dilaudid [in labor], and so it needs to be well-thought out. What do you do in those situations? Because you don't want a mother who never touched an opiate, but got general anesthesia or whatever, and then their kid is testing positive.
>
> I'm at [two public hospitals on the South Side] now. I think mostly everybody gets tested for drugs. But I can see where it becomes like uh some stereotyping is involved. It's almost better just to test everybody and take that out of the equation. But then you'd have a lot of parents here [a private hospital serving mostly privately insured patients]…Like why does my kid got a urine bag? What are you doing with that? (Dr. E, Interview, 10/10/2018).

Universal drug screening poses a different set of problems for providers who may capture patients deemed to be *undeserving* of clinical suspicion and singling out- for example, patients who have never used opiates but were given narcotics during labor to manage pain. Universal drug testing runs counter to the increasing importance of patient satisfaction structuring

healthcare. As healthcare has become increasingly commodified, patient satisfaction expands as an object of interest to hospital administrators and shareholders who have developed a plethora of indicators for measuring, assessing, and rewarding consumer satisfaction. Providers risk upsetting their privileged patient clientele by placing them into a non-clinical surveillance category; a category that is especially tinged with meanings of illicitness and maladaptive and neglectful parenting.

Thus, a program of pervasive testing may be carried out without much consideration for upsetting patients at hospitals that serve low-income, public patient populations that are majority non-white, as Dr. E suggests is the case at the hospitals he practices at on the South Side of Chicago. However, in more diverse healthcare settings that serve racially and financially mixed populations, universal drug testing risks being too inclusive. Providers do not wish to ruffle the feathers of patients who have the power, resources, and cultural health capital (Shim 2010) to question procedures that subject them to considerable legal exposure and state intervention. Universal drug testing was *not* viewed as an appropriate response for the very reason that it is often proposed as a solution to racial inequality- because it threatened to place white, financially privileged patients on the same suspect list as patients deemed to be problematic due to their racialized poverty.

Sometimes the racial targeting associated with drug testing was subtle and loosely framed in the language of medical risk. The doctor in the following account explains how specific "red flags" inform when a test would be ordered:

> When mom comes in—a pregnant woman comes in—in labor, who's never had any prenatal care, that's a huge red flag right there. And why hasn't she? Unless there's really good reason—I've been in Alaska and they don't have any providers out there…you know, I don't know. But that's a big red flag (Expert A, Interview, 5/3/2017).

Lack of prenatal care was the most cited reason for drug testing. Faced with a lack of explicit hospital protocol, testing based on a lack of prenatal care appeared to be medical orthodoxy, the unspoken and collectively accepted criteria for testing decisions. Lack of prenatal care has the appearance of being less biased criteria for testing as one neonatologist put it: "…if there's no prenatal care, they automatically get tested, which seems to be a better, less—involves less stereotyping in some ways than well, you just look like the type of person who would do heroin. But that seems to be reasonable" (Dr. E, Interview, 10/10/2018).

Indeed, it does seem to be "reasonable" criteria relative to using other classed, raced, or behavioral markers to determine testing decisions. However, Vital Statistics data regarding late or no prenatal care utilization suggest that race and resources are deeply imbricated in prenatal care utilization. Black (9%), Hispanic (8%), and Native American (12%) women are more likely forego prenatal care relative to white women (4%) (Osterman & Martin 2018). Age and insurance status also predict adequate prenatal care utilization: women under 20 are the least likely to receive care across women of all reproductive ages, and uninsured women and women on Medicaid are less likely to receive prenatal care relative to women with private insurance (Osterman & Martin 2018). Thus, when criteria for testing are rooted in what are essentially structurally-mediated factors that disadvantage women according to their race, class, and age it is less "reasonable" to label such criteria as neutral or less biased.

In the account above, lack of prenatal care is viewed as suspect in and of itself. The quote suggests that, barring some extreme structural barrier- like a healthcare shortage the likes of which experienced in rural Alaska, prenatal care is an unproblematic resource that is widely and easily accessible. The implication that women who do not receive prenatal care are inherently suspect and purposefully absconding reveals the ways in which the conditions of poverty are

conflated with criminality in medical settings. The relationship between implicit bias, drug testing and utilization of prenatal care as a predictor for substance use is deeply rooted in the recent history of drug testing practices and research produced during the crack era.

Many of the studies conducted at the height of the crack epidemic were conducted at "urban academic medical centers" (Land & Kushner 1990; MacGregor et al. 1989; Melnikow et al. 1991; Miller et al. 1989). Historically, these institutions disproportionately serve low-resourced, communities of color, communities that are more likely to have low healthcare utilization rates and be more likely to be uninsured. It is, therefore, no surprise that providers documented an association between low prenatal care utilization and substance use in these settings (Paul-Emile 1999). It is meaningful that the relationship between drug use and prenatal care utilization emerged from this context. The association between lack of prenatal care and substance use is a scientific artifact that allows providers to continue to disproportionately target black bodies for drug testing and proclaim a particular set of reproductive risks associated with black poverty without making explicitly racial claims. It is these structural and historical artifacts that foster the conditions of oversurveillance and over-testing of black patients.

To summarize, examining the ways that medical actors discuss drug testing practices and decision-making reveals the mechanisms that link medicine and the state or "the medico-legal borderland" in reproductive care. These findings reveal the complementary logics that bridge the medical domain and the state. However, they also reveal that this bridge is built on shaky foundation. Drug testing practices violate both the norms of clinical practice as well as the standards for legal investigation. Clinical standards require that screening be carried out primarily for clinical and diagnostic purposes (Campbell 2018), and that providers follow norms around informed consent and fully communicate the risks and benefits of procedures to their

patients (Warner et al. 2003). On the other hand, forensic protocol requires that suspects be informed of their legal rights particularly in cases where they risk incriminating themselves (Miranda v. Arizona, 1966). According to a report published by the American Association of Clinical Chemistry (AACC) all clinical drug testing should follow legal chain of custody protocol including signatures of all parties handling urine evidence, subsequent testing when immunoassay testing is used (as immunoassay testing- or urine testing- has the highest false positive rate), and in cases in which a mother refuses to allow doctors to test her infant, a court order must be obtained to collect the evidence (Dasugpta 2019). By straddling both medical and legal domains – drug testing adhered to neither. The findings demonstrate that drug testing was anything but neutral, clinical, or therapeutic and yet it was also not solely a tool for forensic evidence collection rather drug testing does much more complex social work. I argue that drug testing is primarily *a surveillance and sorting apparatus* that is historically and structurally calibrated to target black, impoverished pregnant women. That does not mean that white, non-black and class- privileged women do not get ensnared in this apparatus, rather it suggests that there is a reason that more do not and that is because this system is forged in a history of eugenic reproductive science and medical practice and is designed to cull patients according to their reproductive and social value.

Where's the Harm? Risk and Uncertainty in Assessing the Threat of Substance Use

Substance use during pregnancy was deemed to pose a particular kind of harm to infants, yet rarely were respondents able to definitively define what that harm was. The state child abuse statute declaring substance exposure at birth neglect, along with the historical legacy of the crack cocaine era which equated substance exposure in utero with irreparable developmental damage

both powerfully shaped the surveillance cultures within clinical settings. Yet, providers still expressed uncertainty regarding the mechanisms of harm involved with substance use and the appropriateness of child protection intervention. Harm caused by prenatal exposure was perhaps the most ambiguous form of harm. Physicians often expressed that the potential developmental harm caused by illicit substance use was not definitive relative to exposure to other types of non-illicit substances like cigarettes and alcohol. Yet, cigarette smoking, alcohol consumption and increasingly marijuana use, were not deemed threats that required state or child welfare intervention but rather were treated as behaviors that providers were encouraged to address with educational and awareness raising interventions. In several conversations, doctors grappled with the notion of harm and the legal-medical distinctions drawn between illicit substances and non-illicit substances:

> Like if we're concerned about what are the…what are the effects of marijuana? The reason why I don't call [DCFS] is because I feel like well, the marijuana--as far as I can tell--seems to be fairly benign. And so, I don't want someone to have to be in a system for something that's fairly…. Which tobacco is worse, and it's legal. So, I don't call anybody on that person. Versus me coming up saying to the patient,…like this is the reason why you shouldn't smoke marijuana at home with a new baby. I'm not trying to have someone be at risk for losing their children over something that doesn't seem…that seems to be, you know, not as noxious as tobacco use is (Dr. J, Interview, 8/21/2018).

In some cases, the medical staff I spoke with seemed to be aware of the grave and potentially destructive implications of state intervention based on perinatal substance use. The distinctions between substance type and their presumed developmental effects arose in interviews time and again. For providers who thought of harm in terms of developmental effects, the licit/illicit boundary was frequently cited as illogical or an arbitrary distinction, as demonstrated in the account above. The downgrading of the threat of marijuana use was a recurring theme in my interviews. It was no longer seen as posing harm to the developing fetus in the way it had been

prior to recent decriminalization efforts and it was clear that providers were doing the work of normalizing marijuana use and actively shifting their clinical judgements to reflect this change. One might assume that shifting attitudes towards marijuana use might encourage a critical re-examination of the presumed threat of harm associated with other illicit substances. However, it seemed that both the increasing medicalization of opioids and the normalization of marijuana did little to affect the ranking of other substances. In the account below, Dr. M explains why the licit/illicit distinction in drug testing decision-making derives from a forensic investigation logic:

> Why aren't you testing for SSRIs? Why aren't you testing for protein, for tobacco? Right? If there's anything…like oh, we need to look for evidence of IUGR, intrauterine growth restriction? And they say well, cocaine could cause this. It could. Maybe it does. I don't know. The jury's still out on that. But you know what definitely does cause IUGR? Cigarette smoking. Why aren't we testing for that? They're like well, we just asked 'em. Like okay, well why not just ask 'em if they use drugs? And they're like well, they might lie. Okay, I get that. Okay, so you don't trust your patients and your patients don't trust you. And that's a problem right there.
>
> The number one cause of preventable cognitive impairment in this country is alcohol…in-utero alcohol exposure. Why aren't you looking for this? And they're like oh, because that's legal. And then that's proof that what you're doing has a primary programmatic intent of law enforcement. When you say "because it's legal," you're showing me that they're primary programmatic intent is law enforcement or administrative law, or something like that. But it's not medical.

The claims made in the 1980s and 1990s about long-term impairment caused by substance exposure in utero due to crack cocaine use have been debunked (Hurt 1997, 2005, 2009). In addition, the detrimental developmental effects of other substances like alcohol and cigarettes have been reliably and repeatedly documented in developmental research (Behnke et al. 2018, DiFranza et al. 2004). The question of fetal abuse and fetal harm still appears to shape providers initial assessments for drug testing suggesting that the effects of substances on the fetus are not the primary driver of testing decisions.

When I asked Dr. E, a neonatologist, if he thought that the statute that defines substance exposure at birth was an appropriate use of the law, he struggled to locate the medical issue- addiction on the same plane as the legal issue- child abuse or neglect.

> The opiate issue probably falls somewhere in the middle. Yes, I guess it's a form of abuse on the child. But at the same time, I feel like these parents are not…they can't help themselves. They've got a…a medical problem. I guess what needs to change is this notion of reporting abuse like fulfills every bucket. And…look at it more kind of like you know this is not something that's clearly…this is not helping the baby. And some intervention needs to be taken. But is it abuse or not? I don't know how helpful these labels are. And you see some of the parents who are there day in and day out, sometimes high. But they love their kid and they want them back. I don't think they're too happy with their performance. So to label it abuse, it's just not helpful. So I think rather than these terminologies, just get down to matter of fact. The child's health is compromised; that's not good. We need to intervene…social work…DCFS. Then we also need to recognize that I don't think the parents are happy with this. And I think that they would prefer to not be in the situation (Dr. E, Interview, 10/10/2018).

Dr. E appears to be grappling with these categories in real time. For instance, what is abuse? Can "a medical problem" also be abuse? Does reporting to DCFS "fulfill every bucket?" He contrasts these ethical dilemmas with a more humanizing portrayal of substance using parents – as remorseful and not "too happy with their performance," as ultimately loving their children. By situating the parents as flawed, but capable of love, he also suggests that perhaps the "abuse" label is stigmatizing in its own right. It seems that it is the *language* or "terminology" of "abuse" that he takes issue with rather than the medical, state, and legal intervention in these patients lives. Educational awareness around addiction as a medical condition has helped to shift providers and the public's use of stigmatizing language to describe substance use disorders, however, the concern about not stigmatizing patients was narrowly defined as a language or terminology problem rather than a concern about substance using patients' human rights, medical privacy, and autonomy.

It is worth noting that a positive drug test does not indicate a substance use disorder. DSM criteria for a substance use disorder is traditionally established through a psychiatric assessment conducted by a mental health professional. Studies examining the relationship between substance use and substance use disorders reveal that admissions of drug use are not synonymous with a dependency disorder, for example, one study examining substance use among welfare recipients found that while one-fifth of the sample self-reported illicit substance use, only 5% met the DSM-criteria for a dependence disorder (Pollack et al. 2002). I found a tendency among providers to conflate a positive toxicology test with a substance use disorder or to assume that a positive result implied the patient suffered from serious impairments that would put their infant at risk of harm. When physicians argued that drug testing was done in order to "get patients into treatment" they neglected to weigh the possibility that substance *use* (as indicated on a drug test) was not always indicative of substance *abuse*.

In other accounts harm associated with substance use was believed to be rooted in impaired behavior or an underlying notion that substance use was a criminal behavior in and of itself. In the following account, a social worker who worked in the neonatal department of a private hospital explains that substance users were viewed as threatening the safety of not only their infants but of the hospital staff:

> But we've had other times where—especially like parents who we are concerned are using heroin -- that it…it's just…like the nurse feels really unsafe. But like I can kind of understand why she feels unsafe. And especially when it's overnight and there's maybe not as many people around. And so I think it's…most of the time it's coming from a good place. It's not coming…trying to be judgmental. It's more I'm scared for me as a person, but also I'm scared too because of this baby. 'Cause we've had quite a few times where we will have parents under the influence come and like very unsafely hold the baby, and sometimes touch equipment. And um you know so it's…for me I struggle with that because when I've had those experiences personally, it's like…like I've had a few times with moms, I've had to take the baby away from them because they're so unsafe holding the baby. But I really want this

> mom to be able to have this relationship with the baby, so how to balance that (Social Worker O, Interview, 9/21/2018).

Substance using patients disrupt the normative operation of care in the neonatal setting. Their very presence introduces an element of threatening uncertainty, personal unsafety, and a looming sense of potential criminality. In the clinical setting, the signs of drug use are read on bodies and mark those bodies as criminally different. The construction of addiction as a recurring, disinhibiting, chronic disease aligns with cultural and criminological constructions of criminality as an enduring character trait embodied in dangerous individuals (Tiger 2013, Garriott 2013). The medical construction of addiction in many ways is compatible with constructions of criminality and therefore allows the seamless incorporation of criminologic-surveillance logics in healthcare. Nancy Campbell argues that the sense of social offense and threat is heightened in the case of pregnant and parenting women who use drugs because their drug use challenges the essentialist view of women as selfless caretakers, solely responsible for social reproduction. "[T]he figure of the addicted woman encodes compulsion without control, the failures of self-governance, and the overwhelming power of illegitimate desires and insatiable needs" (Campbell 2005). The "insatiable" and "reckless" addict violates notions of maternal sacrifice, particularly during and right after pregnancy, when women are expected to begin bonding with their infants and engage in an increasingly intensive regime of bonding practices from skin-to-skin kangaroo care[8] to breastfeeding. These expectations place drug using mothers at a disadvantage as they must contend with hospital staff both monitoring and limiting their access to their own children while simultaneously expecting them to be responsible and meet rigorous expectations for early bonding and caretaking.

[8] Kangaroo care or skin-to-skin is the practice of keeping newborn infants in constant chest-to-chest contact with the mother and has been shown to improve outcomes in low birth weight and premature neonates.

The Limits of the Medical Gaze: Establishing the Clinical Threshold

The perceptual grid of the hospital provides the context by which to see and understand pathologies, contagions, and disease (Foucault 1963). Armstrong suggests that surveillance medicine and the new preoccupation with "risk factors" blurs the lines between health and illness and re-spatializes risk to an extra-corporal zone outside of the clinic. "The new space of illness is the community. Community space incorporates the physical agglomeration of buildings and homes and their concomitant risks to health, …the grid of interactions between people in the community… and a psycho-social space" in which "individual attitudes, beliefs, cognitions and behaviours, limits to self-efficacy, ecological concerns, and aspects of lifestyle …become such a preoccupation of progressive healthcare tactics…" (1995: 394). Indeed, recent work by medical sociologist calls for the medical establishment to embrace this brand of "progressive healthcare tactics" (Metzl & Hansen 2014, Brown 2011, Link & Phelan 1995). The call for medical providers to widen the aperture of the traditional medical gaze and to incorporate an understanding of illness and disease that is rooted in social relations, structures of inequality, and community environments is well-intentioned (Brown 2011). "Social diagnosis" (Brown 2011) optimistically re-envisions healthcare providers' ability to sociologically diagnose illness and disease as effects of inequality and stratified opportunities. My findings reveal that providers already engaged in a process of "social diagnosis" in which signs of social precarity and disadvantage *were* identified and incorporated into clinical decision-making. However, the ability of providers to identify disadvantage did not improve patient care or outcomes rather it created a new set of iatrogenic effects. Patients that were believed to be substance users were moved onto a "problematic" clinical track in which the medical gaze operated in a way that stymied clinical action and limited therapeutic approaches.

For the providers I spoke to, patients' possible drug use status – *was* a symptom of a larger set of social maladies- rooted in their homes, relationships, and communities- and it was those extra-corporal risk factors that needed to be contained, managed, and disciplined by a differently qualified set of experts (law enforcement, child protection, and social workers). Expert A who boasted a lengthy career working at the intersections of medicine and child protection explained the relationship between medical actors and child welfare as one in which medicine is limited in assessing risks - by the confines of the clinical space, while DCFS is empowered to open up the space beyond the hospital bed for examination and interrogation:

> But it's really is the child gonna be safe in that home? That…safety, safety, safety is the decision maker. So, safety is you know…could be is mom living with somebody? Is she living with an abusive boyfriend? It is safety. That's really the worker who can visit the home, who can talk to the support system or not, to talk to mom's…you know what's happening with her? It's really not so much medical. But in that first decision making, it's really—and rightly so—it is the (child welfare) workers who have been trained to look and to go through is this child safe in this home? Which is not the doctor's job to do. The doctor's to say: "how is the child?" Or the doctor can report about how mom has been acting in the hospital… You know how much prenatal care has she had? I mean all of this factors into the decision making of the worker. And then past history. Is this the first kid, or is this the 10th kid? Or you know…so forth. So, all of that is part of their decision-making… (Expert A, Interview, 5/3/2017).

Expert A's quote emphasizes both the boundaries between the medical domain and child protection, and the *permeability* and *interdependency* that defines those boundaries. Determining the safety of the child is "not so much medical" because "the job of the doctor" is limited by their placement in the clinical setting. Rather Expert A emphasizes that the primary role of the doctor in relationship to the DCFS worker is to assist in populating a report against the family using medical assessments (e.g., the mother's behavior in the hospital, her "past history," prenatal care utilization, number of children). The DCFS worker is described as the "real decision-maker" as to whether a DCFS case will be opened, using information from the home

environment and personal relationships of the patient to assess the "safety" of the newborn. Risk is extra-corporal and diffuse in this account. The search for risk factors brings various pieces of heterogenous and incongruous information together- from medical histories, to time and place observations of behavior, to a drug test result, to a relationship with a boyfriend – each piece of information compounding on the others to create a sort of socio-medical "rap sheet" that is used to predict future behavior. Interestingly, drug use or drug addiction is not mentioned in Expert A's account as the primary threatening or risky behavior that DCFS would use to come to a decision- rather it is the sum of the social conditions of poverty that are framed as compromising safety.

Other individuals that I interviewed expressed their frustration with the *unknown* poverty-related factors that may shape the home lives of patients. As one hospital social worker described: "I think what's hard for us is that you know when the child goes home, there's not really anybody overseeing that family system. And my experience is most of the time [when] a baby is born substance-exposed, there's a lot of social risks" (Social Worker P, Interview, 9/21/2018). The shifting risks associated with substance use reveal that substance use alone is not the determining factor in whether or not DCFS should be involved but rather the presumed association of substance use with other poverty-related social factors are driving the desire to "oversee" the family. In these accounts, the image of a family unable to self-govern and self-discipline emerges. Feminist scholars have noted that the maneuver of erasing or diminishing the parentage in marginalized families due to their economic and social disadvantage is a technique used to justify stripping families of their reproductive and parental rights (Briggs 2012, Roberts 1999).

When I asked Dr. K, an obstetrician, if she thought the statute defining perinatal substance use as child neglect was an appropriate use of the law, she outlined the varying degrees of risk associated with different substances and under which circumstances intervention is acceptable:

> So, if you have a patient who is using recreational marijuana, I don't think that that's an appropriate use of resources or the law. I think if you have somebody who is an opiate-dependent-on-maintenance-medication mother, that—again—that may not be inappropriate use of law or resources, because that's a known entity. That's a known issue. Then obviously for those people who are using more like heroin, they're not known to be a chronic opiate user, or cocaine…or those other…other substances, I think it is an appropriate use. I as a medical professional, I have no way of knowing how to evaluate if that infant is safe to leave the hospital with that mother. *And I don't want to have to assess that. I want no part of it. I have no idea how to go about figuring that out.* And I would want somebody with a lot more skill and experience to be able to come and talk to the mother to kind of figure that out with her. I mean I think there needs to be some ability—I don't know how much ability…. on the social work side, they have to say yes, this is child abuse or no it's not. And I don't know how you even train some…but that's just because my mindset is not on that side of things. But you know, I think in some instances it is important, but in others it's not *(emphasis added)* (Dr. K, Interview, 9/14/2018).

In this account, Dr. K outlines the varying degrees of risk associated with different substances while ironically reiterating her inability to assess risk. By positioning certain types of substance use as representing "known" or "unknown" risks, she gestures to the limits of the medical gaze and medical surveillance. Methadone maintenance is categorized as a "known" risk factor because it falls within the realm of medicalized clinical management by medical authorities, while substances such as cocaine, heroin and other unprescribed opiates, are "unknown" risk factors that allude to a sprawling web of contingencies embodied in the desires of the patient as well as their environment, social networks, and intimate relationships. The "unknown" risk factors are described as beyond the medical scope and medical intervention, unmanaged and un-administered by any system of expertise.

The mark of uncertainty upon the patient reflects the growing "privatization of risk management" in a neoliberal healthcare system, in that risk is increasingly viewed as arising from within the individual, a result of their choices and their proximal environment (Link & Phelan 1995, Petersen 1996). Contemporary risk theory (Beck 1992) posits that the conditions of modernity and advanced capitalism create a "new generalized space of risk" (Castel 1991:290) in which risk is no longer viewed as embodied solely within dangerous individuals who must be contained or sterilized (Castel 1991). Rather risk becomes deterritorialized and universal; one need not be deemed a "dangerous individual" per se to be diagnosed with certain risk factors that require surveillance and management, for instance (Armstrong 1995). In this context, where risk exists in a free-floating "extracorporal" zone, risk management takes on highly moralized overtones as individuals seek to build their identities around their health status and ability to manage numerous risks (Clarke et al. 2010, Crawford 2006, Shim 2010).

It is through these individualized risk management strategies that individuals are ultimately judged as being manageable by normative medical approaches, or as this research demonstrates, unmanageable and requiring more punitive forms of intervention. Substance users are deemed to have "disorders of the will" and lack the features associated with "regulated autonomy and self-governance" (Campbell 2002, Szott 2015). Today, risk management strategies aimed at marginalized populations are reformative and aim to reattach "risky" populations to "circuits of civility" by way of connecting them to "control professionals", a class of experts who seek to transform "dependency into activity" (Rose 2000:334, Willse 2015).

The physician's insistence that "they want no part in" assessing the unknown risks associated with illicit substance use demarcates not only her role as an expert *establishing a clinical threshold for medical care*, but it also demarcates the limit or boundary between patient

and "problem." In that moment of disowning or handing-off the patient to differently qualified experts, the physician downplays her own role in assigning value based on a risk assessment and affixing a powerful and fateful medico-social label onto the patient. At what point in clinical interactions do substance using pregnant women stop being viewed and treated as patients and become categorized as problems that must be managed? In line with a biopolitical framing of population management, the establishment of a clinical threshold of care demarcates the limit of investing in certain populations. In the account below Dr. A explains how she determines clinical thresholds of care based upon the social value she assigns to different bodies and health experiences:

> So, substance abuse is just one of the many things that we're dealing with. So, I have to kind of make sure that I am providing the best possible care—especially with rising maternal mortality rates in this country, um and particularly in our communities. In poor communities…African-American communities, the rate of maternal mortality among African-Americans is just crazy high.
>
> So, I feel like I have to make sure clinically that my patients are okay from the time they walk in here until the time that they leave. And if I get too involved with the social issues… then I risk missing other things. So, it's important for me to stay focused. And as much as I would like—when I've made my rounds postpartum—if I have patients who are using methadone or who have you know…admitted to you know eight bags of heroin a day, I let my nursing staff kinda deal with that. I mean if they have questions about it, but I just cannot sacrifice my mental time and energy there (Dr. A, Interview, 8/20/2019).

Patient issues are presented as a zero-sum investment. By distinguishing between high-priority medical problems, e.g., maternal mortality versus "social issues," e.g., substance dependency, medical actors redraw the lines of the clinic and boundaries between patients based upon what is deemed a legitimate medical concern. In both scenarios, death looms as a potential risk to be managed, however, in the case of maternal mortality that management is located squarely in the confines of the clinic and the objectives of maternal medicine. Whereas in the case of substance dependency, and specifically substance dependency among low-income and racialized

populations, the social conditions and risks associated with it are deemed unworthy of clinical "time and energy" and are shifted into the domain of differently qualified professionals.

Substance using pregnant women experience many dislocations in the medical domain. Their suffering is misrecognized by medical providers, their bodies and the bodies of their infants are used to speak against them, and their medical histories and experiences are compiled for later review by the state. These findings reveal that the window dressings of medical ethics and norms concerning therapeutic safety, confidentiality, privacy, and informed consent are a system of resources and protections carved out for the privileged. The confluence of medical and carceral logics in reproductive healthcare supports a system of racialized surveillance in the clinic, in which women who embody the conditions of poverty in a particular way are systematically extricated from clinical care and patienthood. These biopolitical cuts illustrate the limits of biological citizenship via medicalization (Rose & Novas 2005). These findings demonstrate that the medical domain rejects and abandons certain bodies and that that rejection is rooted in the racialized anxieties framing reproductive politics. For socially, racially, and economically marginalized women interaction with medical providers reinforces their "biological sub-citizenship" or "dispossession and biological disenfranchisement" from medical rights and vital care (Sparke 2017).

Oscar Gandy's *Panoptic Sort* considers the role of surveillance in late capitalism, including its applications in the labor market and economy. Inspired by the etymology of "triage," Gandy see's surveillance in the stratified corporate work force as a tool by which the ruling class sort individuals in the labor market in an increasingly impersonal and automated way. Delineating the multiple meanings of *triage*- from the medical practice of sorting and allocating treatment to patients, to its French roots- *trier* – a form of culling or eradicating

damaged material from the marketplace- Gandy defines the panoptic sort as "as a kind of high-tech, cybernetic triage through which individuals and groups of people are being sorted according to their presumed economic or political value. The poor, especially poor of color, are increasingly being treated as broken material or damaged goods to be discarded or sold at bargain prices in the marketplace" (1995:1-2). Gandy's definition, and use of triage, is helpful in framing the findings outlined here and preempt the findings in the following chapter which document what happens to new mothers on the other side of the "handoff." By establishing a clinical threshold of intervention of this population, medical social control extends its power to intervene on bodies and lives through the increasingly punitive welfare arm of the state. The following sections explore how new mothers who have been abandoned by medical actors provide a steady flow of long-term clientele to the city's sprawling, privatized social service industry.

CHAPTER FOUR: "YOU'RE OVERSEEING ME, BUT YOU CAN'T HELP ME?": DISCIPLINING AND SURVEILLANT CIRCUITS OF EXTRACTION

In the previous chapter, I argued that actors in medical systems flexibly alter medical norms, standards, and practices in order to sort patient populations and mark "problematic" patients for transfer to punitive and re-moralizing human service programs and child protective services resulting in a hybrid carceral-medical form of health governance. In this chapter, I will examine the other side of that handoff, how do numerous carceral and semi-carceral programs increasingly supplant a public social services sector and create an illusion of "service provision" for indigent families in need. This chapter asks: in what ways does a highly networked constellation of carceral, semi-carceral, public and private human services agencies come together to manage, contain, and profit from the conditions of gendered and racialized poverty?

This chapter contributes to literature that considers the ways that state powers expand under neoliberalism. While neoliberalism is often associated with the shrinking of state powers (Harvey 2005), some literature explores how state powers have expanded through the growth of the "strong arm" of the state (the penal state) (Alexander 2010, Richie 2012, Wacquant 2009) and numerous scholars also consider how the "soft arm," or welfare arm of the state, has expanded particularly through its punitive functions (Haney 2010, 2004, Piven & Cloward 1993, Pollack 2010, Reich 2005, Roberts 1997, Wacquant 2009). Neoliberal state governance requires innovating techniques to address the widespread economic insecurity caused by the divestment in jobs and the public sphere. The literature on carceral neoliberalism or "law and order" neoliberalism (Bernstein 2012, De Lissovoy 2012, Katz 2001, Klinenberg 2001, Richie 2012, Wacquant 2009) illustrates the punitive social and political responses to economic insecurity. Although neoliberalism often evokes the image of a shrinking and impotent state power,

contradictory evidence suggests that, in fact, the state's "illiberal" securitizing and governing functions expand along with its involvement in economic processes. Neoliberalism is best conceptualized as macro-level processes that promote and exacerbate economic insecurity and the deployment of meso- and institutional-level processes that seek to manage the effects of social insecurity via punitive and regulatory responses (incarceration, tightening border controls, growing military investment, punitive welfare approaches, and privatizing security responsibilities to families and communities). Neoliberalism first destabilizes working class and low-income communities by rolling back essential and life sustaining resources, and then promotes a climate of law-and-order responses to address the effects of divestment, including criminalizing drug use in low income communities of color (Richie 2012).

As state and local municipalities consolidate state welfare functions within their carceral and punishing systems we witness the rise of monstrous and contradictory institutional and programmatic mashups, such as the recent rebranding of the Chicago County Jail as the largest mental health provider in the US or the rise of mandated and state sanctioned therapy and drug treatment programs. In *Carceral Capitalism (2018),* Jackie Wang argues that state budgets and investments are increasingly subsumed by carceral and police functions which exacerbates local budgetary crises and is used to justify austerity approaches to social service provision. In response to divestment in public programs, the state's carceral apparatus and private sector split the difference, each absorbing and mutating social service provision to fit the end goals of their respective projects (punishment and/or market-compliance) with significant cross-over and collaboration between both.

Loic Wacquant has written about the "new government of social insecurity" (2009) and argues that contrary to popular connotations of neoliberalism that suggest a shrinking state

"neoliberalism entails the enlargement and exaltation of the penal sector" (305). However, Wacquant notes that the neoliberal state expands by deploying two distinct strategies for different class segments of the population; liberal-paternalist regimes treat those at the top of the class hierarchy (corporations and the 1%) with excessive permissiveness and paternalistic and punitive approaches are rolled-out for those at the bottom (the post-industrial urban subproletariat) (2009:8). Punishing the poor, however, requires gender specific tactics, which Wacquant refers to as the "double regulation of the poor" wherein the state steps in to manage individuals who are unable to self-discipline, meting out penal solutions for men and punitive "welfare" solutions for poor women. Therefore, the raced and classed disparities that shape the carceral activities of the state are replicated in the state's "caring" or welfare function. Wacquant's argument focuses on how the punitive welfare state manages surplus populations, transferring chronically unemployed men to prisons and welfare-dependent women to work. Yet, feminist scholars who tackle the "welfare-penal paradox" (Haney 2004) argue that analyses too focused on labor market regulation, miss important opportunities to explore how a "host of other social and familial relations" are affected and leave unexplored "a range of possible linkages between gender regimes, welfare regimes, and penal regimes" (Haney 2004: 335-36)

Feminist scholars have pointed to the specific ways in which "soft" state regulatory systems govern through neoliberal gender regimes (Haney 2010, Reich 2005). For example, state programs that seek to transform maternal identities often use the rhetoric of "empowerment" and "autonomy" in order to imbue a distinctly anti-dependent philosophy in their clientele (i.e., to deter their clientele from viewing the state as a viable source of social security). Such programs use motherhood as an opportunity for intervention and responsibilization (or the privatization of responsibility); and paradoxically, encourage mothers to be more independent while reinforcing

the idea that they are unable to appropriately manage their lives or attachments. The rise of "gender-sensitive" or "gender-responsive" programming in carceral settings and state-monitored therapeutic communities over the past 20 years amplifies the sinister side of inclusionary liberal politics. As women's experiences and unique needs become legible concerns within these systems of coercive social control, vulnerable aspects of their lives are opened-up to examination, correction, and disciplining. Specifically, these programs tend to target women's presumed gendered "dependency" (whether it be relational, economic, and/or substance-related) as the root cause of their personal struggles.

Dependency is an ideological concept that cannot be fully appreciated in the context of neoliberal institutions of social control without excavating the history of the term and the ways it has been deployed to shape welfare policy. Fraser and Gordon (1994) trace the genealogy of the word "dependency" from its preindustrial roots to its contemporary usage. They find as industrial capitalism emerged dependency became associated with "the pauper, the native, the slave, and the housewife" while white workingmen's relationship to the economy and employment exempted them from being labelled "dependent" (despite that fact that employee-employer relations are a form of dependency). These early constructions encoded dependency as a form of sociolegal and economic subordination defined almost entirely by one's relationship to the labor market and ignored the forms of subordinated labor (i.e., the labor of the housewife or slave) that were a source of wealth and capital on which white workingmen and property owners were largely dependent.

Subsequent welfare policy reinforced the notion that dependency is determined by one's relationship to the wage economy by creating a two-tiered welfare system. First tier welfare programs were created to alleviate poverty among white workingmen and programs such as

“unemployment benefits and old age insurance were offered as an entitlement, without stigma or supervision and hence without dependency. Such programs were constructed to create the misleading appearance that beneficiaries merely got back what they put in and excluded most minorities and white women” (Fraser & Gordon 1994: 321). In contrast, second tier welfare programs such as Aid for Families with Dependent Children (AFDC) were funded by federal taxes and were viewed as a form of charity for the deserving poor. Claimants had to prove their worthiness via: “means-testing; morals-testing; moral and household supervision; home visits; extremely low stipends-in short, all the conditions associated with welfare dependency today” (Fraser & Gordon 1994: 133). Thus, "Social Security programs invested in the reproduction of laboring citizenry while public assistance functioned to maintain racialized and gendered hierarchies…and to surveil and regulate the poor" (Willse 2015:33).

As welfare provision became associated with poor black mothers the animosity and derision against welfare recipients could only be understood in the context of racist-misogynist backlash (Neubeck & Cazanave 2002, Quadagno 1994). In the 1990s, poverty alleviation programs came under attack by conservatives and (neo)liberals alike who sought to impose work requirements and reproduction-related eligibility criteria and requirements [e.g., work-fare, family caps, paternity testing, birth control and sterilization (Neubeck & Cazanave 2002, Schoen 2005)]. Today “dependency” is a deeply racialized and gendered term that describes poverty as a personality trait, a form of social incompetence, and labor force abdication rather than a description of social relations (1994:332).

Since the passage of work-fare, welfare provision has become increasingly contractual and punitive. While the number of families living in poverty has increased since the 1960s, the number of families enrolled in assistance programs has dramatically decreased (Center on

Budget and Policy Priorities 2013). Cash assistance has been supplanted by institutional and programmatic forms of "assistance" aimed at reforming individuals' orientations towards their own dependency. Scholars have noted this therapeutic trend reveals a medicalized shift in the approach to poverty management (Schram 2018). Therefore, because welfare dependency is racialized, gendered, and medicalized, dependency must also be understood as a form of exposure to multiple and intersecting types of domination. These notions of dependency converge upon existing approaches to substance dependency.

In institutional contexts, "dependency" is multivalent and can refer to any organic system of social support, comfort, or connection that may exist in a woman's life. Often, dependency is problematized as inter-relational dependence and women's sexual, intimate, transactional, familial, and romantic relationships become targets of intervention as "control professionals" (Rose 2000) seek to instill "self-esteem" and the value of "independence" "resiliency" and "self-reliance" in their clients. (Haney 2013, Hannah-Moffat 2010). In a way that parallels the hollowing out of the welfare state, privatized, carceral organizations meant to manage dependency seek to strip low-income women from their "problematic" "high-risk" social environments without considering the ways in which these relationships and patterns of dependency are shaped by larger processes of divestment and institutional and budgetary abandonment.

Jill McCorkle's ethnographic study of a women's prison (2004) demonstrates that prison and welfare systems share an interpretive framework regarding dependency that is informed by drug war discourses. McCorkle finds that the prison where she conducted her fieldwork promoted a "habilitation" model, which treated women, many of whom were former drug addicts, as fundamentally lacking whole selves. Inmates were disciplined through a surveillance

program that targeted their relationships and encouraged them to become "accountable" for their actions and to take responsibility for forming unhealthy "attachments" (i.e., to drugs and alcohol or to lifestyles and intimate partners who distracted from their maternal responsibilities). McCorkle's work demonstrates that gender, drug treatment logics, and notions of welfare dependency intersect to shape the ways that the penal state tries to punitively reform women's identities as responsible and independent.

Lynne Haney's *Offending Women* explores how human service provision work is done in semi-carceral institutions (for example, drug rehabilitation programs or mandated parenting classes) and reveals the deeply gendered implications of regulating the poor. Her ethnographic work examines how service providers regulated mothers in alternative penal programs. She finds that such programs overwhelmingly focused on supplanting the mothers' desires and own perceptions of their needs. In particular, the most vulnerable women were reoriented to view their needs and dependencies as personal failures and weaknesses. The therapeutic approaches used, encouraged mothers to see themselves as autonomous and discouraged them from seeking support from the state (i.e., in the form of welfare benefits) and also sought to shift the very architecture of their desires – using psychological techniques to convince women that substance dependence- much like welfare dependence- is a choice and that the pleasure derived from using substances – could be replaced with other kinds of pleasures like being autonomous. Haney's findings demonstrate that the function of human service provision reflects neoliberal agendas including burdening women with the effects of their own poverty, responsibilizing them, and stigmatizing their dependency.

Jennifer Reich explores some of these punitive functions of the welfare state in her book *Fixing Families,* which centers on the child welfare system and the ways in which it installs

certain exploitative modes of reciprocity. Her work illustrates how state systems intervene upon poor families and reveals how children act as the state's ultimate bargaining chip to reform women and restructure their lives. Reich notes that child welfare systems seek to install certain neoliberal values in their "clients" by promoting an "empowerment" discourse, compelling women to "perform" empowerment in exchange for rights to their children. Employing coercive pedagogical techniques and regular surveillance, child welfare systems necessitate that mothers take on an autonomous and normative appearance and attitude. However, she notes that the empowerment rhetoric deployed by child welfare workers, is less about actually affecting change in the lives of struggling mothers and more about aligning their desires and life goals with the interests of the state. Reich's work, along with others, demonstrates the subtle ways that carceral and punitive modes of state governance blend with and overlap with liberal modes of governance notions, like empowerment.

While McCorkle, Haney, and Reich find that motherhood was a powerfully effective and affective tool used by service providers to try to reform women offenders, Allison McKim comes to a slightly different conclusion in her ethnographic study of a mandated drug treatment program (2008). McKim finds that treatment counselors perceived their low-income, majority non-white clientele in racialized ways that deterred them from using motherhood as a recovery incentive. Because poor black motherhood is pathologized (Roberts 1997), counselors encouraged women to view their recoveries as part of a personal and spiritual project to build a "new self," completely independent of their familial or intimate attachments.

These studies reveal that an analysis of "system intersectionality" (Roberts 2012) is crucial to understanding how gender, race, and class intersect to shape institutional responses to oppression. They also reveal that carceral approaches to gendered and racialized poverty and

drug-use have seized upon maternity status as a way to both punish and "rebuild" or subjectivize women who are deemed to be outside of the maternal norm. These works demonstrate that the neoliberal welfare state has become increasingly indistinguishable from the neoliberal police state, and that under this paradigm of "security/insecurity" marginalized populations and bodies become liminal –simultaneously requiring state protection *and* posing a threat to national security (Amar 2013). The "threat" that poor, immigrant, and women of color pose, however, is directly related to their reproductive behaviors (Griffin 1992). The studies reviewed in this section demonstrate that the responsibility of managing the risks posed by poor women's reproductive bodies is laid upon the women themselves. State systems are rolled-out but their objectives are to autonomize and responsiblize women through teaching them to view their reproduction, lifestyles, and selves as inherently risky (Pollack 2010).

Contemporary governmentality scholars theorize that criminalized, racialized, impoverished, and otherwise "risky" individuals are no longer controlled via methods of confinement, enclosure, or sterilization but rather various "control professionals" are enrolled to "reattach" and rehabilitate risky individuals via "circuits of inclusion" with the goal of securing their marginalized inclusion in society (Castel 1991, Rose 2000). However, scholars critical of this view argue that Foucault and some of his interlocutors do not fully account for the ascendency of neoliberalism and its consequences for social welfare (Willse 2015).

Craig Willse's study of the homelessness social service industry explores how in neoliberal biopolitical regimes surplus populations are not simply left of die or alternatively treated as a drain on the "health of the nation" but rather, surplus populations play an essential and necessary role in the new welfare system. Foucault's model of biopower "describes a 20th century social welfare state that no longer exists in the US" (Willse 2015:41). According to

Willse, Foucault's biopolitics describes a Fordist Keynesian economic model in which the nation-state thrives by achieving homeostasis via stabilizing economies, avoiding economic crises and warmongering, rolling-out a social safety net, and generally eradicating aleatory events. In contrast, the *neoliberal* biopowerful state capitalizes on catastrophe, invites economic crisis, and invests in risk in both the financial sector and the social sphere (Willse 2015). In this economic context, risk is also reimagined and is "no longer understood as needing to be reduced or contained but rather [risks] become opportunities for capital growth… investment in risk opens up a perception of social problems and their embodiment - permanent surplus populations- as economic opportunities" (Willse 2015:47). Therefore, neoliberal biopolitics transforms racial and class deprivation into valuable economic enterprises within the postindustrial service and knowledge economies in which surplus populations are not left to die, but rather their slow deaths are managed and administered as an economic activity (Willse 20015: 50-51). In this way, surplus populations are moved through the social service complex and serve as "raw material" (Hong 2006) for "competitive neoliberal industries of population management" (Willse 2015:50).

The poverty management industry is a contemporary, neoliberal form of rent-seeking. As forms of dependency become viable sites for extracting value [in this case the value of precarity and risk (Willse 2015)] and social control becomes increasingly commodified, market logics transform not only how deviance is categorized (more expansively) but also the aims of service provision become focused on client acquisition and retention by making programming more specialized, programmatic screening mechanisms more inclusive, and rescaling programs for clients at various risk-levels (Gray et al. 2015, Lucken 1997).

This chapter engages with this body of work to explore contemporary poverty management in the neoliberal era and examines the ways in which privatized social service agencies use the carceral power of the state to punish and profit from dependency and poverty through targeting women's motherhood status. In this chapter, I seek to explore the mixtures of carceral, medical, and therapeutic approaches deployed to respond to substance using mothers. I examine how semi-carceral, social service agencies engage with their clientele to understand: 1) how neoliberal restructuring alters the goals of the welfare state and 2) how "gender-responsive" forms of "soft" institutional power target women's reproduction and motherhood status to discipline their clients.

How does neoliberal restructuring and privatization alter social service provision for the poor? Neoliberalism is not about doing away with the state, it is about "marketizing" the state or getting the state to "operate in market compliant ways" (Schram 2018: 311). The wholesale repeal of the welfare state is not a viable strategy for neoliberalization (i.e., public institutions and programs have proven to be recalcitrant as they are incredibly diffuse, socially embedded, and widely popular). Rather state institutions become privatized over time, in a piecemeal fashion, and through being made to operate in market-compliant ways (Schram 2018). One way in which public institutions and programs become market-compliant is by acting as consumers that offer competitive and desirable state contracts to private agencies. Therefore, private-public ventures are best understood as mutually beneficial institutional relationships by which the state establishes the terms of agreement with private agencies. This chapter considers the ways in which these institutional arrangements are mutually beneficial to the state and private sector.

What happens to the individuals in these private-public semi-carceral and surveillant programs? Scholars of the therapeutic state argue that these disciplining and paternalistic

programs are “circuits of inclusion” by which “control professionals” responsibilize clients to integrate them into the low-wage labor economy (Rose 2001). However, as this research demonstrates, terminology such as “paternalism” and “circuits of inclusion” are far too generous terms to describe the experiences of individuals in these programs- as they are not integrated nor cared for in any traditional sense, yet neither are they contained, warehoused, or exiled in the traditional sense, rather they become *fixed in place* within a highly fragmented, sprawling, and resource-deprived social services economy. The population served by these programs are what Ruth Wilson Gilmore has referred to as a “permanent redundancy” (1999) they exist beyond the requirement of the labor reserve, but their existence must be dealt with and “administered,” nonetheless (Willse 2015). Thus, poverty management services do not serve the economy but rather become a part of the economy (Willse 2015:46). Individuals that move within these institutions are desirable to these agencies in part because of their dependent status and, as the findings in this chapter illustrate, their dependency is both *sustained* and disciplined the more embedded they become in these institutions. Rather than acting as “circuits of inclusion,” I argue that the disciplinary circuits these women find themselves in serve to extract value from their dependency (in its various forms) not primarily by moving them into the labor economy but by sustaining their movement within and throughout the social service economy.

Finally, this chapter explores how the “gender-responsive” or “gender-sensitive” approach operates in these semi-carceral institutions. Motherhood and reproductive status are powerful tools at the state’s disposal. The findings reveal how programs which promise to keep families intact and allow children to stay with their parents within institutions use constant surveillance and the threat of child protection intervention in order to make clients comply with program requirements. In addition, children who join their mothers in recovery homes and

treatment centers become a part of the discipling architecture in institutional settings. How does the state invest in the reproduction of multiply marginalized women and what does the particular form this disciplining takes on tell us about contemporary reproductive politics?

Keeping Families Together: Privatizing the Surveillance of Marginalized Populations

This chapter explores the local institutional entanglements that women who have been singled out for drug use during pregnancy find themselves in. I focus on one such entanglement for the purposes of this analysis. At the center of this constellation of services and programs was a state-funded, privately administered drug surveillance program, the Keeping Families Together (KFT) Program. The KFT program was designed as a catchment for women in the Chicagoland area who have been reported to DCFS by hospital staff for giving birth to a substance-exposed infant. Operating in concert with the Keeping Families Together program is Downtown Recovery Center, a 22-bed recovery home that specifically houses women who were in the KFT program and Community Treatment First a substance treatment center where many of the women in the KFT program had spent time. By examining this small constellation of formally and informally networked programs, this analysis seeks to elucidate the intersection of child welfare and substance treatment services to understand how gendered poverty is disciplined and sustained.

The Keeping Families Together (KFT) program is unique to the Chicagoland area and was developed in 1998 by the DCFS Inspector General in response to the unsustainable bloat in the foster care system during the crack cocaine era. The program is intended to divert women who have had substance-exposed infants to a privately-operated, long-term drug surveillance program. Although DCFS funds the administration of the KFT program and is involved in

transitioning families into the program, DCFS is not actively involved in the case management or surveillance of KFT families. The KFT program which claims to "keep families together and out of the courts and foster care system" (program brochure) allows mothers to keep custody of their children as long as they comply with the KFT program requirements. Federal funding is secured by DCFS and awarded to private agencies that administer the program. Administration of the program consists of frequently monitoring, drug screening, and conducting risk assessments on women who were reported to DCFS for giving birth to substance-exposed infant (SEIs). Bureaucrats and frontline workers at these agencies and DCFS often referred to the KFT clientele as "65s" in reference to the state's child abuse and neglect allegation procedures. A "65" is any case in which a physician detects illicit substances in the blood, urine, or meconium of a newborn and is considered evidence of child neglect.

The KFT program is a long-term program designed to last from 18-24 months (although many of the individuals I spoke with said it could last much longer) in which women who are referred to the program are assigned a child welfare caseworker and an AODA (alcohol and other drug abuse) worker (both of whom are employees of the private agencies) who are tasked with conducting risk assessments and "dropping" or drug testing clients. The program is a "voluntary" alternative to DCFS involvement but is highly coercive in nature as women are often told that refusing to enter the program will result in a custody battle with DCFS in which their refusal to participate in KFT can be used against them by the state as evidence of threatening substance use. Thus, although DCFS is not directly involved in the administration of the program, the Keeping Families Together program uses the looming threat of DCFS intervention and child removal as a powerful tool to encourage compliance to the demanding program

requirements. As of 2016, there were 269 families receiving KFT services (Illinois Department of Children and Family Services Annual Progress and Services Report 2018)

The Keeping Families Together program operates out of four regional sites within the Chicagoland area. I was able to speak to the managing supervisors of each site for the purposes of this study. Through these conversations as well as conversations with DCFS officials and women who were in the program, I was able to gain insight into the ways that the program operated and affected the lives of its clients.

Privatizing and Sustaining Dependency

The privatization of the KFT program made it unique in several ways. There were significant agency-level variations in the ways that the program was administered. For example, it was unclear how decisions were made regarding when a case could be successfully closed. At one site, 1 year of "clean drops" (i.e., negative drug tests) was the stated required amount of time before a case could be successfully closed, at another site the manager mentioned that 5 successive clean drops was enough to close a case, for another, closing a KFT case was determined by clients meeting several requirements like being in treatment and "making themselves available" to the intensive surveillance program. The mothers in the program were also uncertain as to the conditions, expectations, and duration of the program. One mother that I spoke to, Gabriella[9] explained that sanctions were often uncommunicated and seemed to be applied arbitrarily by her KFT caseworkers. She had been staying at Community Treatment First– where women may stay with their children while they receive inpatient care- and opted to leave her infant in the care of a family member while she finished up her final weeks in the

[9] All real names have been changed to pseudonyms to protect the privacy of the women who agreed to be in this study.

program and prepared to transition to a recovery home. In particular, she was worried about recent outbreaks of lice and bedbugs in the treatment facility as well as several cases of foot and mouth disease among children who attended the treatment center's daycare. Because she refused to have her infant join her in this environment, her KFT caseworker sanctioned her explaining that her choice to leave her infant in a family member's care constituted a "slap in the face" for which her time in the program would be extended. Another mother, Rose, who had been in the program for two years and had been sober for 1 full year, explained that she was not sure why she was still in the program as she had met the program requirements of providing "clean drops" for over a year and had secured stable housing and a full-time job. She explained: "I don't know to this day why I'm still in the program. My case worker told me six months ago that they should be lookin' to close it. But I still ask that question… Why do I still have a case? I'm not gonna question it 'cause I'm like if it wasn't for me and my actions, they wouldn't even be here" (Rose, black mother of 4, Interview, 10/17/2018). Meeting the program's stated goals (e.g., long-term sobriety, employment, and housing stability) did not appear to be enough to release some women from the grip of Keeping Families Together. The lack of clear guidelines for completing the program, along with subjective assessments by caseworkers contributed to keeping women in the program for long durations of time without a clear end in sight. However, like Rose, several women expressed ambivalent or at least complicated feelings about their participation in the program. There was a sense that they were not entitled to air grievances about injustices they experienced through the program given their "bad" behavior in the past. For some, the punitive burdens imposed by the program were just another thing which they felt they should personally shoulder just as they did the other encumbrances of their lives such as caring for their children while getting "clean" and remaining sober according to restrictive program guidelines while

securing housing, child care, and employment with little support but under the microscope of unsympathetic and powerful social service workers.

Macey, who had been sober for 4 years, was also concerned that there appeared to be no progress on her KFT case. She recounted that her recent diagnosis of a health condition- liver damage due to her prior opioid use- was being cited by her caseworker as a reason why she should be continuously monitored by KFT, in addition to being unemployed. Thus, without a flow of income her case was being extended well beyond the advertised 2-year time span. She explained that she felt trapped by the circumstances of the program because her financial precarity was inextricably linked to her participation in the program and was used as a reason to disqualify her for ending the KFT program despite the progress she had made to demonstrate that she was able to provide appropriate care for her child.

> But I've never had a bad report. Never had a hotline call. If I ask KFT for help it's gonna show that I still need to be followed because I need support still. So, it's been hard. It's been never-ending. And that's how they look at it at the recovery home too. Like well, if you're asking for support, then we're not gonna recommend you could make it on your own. It's like a double-edged sword. And I have to be scared of DCFS taking my kids. And they're like no, we're here to help you. But like this whole time they've just been followin' me. It's just checkin' in, checkin' in. Everything's been good, good, good, good. But yet, you still wanna follow me, but yet you can't help me. You can't help me with a housing advocate? You can't help me with funds? You can't help me with nothing. And if I do ask for it, that's proving I need support still.
>
> It's very frustrating. And I'm like even if you're doing everything you're supposed to be doing, 'cause I've already done all of my services. All her doctor's appointments. My therapist says I can do it on my own, but because of like just little problems, they don't know. So, they're all waiting for like this piece put in black-and-white that yes, she's good enough to go on her own. But ain't nobody gonna put that in black-and-white. Like nobody wants it on their shoulders to make that decision. So now it's just like I keep doin' this, doin' this, And that's the biggest part. Like you're overseein' me. You can call me and ask me all these questions, and be in all my business all my life, but you can't help me (Macey, white mother of 2, Interview, 7/9/2018).

Exasperated with the contradictions of the KFT program, Macey faces the "double-edged sword" of being expected to demonstrate financial and social autonomy by multiple experts (doctors, therapists, caseworkers) while being judged unable to do so when she asks for access to tools and resources that would most help her achieve that goal. Like Macey, many of the women I spoke to felt they were caught in the gray zone of intervention. For example, although Keeping Families Together is not a legally mandated program it is ran and operated like a court mandated program using surveillance techniques and punitive sanctions to coerce clients to comply with burdensome, life-altering programmatic requirements under the threat of having their children removed by the state. Child removal is the ultimate "incentive" and pressure point within these institutions. The KFT program boasts of keeping families "out of the court system," however, because the program is privately administered and operates outside of a system of legal protections and state bureaucratic oversight it leaves women with no legal or institutional recourse to "make their case" or advocate for their parental and civil rights while in these programs. Therefore, these programs are, for all intents and purposes, a-legal (in that they operate outside of law without expectations of public transparency or legal rights) yet, they simultaneously wield the full power of the punitive state as legal parental status becomes the means by which behavior change and compliance are attained.

State-private ventures, like the Keeping Families Together program are mutually beneficial institutional arrangements. For example, while DCFS may worry about the public perception that they are overstepping their reach, for example by having high caseloads and high parental termination rates, privatized programs offload some of the intervention activity of DCFS while allowing the state to claim that they are committed to "keeping families together." In this way, the state may present itself as increasingly liberal in its stated goals (keeping families

intact) while their relationships with private institutions allow the state to obscure illiberal activities.

Moreover, for private programs like KFT, long-term client-retention demonstrates efficacy and value in the private social service sector. Programs like KFT assume a managed care model of privatization by which they rely on practices that artificially inflate their metrics for success and simultaneously reduce their expenditures. By engaging in risk-pooling and "creaming" practices (i.e., taking in and retaining less-disadvantaged clients who require less institutional investment) private agencies can optimize performance outcomes and as a result retain and renegotiate competitive state contracts. In the contractualized, social service sector, client characteristics fold into considerations regarding competitiveness and market value. Clients like Rose and Macey are prized for the same reasons that they are personally frustrated-because they demonstrate success and meet program requirements across several domains (i.e., sobriety, therapists' assessments, employment, etc.) yet remain in the program. If programs have a limited number of clients they are contractually able to serve, it is to their benefit to select for and seek to retain clients that require the least investment and whose continued and long-term success may be used to inflate programmatic indicators of success (a process referred to as suboptimization). By making program requirements and duration ambiguous and subjective, the administrators of KFT solidify their hold on their clientele base and illustrate their value within a competitive social service market in which state, federal, and private funding agencies demand outcome measures to make funding determinations.

In addition to the inconsistency regarding program duration, there were several work-related issues that contributed to across-site variability in the administration of the program and affected the ways in which the agencies responded to their clients' needs. For instance, the KFT

program operates out of private agencies for which there are different hiring practices and qualifications for staff. One of the difficulties of contracting out child welfare practices is that such work is defined by the provision of "deep-end services" or relatively complex, intensive case management with high need families. As a result, the privatization of child welfare programming has been by and large deemed unsuccessful in most cases where it has been implemented (Petr & Johnson 1999, Yang & Van Landingham 2012). The kinds of standardization one would expect from state child protective services would include standard qualification criteria for potential employees. In addition, DCFS is unionized in the state of Illinois which means that workers have protections regarding their working conditions, hours, and compensation. In stark contrast to public institutions, particularly unionized ones, private agencies often cut costs by hiring less experienced personnel at lower wages with few to no fringe benefits.

As a result, private agencies often experience high rates of turnover, which negatively impacts clientele. One manager explained the difference this way: at their site they only hired social workers with master's degrees as a result they believed that they saw higher levels of turn-over among their caseworkers because their advanced degrees afforded them more employment and labor market opportunities. Whereas another agency hired individuals with less education and fewer qualifications which they believed reduced turnover because they had fewer labor market opportunities available to them. I learned from the women with KFT cases that because they were often enrolled in the program for long durations of time, sometimes over 2 years, changes in their case management had meaningful and sometimes profound consequences in their lives and often resulted in an extension in the amount of time they had to remain in the program.

The Continued and Constant Drug Testing of Women

In the previous chapter, I argue that drug testing practices are a racialized surveillant technology used in medical settings to sort patient populations into separate clinical tracks. In this chapter, I explore how women continue to experience drug testing at the hands of these surveillance programs. The primary purpose of the Keeping Families Together program is to conduct frequent drug tests on the women in the program. What is the purpose of frequent drug testing and what does it mean to conduct frequent drug testing as a primary "service"?

The drug surveillance program begins at the first "transitional" meeting that the woman has with her KFT team and the DCFS KFT liaison[10]. This usually takes place within a couple of weeks of the birth of her child. In the initial weeks and months of the program, testing is conducted frequently (at least once a week) and randomly and eventually tapers off to less frequently the longer the woman remains in the program. The frequent and random testing turns women's lives upside down as they adjust their lifestyle to meet the requirements of the intensive and constant surveillance program. Aletha, a mother of 3, was in KFT because her youngest baby tested positive for cocaine at birth. She explained that the KFT program was first presented as an alternative to DCFS intervention and was not aware of the ways that the program would fundamentally alter her life for several months to come.

> A: KFT's crowded. Like you're not in charge of your life no more. It's like they in charge of your life. I mean they like…they cram your space. You know they always comin'…poppin' up. They just pop up and drop you. And if you're not home, that's considered a dirty drop. So, I didn't like that, because if you don't call me and tell me you're coming, how am I gonna know you come. And then if I'm not there, you know, just 'cause I got KFT don't mean I'm bound to the house. I don't hafta stay at the house.

[10] Although DCFS is involved in the hand-off of the case to Keeping Families Together, they are not actively involved in the KFT case. Rather, if a new case of abuse or neglect is reported while a client is in the program, DCFS will be brought in to open and investigate that case. However, the presence and known affiliation between DCFS and KFT does loom over the clientele and is used by KFT caseworkers to remind clients about why they should comply with the program protocol.

> K: So, it counts as a dirty drop if you're not at home?
> A: Yeah. If you're not there to take the drop when they come, that's considered a dirty drop. I didn't like that part. I said I still have a life. I can go outside if I want to. You know? I'm not bound…I'm not on house arrest or anything, so that was another problem. So that's why I had a lot of dirty drops, 'cause I wasn't there a lot of the times. I mean basically I thought they was just…oh, just tryin' to be—spiteful to me and stuff. I was like I wish I never even signed up for this. I was like …they tricked me to sign. You know it was crazy to me. I was like no, they want too much outta me. You know…it's like too much (Aletha, black mother of 3, Interview, 7/9/2018).

The Keeping Families Together program is slated as a program that allows women some sense of normalcy in their lives while enrolled, including maintaining custody of their children, yet the rigorous and invasive nature of the program places a wedge between clients and their normal day-to-day activities, relationships, and responsibilities. The program fosters immobility. By treating no shows as equivalent to a "dirty drop" women are forced to comply with the program requirements that they remain readily available for unscheduled drug testing or risk losing their children. Aletha's suggestion that the program feels like house arrest reveals that even though Keeping Families Together is not administered by the state, private agencies mimic the trappings of carceral discipline in order to both gain compliance from clients as well as demonstrate to state funders that their methods and logics align with those of the state.

Jayde who was in Keeping Families Together because her youngest baby tested positive for PCP at birth struggled to maintain employment and meet the program's drug testing requirements, so she eventually chose to leave her job and enter drug treatment to achieve abstinence in hopes of breaking free from the program.

> K: And would they let you know when they would come over to test you?
> J: That's the problem. Like what type of people…I'd say ya'll let me know you're comin'. I'll get prepared. It was just crazy. You know like one day I just woke up and I was like I'm tired. I'm tired from runnin' from DCFS. My son's gonna be four, and these people still in my life. Four whole years, 'cause I was gonna get my case closed at one time. But they switched KFT workers on me. And I had just recently dropped dirty. And she was like since I dropped dirty, I gotta continue your

> case for five more months. And that turned into a whole other thing. They wanted me to go to meetings. I couldn't make the meetings 'cause I had found a job. And I was like I can't make these meetings. You know I'd rather work and make money 'cause I have two kids to support…and myself. And I gotta pay rent. You know it's a lot right now. It was just a lot then. And then like one morning I woke up and I just said I was tired. You know? I was just so tired. I was just so tired of running. It was like I was just running, you know? And…and I went to the treatment center (Jayde, black mother of 2, Interview, 7/14/2018).

One of the paradoxes of the Keeping Families Together program is that because it is centered around maternal drug use being the most problematic and high-risk aspect of clients lives, it neglected to address or ameliorate the numerous structural, economic, and social factors that precipitated the drug use in the first place. By insisting that women become abstinent for the duration of the program, KFT used coercive and threatening techniques that placed women who were already in precarious situations into untenable ones. As women sought to meet the requirements of the program, they were forced to walk away from the forms of stability that existed in their lives- whether that be jobs, homes, intimate relationships, or family networks. As women entered long-term treatment and recovery programs the restrictions of the programs (curfew times and lack of child care) made it difficult for them to find viable employment and housing, which could then be used by the KFT program administrators and caseworkers as a sign that they were not able to live independently and therefore should not be allowed to exit the program.

The irony of the situation was not lost on the women in the program. Sharmaine, who had been in the program for over a year noted the short-sightedness and counter-productive nature of the program requirements:

> They don't help you…like everything is basically on your own, which as a grown person that's what you're 'sposed to do. But if ya'll wanna be all in my fuckin' business, help me with childcare, help me with clothes, help me with public transportation. Shit, help me find a place, 'cause I got an income that's nothing. Help me find a fuckin' place. I just feel they're not doin' what they should be doin.'

> Instead of getting in everybody business, help them. Yeah, I tell these people…what if these mothers goin' back out there to bein' homeless with their children? They gonna be fuckin' using (Sharmaine, black mother of 2, Interview, 7/9/2018).

In many ways, women are initially singled out to be in this program because of poverty. As was discussed in the previous chapter, medical actors often used signs of poverty (lack of prenatal care utilization, reproductive history, insurance status, race and appearance) to determine which women should be drug screened and reported to DCFS. However, once women enter these programs the conditions of poverty that shape their lives are rarely addressed as the program narrowly focuses on drug use and abstinence to measure progress and global well-being. In particular, the use of regular drug testing as a measure of progress is an example of suboptimization. "Suboptimization occurs when a measure of one particular outcome of service provision implies that other dimensions, usually less measurable, if no less important, have also been met. Suboptimization is rife in human services where the intended outcomes almost always include difficult-to-measure subjective states of being, including improvements in overall well-being" (Schram 2018: 319). Drug test results are a cardboard stand-in for the well-being of the clientele in these programs, but in a social service field where subjective assessments are widespread and where administrators seek "black and white" assessments, drug test results stand out as a formidable tool- seemingly measuring something "objective," "real" and "biological." It is no surprise that the devolved social service industry prefers quick and easy assessments deemed more legitimate, rational, and objective versus the costly investment in "deep-end" services and intensive case management.

By refusing to provide material or instrumental support and relief to the women in their program, the KFT program does not adequately address the problems it claims to address. Using non-drug use as the gold standard for success decontextualizes drug use from the conditions of

poverty and stress that typically surround drug use patterns among low-resourced populations and in many ways exacerbates the very stresses that push women to use drugs.

Drug Logics, Child Welfare Intervention, and Constructing Risky Mothers

Constructions of risky mothering and risky maternal behavior pervade this institutional space. The rationale that keeps these institutional responses afloat is the culturally embedded ideology that drug use, especially maternal drug use, is synonymous with child abuse or neglect. However, years of research cast serious doubt on a causal link between substance use and abuse. Fetal harm arguments i.e., that substance exposure in utero is tantamount to abuse because of its presumed damaging effects, have been discredited (Bauchner et al. 1988, Frank et al. 1998, Hurt et al., 1997, 2005, 2009, Martin et al. 1992). As have arguments around impairment and abusive behavior (DeBertoli 2014). Yet, drug policy, state laws, and various state and private institutions still treat substance use as a sign of imminent threat to offspring and cause for intrusion.

Constructions of harm and substance use were gendered among the staff at Keeping Families Together. KFT and DCFS staff openly embraced stereotypical views of drug users as dangerous individuals and bad breeders. Harm was viewed as occurring before the birth of the infant. When I asked about the relationship between substance use and child neglect or abuse one supervisor responded that when the mother uses substances during pregnancy then "the child is obviously harmed because it was born addicted to drugs." He later clarified: "whatever mom is taking, they're taking, through the tube, they come out addicted, they're born addicts" (Supervisor 1, September 1, 2017). The language of being "born an addict" is a holdover from the crack era when overblown claims of long-term developmental damage were touted by researchers, physicians, and the media. Maternal addiction experts, drug policy experts, and

reproductive rights groups have made great strides since then to battle the misleading language of babies being born addicted, particularly in the media (Newman & Paltrow 2013). Addiction research supports a distinction between the processes of developing a physiological dependency which is accompanied by symptoms of withdrawal when an individual is no longer exposed to addictive substances versus "addiction" which is viewed as both a chronic neurochemical genetic predisposition as well as a set of complex social behaviors, psychological compulsions, and drug-seeking behaviors (Volkow et al. 2016). While newborns can display the signs of a dependency via withdrawal symptoms they are not "addicted" in the sense that they do not have a meaningful, behavioral, psycho-social attachment to the substance for which they have a dependency. "Born addicted" does, however, effectively stigmatize the pregnant women struggling with a drug dependency and reveals that it is the act of reproduction that makes drug use for women a punishable act, for if they were not to become pregnant it is unlikely their drug use would be sanctioned.

Another Keeping Families Together supervisor explained that parental substance use in and of itself posed a significant threat to the infant creating a context of potential harm.

> If mom is positive, we do not leave baby alone with the mother, because even though mom appears to be okay, we don't know…. Because of the fact when we did that urine drop and it said you're using, and you put that baby at risk, even though…. Of course, mom says I'm okay, blah-blah-blah. And they appear to be okay. But we don't know the effects that these drugs are gonna have on mom. And we do not wanna put a baby—or children—in a risky situation where this child ends up bein' hurt (Supervisor 3, Fieldnotes, June 6, 2017).

A link between drug use and child unsafety was implied in many of the conversations that I had with KFT staff. For instance, there were specific stories that circulated across the KFT agencies that promoted a macabre lore around parental substance use and child death. One story that was repeated to me by two different agency supervisors, involved an intoxicated KFT mother who

accidently ran over her infant after setting the baby carrier behind her car. PCP use was presented as inducing hyper-violent and unpredictable behaviors. One supervisor explained that as a part of their annual training the team watches a particularly disturbing youtube video of a man, allegedly on PCP, who believing he is on fire, runs into oncoming traffic to put out the flames. By elevating and memorializing the most extreme and violent cases of drug misuse, KFT staff revealed a bias in the ways they viewed and responded to parental drug use and risk, in which all drug use was deemed high-stakes and extremely dangerous thereby justifying an abstinence-only model for their clientele and a hyper-surveillant approach by staff.

As I tried to understand the frameworks that KFT staff used to situate their clients' drug use, it became apparent that the medical frame for addiction- as a chronic relapsing condition- reinforced workers stereotypical views of drug users as irrational, lacking self-control, and incurable. One supervisor likened addiction to diarrhea, a vulgar analogy that both aligned with the frame of addiction as a physiological response that cannot be controlled and also harkened to connotations of "dirty" and "clean" which were pervasive in the semi-carceral treatment domain. When discussing the intensive nature of the surveillance program the same supervisor shrugged off concerns about women's rights and liberties with the refrain: "once a junkie, always a junkie" (Supervisor 1, Fieldnotes June 12, 2018). While the medicalization of addiction positions it as "a brain disease," the bio-physiological neurochemical framing biologizes the social and moral meanings associated with addiction (e.g., as a personal weakness and sign of incompetent recklessness). In some ways the biological frame makes addiction seem more fixed and intractable than perhaps a social or moral frame would and bolsters the argument for a long-term, punitive, surveillance system that treats abstinence as the gold standard for success.

Maintaining Dependency: Testing Survivor-hood in the Social Service Abyss

The Keeping Families Together program bills itself as providing services to help families move towards sobriety and successful recovery. As I spoke with the administrators of these programs, I inquired into the sorts of services that they provided to meet that end. One manager explained that the program was more than a drug testing program and that the goal was to become "fully engaged and enmeshed with families" (Supervisor 2, Fieldnotes, August 8, 2018). As I tried to gain clarity around what that meant, I explained that among the women I had spoken to, the most common barriers *they* cited to a successful recovery were the lack of childcare, employment, and housing, in other words the lack of essential resources that provide the foundation for familial stability. In response, the manager warned me that the clients in the program had a penchant for "complaining a lot" and that the services that they provided were directed more towards inculcating autonomy, responsibility, and better decision-making in their clients (Supervisor 2, Fieldnotes, August 8, 2018). Another KFT worker explained that they provide referrals to resources and services but that such referrals were not a given feature of the program but rather needed to be earned by the clients. She explained that it was up to the clients to build trusting and meaningful relationships with their case managers in order to receive referrals for the resources they need (Supervisor 4, Fieldnotes, June 15, 2017). Another KFT manager viewed referrals and the work around accessing resources as opportunities to instill autonomy in their clientele, she explained: "One of the things that we like to do, we don't wanna do the work for the parent. We wanna help the parent to do the work" (Supervisor 3, Fieldnotes, June 6, 2017).

It was clear through these conversations with the program administrators that they viewed their role and KFT's role more broadly as providing a pedagogical service, they were teaching and indoctrinating values of self-sufficiency and independence in a void of other concrete or life-enhancing opportunities or supports. It seemed that they viewed their lack of service provision or

care as their primary programmatic service. Withholding resources from women in the program was part and parcel of a larger curriculum on tempering clients' expectations about what sorts of social goods the privatized social services industry offers communities in need. As the welfare state dwindles and becomes increasingly penal and privatized women and families who rely on social services must also learn to redefine "help" and assistance.

For the women in the program, autonomy and self-sufficiency was both expected and required while being restricted and withheld. The ethos of autonomy was weaponized by the program as a test of will and ability. However, when autonomy came in the form of material and financial resources staff were deployed as the trusted gatekeepers over valued commodities. From interviews with clients in the program, I learned that material and financial aids were rarely and randomly dispensed by KFT staff. Sometimes financial aid came in the form of bus passes for travel in and around the city and/or gift cards which were intended to be used by the clients to buy groceries and other essential goods. In the account below, Aletha who had been in the program for 10 months was worried about the decreased resources she was receiving as she neared what she thought was the end of her case. She explains how gift cards-–were closely guarded by the caseworkers.

> A: I'm still in KFT. But the thing is I've got so far along with the…you know been in here [in recovery] for almost six months. So now they like…they barely help me with things now. So now, it's gettin' close to my case dropping. So, it's like man, now they gonna drop your case, then you're gonna be stuck with nowhere to go. 'Cause they can't…they not helping me with housin' or anything.
> K: Do they help you with anything? What does KFT do? Do they give you any services?
> A: Well, they…well, they give gift cards, but they don't give *me* gift cards. They go and do the shopping, the workers, for me, for the kids, with the gift cards. But I haven't gotten any in like three, four months. And basically, nothing really, not too much of nothin'. When I call and ask for stuff, the caseworker will be like well, you can't…you haven't got to depend on me to do everything. *But that's what ya'll here for, to help*. And basically really they not…I'm doin' everything myself now.

> I try to—you know—make ends meet (Aletha, black mother of 3, Interview, 7/9/2018).

It was a common refrain among the women in Keeping Families Together- *"what are they here for?"* On its face, the program appeared to be designed to move women to a place of stability in their addictions and drug use habits only to leave them hanging when it came to providing resources, services, and referrals that would help them move into the next chapter of their lives as autonomous parents. The contradictory style of intervention left women confused and angry. On the one hand the women were not even trusted do their own grocery shopping, while on the other they were expected to meet all of their material needs themselves without calling upon help from service providers or the state. Sunny, who had recently been placed in the KFT program, shared in the puzzlement of her peers: "And they don't take care of no type of business. They don't help you with bus passes. They don't help you with jobs…job hunt. They don't help you with nothin. You gotta do it on your own. It's like *why is ya'll here?"* (Sunny, black mother of 1, Interview, 7/10/2018).

In many ways, the women in the program had been thrown into a service provision abyss, in which they were deeply entangled and coercively locked into a program that, rather than providing services, appeared committed to test the survivor-hood of clientele. While some of the restrictions on the women stemmed from the KFT program, it was, in reality, a constellation of programs that infringed on their autonomy, rights, and mobility. I interviewed women from sites that worked closely with or were affiliated with KFT, the Downtown Recovery Center- a recovery home funded by DCFS specifically to house KFT clients- and Community Treatment First which offers residential treatment and recovery for pregnant women and women with small children. Each of these programs also involved a high degree of surveillance and restrictions on women's autonomy. For instance, the Downtown Recovery Center had restrictive curfews that

limited times women could be out of the home. Many of the women in this program were sober and had completed their substance treatment programs, therefore, the next step for moving their lives forward was to find viable employment and housing. Without a record of stable employment experience or skillsets and without a strong educational background many of the women at were left to compete over low-wage, low-skill jobs that require high levels of flexibility in terms of hours and commitment. The strict curfew requirements left many women with a small handful of opportunities to work in low wage jobs within close physical proximity of the recovery home so that they could make it back on time for curfew. In addition, the recovery home was reluctant to provide basic resources for mothers and their children like diapers and baby wipes, so that mothers were required to spend their limited income on these basic essentials rather than putting money aside to save for future housing and moving costs. Davina, a black, mother of 3, who had been in the program for a little over a year, explained the lack of basic services in the exchange below:

> K: Do they have diapers, clothes, things for the kids?
> D: They get donations frequently. But I don't…I've never heard anyone having a successful time at getting that. So, I don't really know what happens with the donations. I had miscommunication about here. Because I was told that they…you know they set you up for success. Not that whatever you're doing, you have to do. I mean I understand that you need to be your own person, and you know take care of whatever you're gonna take care of. But they don't even have like a guidance plan. You know what I'm sayin'? (Davina, black mother of 3, Interview 7/12/2017).

Macey, who was staying at Downtown Recovery Center with her two-year-old toddler, expressed her frustration with how women who ask for help were treated with derision:

> There's a big, huge misconception that as soon as women with kids get into these places, they're just gonna ask for more, and state benefits, and help in all of this. But it wouldn't be bad if true. What's wrong with their kid havin' diapers and clean clothes. But they just think that once women get in these centers…. well, when you're in that center, they're gonna help you with housing. No. They don't.
>
> They make you feel bad for taking advantage of what you should be takin' advantage of. Like if I need diapers or wipes, [they say] so go buy 'em. Well, I

> understand that, but I am supposed to be saving money to get a place. It's like I know you guys get funding. I've seen all the stuff dropped off for us. You open the cabinet and there's tons of 'em…tons of diapers. But they kind of…use it against you, you need to find your own stuff, you need to get your own stuff, and I understand that. But that's why I'm here so that I can take advantage of your help and save what I have, to get out. I mean I understand they want to see you be independent and be able to afford it yourself. But in the long run to get us stabilized and get us out of here, why wouldn't you—if you guys have the funding and you have the supplies—have no problem giving it to us so we can save? (Macey, white mother of 2, Interview, 7/9/2018).

Mothers were expected to demonstrate autonomy under herculean circumstances. Over and over again in interviews, the clients in these programs expressed nearly identical frustrations- *why do these programs exist*? *What is their purpose?* These programs posed the ultimate paradox for the clients within them. They imposed themselves into the lives of indigent women, overturning their lives to examine the most desperate parts, demanding compliance and significant personal sacrifice and then once women asked for help or care of any kind in return, they were told they were on their own. The penal social welfare complex that manages marginalized women requires that they "perform empowerment" to be counted as success stories but offers no real system of supports to actually empower them (Reich 2012). These findings demonstrate how neoliberal helping operates through the hollowing out of the state's welfare programs and their replacement by private contracted agencies that provide even fewer vital services. As women navigate these hollow and stripped-down institutions, they must reckon with their own dependency which is at once a boon for private agencies as well as a lived reality and insurmountable obstacle for the women being managed. Dependency is a multi-faceted aspect of these women's lives as it defines their socio-economic circumstances, their relationships to institutions, and their substance use issues.

Institutional Parenting in Strong-Arm Rehabilitation Facilities

Treatment and recovery were central experiences for the women that I spoke to. I recruited my sample of women from the Downtown Recovery Center and Community Treatment First and learned about the types of barriers that they experienced as they went through the ups and downs of substance treatment and recovery. The structural barriers for women receiving adequate treatment were evident to all parties I interviewed; issues with managed care, decreased insurance coverage for inpatient stays from 90 to 30 days, limited treatment capacity, and long waiting lists for women with children who needed treatment were issues that treatment providers and clients had to attend to. In addition to these structural barriers there were barriers to care that came from within the facilities.

Women described their experiences living and struggling to remain sober in these facilities which were often described as chaotic and stressful places to reside. The list of grievances among women in the treatment facility was long. I learned from the women staying at Community Treatment First that the administrators had recently changed the living arrangements so that the women who had families were no longer assigned private rooms but were required to share a room with another woman and her children. The chaotically cramped living quarters and lack of privacy were cited as concerns among the women who felt that the stress of the living environment impeded their path to recovery. But more so than their relationships with other women in the program, the women felt that the relationship between the staff and the residents was especially tense and acrimonious. Numerous women mentioned that they were significantly distressed by the way that the staff treated them. Conflict between the residents and staff was described as frequent. Staff were described as holding grudges and playing favorites among the residents. In addition, residents complained of a lack of autonomy, lack of structured time, and a militaristic boot-camp style approach among staff.

Teresa Gowan and Sarah Whetstone refer to facilities like Community Treatment First as "strong arm rehab" which they define as a "particular type of court-mandated rehabilitation emphasizing long residential stays, high structure, mutual surveillance, and an intense process of character reform" (2012:70). Although most of the women in the program were not court-ordered to go to treatment, they were compelled to enter and remain in treatment through programs like Keeping Families Together which made DCFS involvement an implicit threat of non-compliance. One effect of strong-arm rehab, which uses carceral techniques to manage clients, is that it naturalizes addiction as criminality, by which "'using' and 'criminality', like 'prison' and 'treatment 'become practically synonymous pairs" (Gowan & Whetstone 2012:81). Just like the rest of the healthcare system, substance treatment in the US is highly stratified. Affluent populations with substance use issues have access to posh facilities with boutique and customized services that employ innovative, humanizing, and consensual therapeutic approaches like motivational interviewing (Carr 2013, Clarke et al. 2003). Poor and court-involved populations must contend with second tier treatment modalities and facilities which treat addiction as a hybrid medical-criminal category. However, in semi-carceral treatment settings that cater specifically to women who have children, motherhood and maternity status played a significant part in the ways that punishment was conceived and doled out.

Both Community Treatment First and Downtown hailed their programs as progressive because they allowed women, with some restrictions, to keep their children with them while they completed the treatment and recovery process. Many of the women also found the option to keep their children with them preferable to the alternative. However, institutional responses to motherhood and child rearing complicated the treatment and recovery process and created uniquely gendered challenges and stressors. Women reported that their mothering practices were

closely surveilled and could be used to by staff to punish them. At Community Treatment First there had recently been an accident during which a woman rolled over her infant while in bed and asphyxiated him. The infant death rattled the staff at Community Treatment First and resulted in the implementation of strict rules against residents being in their beds with their children. For the residents this meant increased surveillance and more threatening behavior on the part of the staff. In the account below, Leanne who had recently handed over temporary custody of her son to his father because she felt the treatment center was not the ideal environment for him, explains enjoying her free time visiting her one- year-old outside of the clinic:

> L: I get to lay in my bed with him and all…and cuddle with him at home. And not be wrote up and have DCFS dangled over my head all the time. Like that's just bullshit. The big thing around here is if you didn't come in with a DCFS case, you're gonna leave with one because you know it's just how it is. I mean they can make a hotline call whenever they want to.
> K: Do they do that kind of thing?
> L: No, they didn't to me, but they surely threatened it. I had a lot of write ups though, because I wanted him in my bed. I wanted him to lay with me. I wanted him to sleep, even if I was layin' there reading or something, I liked having him…. You don't have any children yet, do you?
> K: No.
> L: So, when you…when you get children, you're gonna remember this and be like she is so right. 'Cause just that feeling of holding them and having them fall asleep with you is just…there's nothin' like it. (Leanne, white mother of 1, Interview, 7/14/2018)

At Community Treatment First the experience of relaxing with and enjoying time with one's children became a disciplinary offense. Brianna, an older Puerto Rican mother of 3, had a similar experience with the Community Treatment First staff when she was threatened with DCFS intervention because she had been caught with her child in her bed.

> The baby did not wanna stay in his crib. So, we got caught in one week of [him] sleepin' with me four times, and I was threatened with a DCFS call. Oh my god. Whoo…I went through the roof. How dare you threaten me with a hotline call! Who do you think you are?! I was so mad. I took that very personal. Don't threaten

> me with my child. Don't do that. My thing was you shoulda came to me and spoke to me. Don't—in the open, with an attitude—tell me oh, I'm gonna have to make a hotline all on you. You know, NO! You're threatening my child! You know what I'm sayin'? I take things very personal because let me tell you somethin'…I mind my business. I don't like conflict. I'm not a fighter. But when it comes to my child, you bring out nasty outta me. And it's not a pretty thing. You know? Like don't do that. You don't do that. It coulda been addressed in a different manner [by staff] (Brianna, Interview, 7/15/2018).

Threats to call DCFS on mothers as a form of retaliation for not following the facility rules heightened the sense of unease between staff and clients. Staff's willingness to use DCFS as a means of exerting power and control over clients was also strategically used by the clients when they got into conflicts with one another. The lack of privacy meant that clients could monitor and surveil each other and when they had disagreements or arguments with their peers, they could use observations of their parenting to gain the upper hand with staff. Some institutions allow mothers to keep their children with them as they go through the ups and downs of treatment and recovery, living in the treatment facility or recovery home with their mothers. However, the seemingly inclusive and progressive policy has a dark underside. In a restrictive and punitive total institution, the day-to-day, lived realities and experiences of being a parent are weaponized and become a liability for mothers.

Besides concerns about staff abusing their power, mothers worried aloud about how institutionalization might adversely affect their children's development. Macey, who was living at Downtown Recovery Center was concerned that when staff were unhappy with her, they would take it out on her daughter, and she worried how her daughter might internalize rejection by the staff:

> One of the staff here, me and her butt heads. We don't agree on some things. And she usually loves my child. She hugs her, gives her gifts. But we just butt heads then she takes it out on my daughter. Like [my daughter] will run up to her and she'll be like 'go away, go to your mom.' And that's where I draw the line, 'cause now you're teaching my daughter if she doesn't kiss your ass, then she's not gonna

> be loved. That's not something that I'm gonna allow my daughter to [learn]. So I mean you're gonna have it everywhere you go, but I think they need…more education for the staff, how they treat people (Macey, Interview, 7/9/2018).

Leanne, who had recently sent her one-year-old infant to live with his father, noted that he appeared to be happier and healthier outside of the institutional setting:

> I left him at his father's house for a few days. I was gonna bring him back, but I saw just how happy he was like just bein' a kid, not havin' to go to groups, or going to AA meetings, or bein' stuck in a stroller all the time. And you know I had to be not selfish. And I saw that he was happy. He went from not walking to like walkin' around with his like walker within like 24 hours. So, I'm just holding him back here. I mean I just didn't want him to have to go through it as he was getting older. You know? When he learns how to walk and stuff. I don't want him raised in a treatment facility. Fortunately, I had a choice (Leanne, white mother of 1, Interview, 7/14/2018).

The living arrangements for the children were as repressive as the they were for mothers and they were similarly affected by the lack of privacy and agency. Children were often forced to stay in strollers and carriers for hours on end as their mothers attended groups and other required activities. As a result, the young children in the facility were often restless, cranky, and quick to cry out, leaving their mothers persistently frustrated and exhausted. The inability for children to freely move around extended to the organization of the living facilities themselves. For example, parents at Downtown Recovery Center did not have access to their own private rooms, instead the staff kept keys to the women's rooms as well as the entrance ways to the residence halls. The residents noted that the lack of control or access to their private living spaces made things "awkward."

> The awkward part about here is you can't go anywhere in the building without a staff, because they have to unlock the door. So, if we come downstairs, we have to knock so you can get let in the living room. So, it's kind of a little awkward. You know it's a lot of adjusting for a child to—you know—have to actually knock or ask someone to unlock the room—you know—'cause we don't even have a key to our bedroom. It should be a little more relaxed, because of the children. Like at least maybe we should have our bedroom key. They should too—but maybe we

> could have it too so it would look more like home. We're going home…you know what I mean? (Davina, black mother of 3, Interview, 7/12/2018).

Programs like Keeping Families Together, Community Treatment First, and Downtown Recovery Center all employed techniques for managing their clients via their motherhood status. The lack of mobility, curfews, and restrictions on movement within the facilities made day-to-day living onerous and made simple tasks like going to one's room or laying in bed with one's child punishable offenses. Parents worried how these environments might affect their children and their relationships with their children. Institutional parenting, while often couched as a privilege, was more often experienced as another way by which institutions could surveil, judge, threaten, and punish mothers. As Lynne Haney notes in her ethnographic study of a women's prison that permits women to keep their children with them, "punishment operates not only through familial separation but also by remaking familial relationships" (2013:109).

Parents worried about how institutionalization might impact their children. Were they scaffolding and normalizing incarceration and preparing their children for a life of surveillance and institutional oversight? Or worse yet, did they risk their children associating institutional life with stability and safety that they, as providers, could not secure for them on the outside? Jayde, who was living with her older daughter and infant at Downtown Recovery Center, explained that her daughter was reluctant to leave the recovery home because of the stability it offered and because her mother had come so far in her recovery:

> She told me the other day, she's like she don't wanna leave. She wants to stay. She's like mom, I don't care how long we gotta stay here, as long as we keep you okay. And for her to say that—you know—I wanna stay here. If I could go to school at night and work in the morning, I'd love to stay here. But I can't do that. And I'm tryin'…we can't stay here forever. And it's…it'll institutionalize her. Make her like that. I want her to be like…free, explore the world. You know this ain't everything that is. (Jayde, black mother of 2, Interview, 7/14/2018)

Women's relationships with these coercive, restrictive, and punitive institutions were complicated. They expressed anger and frustration, a sense of injustice at the daily indignities they experienced, and concern for their children but several participants also expressed varying degrees of appreciation for these programs. Some women described a sense of indebtedness or a feeling that their placement in these programs was fateful. Therein lies the paradox of penal welfare. Dorothy Roberts' qualitative study with women in the child welfare system in the deeply segregated community of Woodlawn Chicago, reveals a similar paradox (2007). She found that the residents experienced child protection services as a threatening form of coercive and invasive control as well as a valued resource in a community that is defined by considerable divestment. Conditions of extreme precarity and instability foster these forms of *coercive reciprocity* between poor women and semi-carceral institutions, by which a very limited form of care provision is exchanged for certain material, biological, and symbolic sacrifices made by recipients (Decoteau 2013).

Conclusion

This chapter documents the rise of the *re-privatization* of gendered and racial dependency and subordination. The response to substance using low income women of color exists somewhere between the penal welfare state and the carceral state. Contracted private semi-carceral institutions administer poverty, risk, and precarity differently than state systems and because they are once removed from a system of public oversight and legal protections, much of their activity is obscured from public view. For one, private institutions in private-public ventures operate in market-compliant ways (Schram 2018) and strive to increase efficiency while cutting costs. The primary way they achieve this goal is by demonstrating success through a

process of suboptimization and creaming – retaining relatively lower-risk clients over long periods of time and documenting their continued "success" vis-à-vis superficial indicators of well-being such as successive "clean drops" or negative drug test results. Furthermore, the medical framing of addiction, which emphasizes lengthy treatment and recovery trajectories and the relapsing nature of substance use, reinforces long-term, surveillant, and restrictive approaches to substance dependency.

In this chapter, I conclude that substance using mothers must survive within a *social service abyss* where clients have few rights or resources and, thus, are ideal candidates for long-term service provision. The women in this study were shuffled between various fragmented worlds of multi-institutional management (e.g., case management, surveillance programs, drug treatment programs, counseling and rehabilitations groups, and restrictive temporary housing programs) without access to resources that would enhance their social mobility or life chances (e.g., stable housing, job training and placement, educational investment, or childcare assistance**).** At-risk women are incorporated into an "economy of abandonment" (Povinelli 2011) in which life is differentially valued and politically included; leaving those least valued to the processes of capital accumulation, most exposed to death, and whose very exposure to death still renders surplus value in the political economy.

Moreover, the privatization of poverty management through interventions and intrusions upon the family, disenfranchises women from legal rights and protections offered under a state-administered system. Although state child protective systems are not known for being particularly just and rights protecting systems, especially for women of color who have been disproportionately targeted by child welfare systems, they do at least offer recourse to legal representation, judicial oversight in child custody cases, and multiple forms of institutional

oversight and regulation. The private social services system is essentially an a-legal system imbued with state-like powers; the individuals within these systems have few legal options or protections. The lack of transparency within these private systems incentivizes and obscures abuses of power and illiberal activity. Moreover, since structural racism is built into the very foundations of state child protective systems (Roberts 1999, 2009) part of what is being privatized in these opaque social service programs is a system of racial reproductive disinheritance. Privatization is the institutional equivalent of colorblind ideology which obscures and hides structures that produce death and disadvantage (Giroux 2006). Privatization and institutional fragmentation obscure racialized technologies that administer death.

Yet, it is not accurate to suggest that the private sector has "taken over" or subsumed state systems wholesale. Rather, public and private systems work collaboratively in mutually beneficial ways. DCFS hands over parts of child welfare management that are particularly taxing for the overburdened system to manage in house- like intensive, long-term case management and drug surveillance- and contracts with outside private agencies that are believed to be able to operate in a more nimble, efficient, and cost-effective manner. In exchange, DCFS can claim that they are engaged in community partnerships that help divert families from courts and children from foster care, portraying DCFS as far more invested in reformatory measures, progressive policies, and service provision than it has been in actuality (Austin 2003). By creating the Keeping Families Together program, funding it with public monies, tasking outside agencies to administer the program, and "enrolling" clientele into the program- the state governs the reproductive lives of at-risk drug using mothers "at a distance" (Rose & Miller 1992) as it is not actively involved in the day-to-day administration of the program. In order to ensure that women comply with the sapping material and symbolic demands of the program, programs like Keeping

Families Together which are technically a-legal and "voluntary" rely on the carceral and punitive trappings of the state to gain compliance from clients. DCFS assists KFT in this objective by appearing to be omnipresent throughout the administration of a KFT case, available, if necessary, to remove children from unruly and non-compliant mothers. While there has been plenty of critical commentary about the rise of corporate welfare- or state support, subsidizing, and tax breaks for the business sector, there has been less examination of the *carceral safety net* or the ways in which the private sector may lean upon the punitive and securitizing functions of the state in order to police surplus populations who either may pose a threat to business as usual through forms of resistance or whose participation in the private sector is mandatory for its financial success.

This chapter critically examines how women's immobility and dependency is fostered and sustained for the purposes of maintaining them and fixing them in place within the privatized sprawling and fragmented social services complex. Silvia Federici's work reveals that the sexual division of labor and women's dependency was not a "natural" or adaptive relation that emerged within communities and families but rather was the accomplishment of a murderous and genocidal state-sponsored campaign spanning centuries. The witch hunts of the 16th and 17th centuries, led to the social degradation of women which was "fundamental to the accumulation of capital" (2004:75). Federici's work demonstrates that biopower must be understood through the processes of capital that dispossessed women of control over biological reproduction and constructed them as "non-workers" at the service of the production of labor-power (2004:16). In a post-welfare state where surplus populations exceed labor demand, forms of racial and gendered dependency are repurposed not as uncompensated labor or social reproduction, but rather their mere dependency becomes a valuable site of extraction in the private poverty

management sector. This re-privatization of dependency illuminates more than novel processes of commodification, it also suggests that women's rights are fundamentally being rolled-back as their experiences of exploitation recede back into the private sphere. Although the control of women's reproduction has always been of interest to the state, this variant of reproductive regulation is part of a contemporary eugenic strategy which regulates reproduction "at a distance" through increasingly privatized networks, agencies and organizations. Unlike previous eugenic methods which sought to restrict, limit, and discourage the reproduction of marginalized women, women of color, poor women, immigrant women, and drug using women, the contemporary methods deployed by penal welfare programs are pedagogical in nature and insidiously institutionally reinforce that reproduction is, in and of itself, a mode of punishment.

CHAPTER FIVE: STRUCTURAL VIOLENCE AND MATERNAL AMBIVALENCE: DRUG USING POOR WOMEN AND THE LIMITS OF RESPECTABLE REPRODUCTION

This chapter seeks to complicate the ways social scientists tell the stories of drug using women's reproduction and maternity experiences. In this chapter I consider the stories of the women that I interviewed for this study and like most social scientists who study drug using women, I seek to "do something" with their stories. How do we understand maternal status and reproductive experiences that are constricted by and defined by various forms of structural violence as well as challenge common portrayals of mothering among drug using women in social science research? Feminist ethnographies and qualitative studies of populations of drug using women are often obviously wrestling with humanizing and non-stigmatizing ways to depict their subjects. The agency/structure paradigm emerges in most major works on this population as feminist social thinkers struggle to write across difference and imbue their subjects with humanity, wit, and willfulness. These efforts are laudable and suggest a sense of ethical obligation on the part of feminist knowledge producers, but when reading works like Marsha Rosenbaum's *Women and Heroin* or Elizabeth Ettorre's *Women and Substance Use*, one can see the authors straining to have their subjects "fit the frame" particularly around motherhood. This is largely due to the fact these works exist and operate within a culture in which motherhood exercises a powerful symbolic force.

Motherhood is redemptive; it is the primary way by which women manifest their social worth and value. For drug using women, it is the antidote to being forever cast as the junkie, the druggie, the loser, the burnout, the monster; it is viewed as the motivator to getting clean, staying sober, and rebuilding a good, clean, sober life with the material trappings of a good, clean, sober life. Social scientists tend to focus on mothering as a practice that has the power to transform

"spoiled identities" (Goffman 1963). Motherhood is the means by which drug using women can become clean, palatable, recognized and valued (Baker & Carson 1999, Ettorre 1992, Couvrette et al. 2016). This mirrors the logic of carceral institutions like the criminal justice system, child welfare, penal welfare programs, and strong-arm rehabilitation services which seek to induce behavior change in drug using women through their maternity status. This is not the subtext of these programs; it is the banner. It was said out loud and often by the people that I interviewed; doctors often referred to pregnancy as a "window of opportunity," caseworkers and child welfare workers viewed motherhood as the ultimate tool for coercing behavior change and children as the ultimate bargaining chips. The question underlying this chapter is, why are feminist scholars and the punitive carceral institutions they often critique, using the same frameworks to ascribe value and worth to drug using women? How do we do research that doesn't reproduce the logic that motherhood will clean you? How do you discuss the discomforting and sometimes dark realities that motherhood can harm; that there is ambivalence, distress, and pain in the process of bringing life forth, reproducing, pregnancy, child rearing, and that poverty, violence, and drug addictions make the tasks of social reproduction even more fraught than it already is?

Is there space in our discourse and scholarship for interrogating marginality and maternal ambivalence without caricaturizing women as pure victims or empowered, gender subverters? More importantly, can we examine this ambivalence without fear that such an analysis could do additional harm to women who already face considerable prejudice, suspicion, and distrust in their mothering capability and love for their children? Or feed into beliefs that the only way to ensure that drug using women are adopting the appropriate maternal register is via constant surveillance and intervention by state institutions and social service actors? How can researchers explore ambivalent motherhood when marginalized women are already presumed to pose an

inherent threat to their offspring, without contributing to their oppression or emboldening their critics?

I argue that we must make space for maternal ambivalence among non-normative and multiply marginalized women. Women who engage in risky behaviors, women who live in risky environments, women who are often not trusted to reproduce by the wider society must be included in a feminist, intersectional reproductive justice framework that pushes against notions of "respectable reproduction" and creates the possibility for uncertain, unwanted, inconvenient and ambivalent motherhood. Recognition of this space is vital. Ambivalence regarding motherhood is rarely considered in social science. The few occasions in which maternal ambivalence arises in feminist work it has been relegated to and defined by the experiences of privileged women (Donath 2016, Rich 1995). One might argue that the animus at the center of the anti-abortion movement and the historical and cultural discomfort with women who are willingly childless is rooted in a strong ideological commitment to "compulsory reproduction" (Mamo 2007, Waggoner 2017). In general, our cultural tolerance for women's ambivalence around reproducing and mothering is low and rarely depicted in social science, feminist scholarship, or cultural representations in art and mass media.

In *Regretting Motherhood: A Study,* Orna Donath goes against the bias in social science that attributes the feeling of regret exclusively to experiences of *not* having children [as has been documented in the case of adoption (Ramanathan & Mishra 2000), sterilization (Jequier 1998), abortion (Appleton 2011, Hoggart 2012), and vasectomy (Hoggart 2012)] and examines the emotional terrain of having and caring for children, or "regrettable motherhood" (2017). Donath's findings were picked up by several major, global news outlets upon the publication of her book (uncommon for feminist research in today's media saturated environment). Outlets like

the BBC, the Guardian, and Vice published reviews that reveled at Donath's study. It seemed the mere suggestion that a mother *could* regret having children and may entertain the counterfactual of a life of freedom from childrearing was an unprecedented and provocative portrayal of motherhood. Even so, Donath's sample consisted of a relatively privileged group of Israeli women, if *their* feelings about the experience of motherhood were deemed controversial, how might contemporary audiences respond to depictions of ambivalent mothering among extremely marginalized women for whom motherhood is often seen as the sole vehicle for vindication and legibility (Michelson & Flavin 2014)? Can social scientists, researchers, and feminist scholars make space for this group of women to have complicated feelings about their reproductive lives and experiences as mothers?

As Adrienne Rich illustrates in her own confessional and philosophical exploration of "the exquisite suffering" and ambivalence of motherhood in *Of Woman Born*, motherhood carries two superimposed meanings, "1) the potential relationship of any woman with her powers of reproduction and to children and 2) the *institution* which aims at ensuring that that potential - and all women - shall remain under male control" (1995:13). A critical analysis of the *institution* of motherhood is essential for understanding various modes of oppression. The only way of building a justice-oriented reproductive politics is to undo the deeply engrained belief in *respectable reproduction* rooted in notions that biological reproduction is valued and deserving in that it is controlled, planned for, and unfolds in a relatively normative environment populated by resources and various forms of capital. I use the term "respectable reproduction" to puncture liberal conceptions of reproductive rights which is framed as individualized, hyper-control over one's reproduction and is imbued with the historical remnants of racial and sexual anxieties about citizenship and national belonging. Respectable reproduction animates our representations

of the ideal mother whose decision-making, prudentialism, and productivity may be understood or read through her reproductive experiences and choices. In this chapter I seek to demonstrate the ways in which respectable reproduction is a "technology of citizenship" (Cruikshank 1999) or a pathway to inclusion that grants access to legal, political, and social recognition via modes of "normative" and "controlled" reproduction. In this chapter, I hope to illustrate that respectability politics does not serve those most marginalized by the institution of motherhood and feminist scholars should interrogate the stories we tell about poor women, drug using women, and women who exercise their trauma for our research projects.

Stories We Tell about Drug Using Women and Motherhood

There is a rich ethnographic, anthropological and sociological tradition of studying deviant and criminalized groups and troubling their lived experiences and life worlds. Drug ethnographies emerged as a social scientific genre in response to the urban heroin epidemics of the 1960s and 1970s. Early examples including Edward Preble and John Casey's "Taking Care of Business: The Heroin Users' Life on the Street" (1969) and Michael Agar's *Ripping and Running: A formal ethnography of urban heroin addicts* (1973) though focused exclusively on men's experiences of heroin addiction, provided a nuanced view of drug use and informal street economies and challenged stereotypes that drug users were passive, irrational actors by highlighting the amount of effortful work involved in the daily process of procuring drugs. These ethnographies provided the blueprints upon which later ethnographies of women's experiences were modelled.

Marsha Rosenbaum's ethnography *Women on Heroin* (1981) was the first to examine the experiences of women drug users and considered the ways in which motherhood and childcare

responsibilities constrained women's ability to "take care of business" (of course, this could be said of women working in "formal" economies as well). Rosenbaum's work centered mothering in her narratives of women's drug use careers and revealed that drug use was experienced as at-odds with parenting. She found that caring for children was profoundly influential in shaping women's motivations and desires to exit "heroin world." *Women and Heroin* brought the experiences of women, reproduction, and caretaking to the fore within the andro-centric field of drug ethnographies, which up to that point cared little about the experiences of women let alone their struggles in a patriarchal and hierarchical illicit economy. However, Rosenbaum also helped established a paradigm that would come to dominate research on drug using women for decades to follow, namely that women who use substances are depicted as the owners of two competing master statuses, "drug user/addict" and "mother" and that these two oppositional statuses vie for dominance and come to define women in their entirety. To be fully defined by one's drug use behaviors or motherhood status, or the tension that arises between the two, renders a one-dimensional character on a moral quest at which she can fail or prevail. *Will maternal instinct and love triumph over hedonism and self-destruction?* However, women's drug use, sexuality, reproduction, and maternity experiences are certainly more dynamic, fluid, and overlapping than such a narrative construct would suggest.

In the 1990s, two distinct strands of research emerge to capture the experiences of drug using women. The first, which I am calling the "inclusionary feminist lens," seeks to validate and at times appreciate drug using women's experiences and the other, the "feminist nightmare lens" (Campbell 2002: 206, 209), views women drug users as hopelessly victimized by their drug use and gendered and sexual submission within the informal drug economy. Race and substance type play heavily in determining which strand was employed to describe drug using women, the

nightmare lens was typically employed to gaze upon indigent black women who used crack cocaine (Inciardi et al. 1993, Mahan 1996, Ratner 1993, Williams 1992). Research that employs the inclusionary feminist lens seeks to reframe women's substance use and lifestyles as feminist expressions of upheaval, revolt, and resourceful game-playing in a rigged patriarchal society. If men who used and dealt in illicit economies were pioneering and ingenious entrepreneurs (as early ethnographers depicted them), then women were their enterprising, gender-rebelling counterparts, challenging gendered hetero-norms to find freedom, pleasure, and escape from sexist societal expectations in the illicit drug economy (Baker & Carson 1999, Ettorre 1992, Friedman & Alicia 1995, Rosenbaum 1981). Furthermore, the inclusionary feminist lens also challenges conventional understandings of mothering and suggests alternatives to the ideal of middle-class, "intensive mothering" practices (Hays 1999). In these works, drug using mothers could be "good" and deviant, self-indulgent and providers, risk-takers and care-takers (Baker & Carson 1999, Couvrette et al. 2016, Friedman & Alicia 1995, Flacks 2018, Grundetjern 2018). The inclusionary feminist lens invites the subjects of these studies to inhabit the same ideological plane as the women and researchers writing their narratives and, in doing so, constructs a kind of imagined community of feminists (populated by drug using women and the women writing about them).

In stark contrast, the feminist nightmare lens treats women drug users, specifically crack cocaine users, as irreparably damaged and victimized by both crack cocaine (and its presumed ravaging effects) and the illicit culture surrounding crack cocaine use. These ethnographies assumed a voyeuristic style and sought to provide a glimpse for the uninitiated into the brutal and depraved "realities" of crack cocaine addiction (Inciardi et al. 1993, Ratner 1993, Williams 1992). In these studies, crack cocaine was a symptom of urban decay and social disorganization

(Mahon 1995) and black women's crack use was particularly problematized as perpetuating a "culture of poverty" (Moynihan 1965, Wilson 1978). Unlike research carried out by feminists on mostly white, heroin-using populations in cities like New York and San Francisco, studies of crack cocaine users did not invite identification with or sympathy for their subjects nor did they express admiration for their subjects' gender and sexual subversion. Rather these studies painted a stark portrait of crack users as locked into oppressive relationships defined by abuse, exploitation, battering, and sexual assault, and disallowed their subjects' own claims to agency (Inciardi et al. 1993, Mahon 1995, Miller 1995, Ratner 1993, Williams 1992). In these objectifying accounts, social scientists' depictions situated black crack using women as central characters in the larger social science project of constructing a sexually perverse black underclass. The black underclass narrative strategically offloads inner city poverty, violence, and divestment onto black mothers who were deemed to reproduce too early, too often, and outside of the institution of marriage (Moynihan 1965). The pathologization of black motherhood reached its zenith during the crack epidemic and ethnographies of crack using populations provided the social scientific justification for the punitive management and containment of poor black urban populations.

The "witnessing genres" (Berlant 1998) discussed above, the inclusionary feminist lens and the repudiating, feminist nightmare lens, both provide an inside look at the life worlds of drug using women and an abstracting interpretation of where their subjects belong in the social order. The drug ethnography genre, much like addiction itself, is "a historical and discursive accomplishment rather than a [record of] scientific discovery or fact" (Tiger 2013:81). In this chapter, I contend with the construction of narrative and writing across difference, however, I hope to move away from creating what Lisa Cacho has referred to as "cover stories" (2007) -

stories we tell about people whose lived realities defy tidy explication and respectable representation and the violence we do to them when we redact, contort, and amplify parts of their experience in order to fit a normative mold or a readily available stereotype. Moreover, "cover stories," whether they are inclusive or repudiating, reinforce the "violence of value" and distract from the experiences and modes of oppression that may be detected within the redactions (i.e., what slinks out of sight when we rehearse the cover story?) (Cacho 2007, 2012). This chapter explores the narratives surrounding the context of reproductive experiences. In doing so, it pushes back against narratives of "respectable reproduction" that frame reproduction as a moral and social achievement.

Exploring narratives of ambivalent motherhood is further complicated by the fact that the institution of motherhood is not a monolith but rather is a multi-dimensional historical effect, shaped by relations of gendered, sexual, and racial domination. Cultural and scientific depictions of black maternity have colonized black repro-futurity as a site of disqualification and degradation, wedding together constructions of social disorder and broken windows with black sexuality (Collins 2004). Thus, writing about maternal ambivalence among black disadvantaged women requires an attention to the "differential economy of risk" (Farmer 1999) that structures the institution of motherhood. In other words, it is a tricky business writing about the gray area of desired reproduction among a population whose reproductive capacities and experiences have been so thoroughly maligned and pathologized. Such an undertaking must be done with a lens that contextualizes the role of the eugenical state and specific techniques of racialized sexual oppression.

Finally, narratives of value and other "cover stories" do not only pervade the social sciences but also circulate within addiction treatment and recovery communities. As I carried out

this research, I came to refer to such cover stories as "addiction talk" or the ways in which people within therapeutic communities perform healing and resilience in order to gain access to resources or exit from coercive institutional entanglements. Oftentimes, this required women to self-censor their struggles or re-narrate them in the language of neoliberal advancement. Summerson Carr uses Derrida's *Pharmakon* to explore the ways that notions of reality, truth, and denial overwhelm addiction and recovery logics and therapeutic communities. Carr highlights how addicts are often viewed by authorities as lacking "accurate self-insight" and that their denial and inability to see themselves drives their addiction. It is only through adopting recovery language and scripts that addicts are able to demonstrate their grasp of "reality" and begin to exercise self-restraint and rationally self-govern (Carr 2013). In other words, addicts are encouraged to adopt cover stories in their performance of recovery.

These individualized notions of addiction bracket structural violence and thus leave aside the rational and strategic reasons that people with addictions "lie," "deny" and "manipulate." For example, in an exchange that I had with Bernadette, a former addict who was currently working as a peer advocate for other drug users navigating the system, she explains that narrow definitions of success in the recovery world limit the ways that women can authentically engage in the healing process:

> I was in a therapeutic community for about two years, once I got clean. It was a fantastic one. I was allowed to live there with my children. [In the past] I supported my drug habit through prostitution…. And I remember my baby got sick, and the medicine that she needed was not covered by my insurance, and it was $900. And I remember thinking, there's only one way I know how to get $900 cash today. And so, I went back to something I knew I shouldn't do. But because I needed that medicine, I returned to a life that I knew I should have stayed away from, but I also couldn't tell anybody. Because if I would've told 'em what I had done, I could have lost my housing. So little things like that. I had to wait two years after I graduated the program then I started being honest about that stuff. So honesty did not benefit… 'Cause in our using-life, honesty was not the best policy when you're an addict (Interview, 6/2/2017).

Bernadette's cover story is a survival strategy. "Honesty" is at once demanded and rejected in addiction treatment cultures and users are left to find a version of the truth that limits their exposure to risk. Cover stories cover up for the true culprits underlying conditions like addiction, a broken healthcare system, a segmented and stratified labor market, and a penal welfare state more interested in policing poverty than ameliorating it. Neoliberalism offers and rewards cover stories about individual feats of strength and survival in the face of institutional abandonment.

However, when researchers craft cover stories, we not only engage in a form of abandonment, but we leave aside the "complex personhood" of the people who share their lives with us (Cacho 2007). In this chapter, I strive to fuss less with the messy parts of my subjects' narratives and interrogate how the institution of motherhood operates alongside and within various spaces and techniques of disqualification. In the following sections I highlight 3 specific themes around reproductive experience: 1) reproductive intentions, 2) the experiences of being pregnant and the institutional confrontations that occur during pregnancy, and 3) the role of maternal feeling rules in women's narratives of reproducing and parenting.

By exploring substance using women's reproductive experiences and interrogating their feelings of ambivalence towards motherhood, this chapter seeks to elucidate the ways in which "respectable reproduction" and other neoliberal notions of motherhood become internalized among a population that is disallowed from claiming their motherhood status as a form of political recognition and social validation. For this population, motherhood confers few if any rights, and in most cases occasions women's inclusion into a system of long-term carceral surveillance. How then is reproduction, motherhood, and child rearing experienced among this subgroup and in what ways do their reproductive choices subvert contemporary understanding of "empowerment" and reproductive agency?

Intentions

It was not uncommon for the women in this sample to report discovering they were pregnant late into their pregnancies. On average, most women discover they are pregnant between 5-6 weeks into their pregnancies (Branum & Ahrens 2017). The women in this sample reported discovering their last pregnancy, on average, between 16-20 weeks into their pregnancies. This pattern of late awareness must be understood within the context of their lives. Of course, being deep in an addiction could prevent someone from realizing they're pregnant, particularly if the substances they are taking affect their ability to recognize bodily changes, e.g., a heavy cocaine user may not gain much weight during her pregnancy. Other factors that seemed to influence when women became aware that they were pregnant were 1) previous pregnancy experiences, 2) the belief that they were infertile and 3) their age.

The most extreme case among the sample was Katelin, a young white woman who discovered that she was pregnant while she was in the process of delivering a baby. Not knowing that she was in labor, Katelin went to the emergency room to see about the acute symptoms she was experiencing. She was shocked to discover she was in labor: "they told me to take a pee test and instead of pee comin' out, he came out. I was goin' to the bathroom and all a sudden I started gushing blood…Yeah, it was scary. It was overwhelming, but I got through it" (Katelin, mother of 1, Interview, 7/10/2018). Many of the women explained that they just did not detect the early signs associated with pregnancy. Sunny, who had never been pregnant before, went to the ER after experiencing morning sickness – although at the time she did not know that her symptoms were pregnancy-related. Upon the medical staff informing her that she was 4 months pregnant, she was incredulous and asked to see a sonogram for proof. In hindsight she joked that she could

have been on one of her favorite TV shows, "I Didn't Know I was Pregnant" which documents the stories of women who do not realize they are pregnant until they give birth.

Discovering a pregnancy so late into the gestational process either inspired women to make changes to their lives or discouraged them from doing so (since, in their minds, they had already exposed their fetuses to harmful drugs). Brianna, a 41-year-old Puerto Rican woman, did not think she could get pregnant. She had not been pregnant in decades and described experiencing pre-menopausal symptoms years earlier. When she first learned she was pregnant, she was emotionally-floored but viewed the pregnancy as an opportunity to try to get better: "I cried like a baby. First outta guilt. Second, because I was in disbelief. Third, I said this is what's gonna save my life" (Brianna, mother of 3, Interview, 7/14/2018). The view that pregnancy is *the* life event that will dramatically alter a woman's receptiveness to substance treatment is pushed by public health approaches. It is the logic underlying the use of child protection to coerce treatment compliance and was embraced by the service providers and physicians I spoke to, who often referred to pregnancy as a "window of opportunity" for intervention. Although the sentiment has been co-opted by various institutions of social control, it was also grounded in women's own experiences. Several of the women affirmed that pregnancy was a real turning point in their lives. For instance, Sharmaine, a black mother of two, shared her experience discovering she was pregnant with her second child:

> It was time for a change. Like I can't keep living the same lifestyle that I was livin' because it wasn't gettin' me nothing but slower and faster towards death. Literally. I was slow with it [addiction], but I was fast to my death. Like I was on my way there. If it wasn't for god, like I'm gonna put this baby in your life…because this is what you need right now (Interview, 7/9/2018).

The proximity between life and death in women's stories was often a hair's breadth apart. The desperate living conditions of existing in a landscape of poverty, violence, homelessness, and in

the fog of addiction contrasted starkly with the possibility that a pregnancy represented. Therefore, although most of these pregnancies were not intended or planned for, they were still experienced by some of the women as a choice, and not merely a choice about carrying a pregnancy to term but a choice regarding the shape of the rest of their lives. This was the case even when the circumstances surrounding pregnancy were far outside the realm of what feminists and reproductive rights advocates would consider willing, desired, and agentic. Sharmaine's pregnancy, for example, was the result of one of her sex partners purposefully breaking a condom to coerce her to stay in a relationship.

> At this moment, I wasn't ready to have no baby 'cause I was still gettin' high. And I was spending money. I didn't wanna bring no baby into this life and I'm doin' this shit. I wanted a healthy, clean baby. But this one tricked me 'cause the bitch broke the condom…dude broke the condom. Some guys out here foul. They do shit on purpose. Why would you even do me like that? So, you try to set me up for real, on purpose. But I don't wanna talk about that no more. Shit. Son of a bitch. And now my life is how it is. I don't think about that shit no more, it's just like fuck it. (Interview, 7/9/2018)

Reproductive coercion is a form of sexual and intimate violence that includes behavior like "birth control sabotage" or the willful destruction or undermining of birth control measures by another (ACOG 2013). Sharmaine was clearly angry that she had been forcefully impregnated and lamented that the actions of another person dramatically changed the course of her life. Yet, the violation is treated as an inextricable part of her life record, while she doesn't accept it, she also refuses to regret it, and instead the feeling around the violation and resulting pregnancy land somewhere in between with a "fuck it." When I asked her if she considered terminating the pregnancy she responded:

> I don't believe in abortions. So, I said I'm gonna have this baby. Now what I was thinkin' was putting the baby up for adoption, 'cause I'm like I don't know if I can care for a baby. So, I was like debating like…but I said no, I wanna see how this baby gonna look. And she was a beautiful little baby. She was my dream girl. And

> I always wanted a girl. I said Lord, please let me have a girl. I said thank you, God, you gave me what I wanted. (Interview, 7/9/2018)

Although Sharmaine wasn't happy about the timing or circumstances under which she became pregnant, she left the issue of wanted-ness an open question throughout her pregnancy and bracketed desire for later consideration. The stories of marginalized women reveal the complicated meanings of reproductive choice. Reproductive health agendas and discourses use the "choice" framework to define situations in which women rationally plan the timing, spacing, methods of conception, and regulation of their reproduction, reflecting the "liberal fetishization of bodily integrity" (Ruhl 1999). However, reproductive choice is far more unbounded than such a framing suggests and can be experienced as a range of potentialities, opportunities, or liabilities.

Aletha, a young black mother of 3, did not think she could get pregnant because she had previously suffered an ectopic pregnancy and miscarriage. She had been told by her medical team that she had a 1% likelihood she would ever have a live birth again. When she learned she was pregnant she was both dismayed and very unhappy.

> And then when I get pregnant, like oh my god. I couldn't believe it 'cause I was five months pregnant.…I'm like I can't be pregnant. I just start cryin' because I was like I don't want babies. They told me I couldn't have any babies. I was like no, it can't be. I didn't believe it because my stomach was so flat. I didn't…I wasn't nauseous. I didn't feel anything. So I'm like it's not a baby in me. I'm tellin' them. And they like we're gonna hook you up to an ultrasound. They gave me an ultrasound, they like there's the baby. I'm like how is that possible? So I was just in shock. Like oh my god, I'm really havin' a baby. I had a point like when I have this baby, I'm gonna give it away 'cause I didn't want it. I wasn't—you know—in the right state of mind for another baby. I'm already messin' up my two boys. At this point, my mom was always watchin' 'em. But then in my mind I'm like I really don't want this baby. But then again, I don't want the baby to get taken by the state. You know I'd rather do it the right way. (Interview, 7/9/2018)

Aletha's desire lay somewhere between two unwanted outcomes – not wanting another child and not wanting that child to be taken by the state. When I asked her what her parenting experience was like, she replied:

> It's stressful. But I have to suck it up and I got to do it. These my kids. A lot of stuff that I need that they don't help me with, and I just like…I just suck it up. I gotta make a way for my kids. These my kids. So, I can't be dependent on people. I got to get out there and get it myself. So, I just relay…if I want it, I have to get it. You know I gotta take care of these kids. I can't bear the thought of losin' them. That really woulda took me somewhere. So, I had to get my stuff together. (Interview, 7/9/2018)

Aletha's response is saturated in the language of responsibility and duty. It is no wonder that she did not want another child as the circumstances surrounding keeping and raising children were experienced as isolation, self-negation, and struggle. Aletha's story demonstrates the ways in which marginalized women are cut off from "the potential relationship of any woman with her powers of reproduction and to children" (Rich 1995). Rather than accessing privileged frames of maternity and childrearing such as the enjoyment of raising children, the relationship and bonds built with children, or the cultivation of a maternal identity, motherhood is experienced as a constantly unfolding experience of "sucking it up" under conditions of institutional oversight and abandonment. Aletha's experience exemplifies precarious mothering in a neoliberal era.

Addiction, violence, and trauma were often intertwined and indistinguishable from women's reproductive trajectories. Nayeli was a 43-year-old, mother of 5, Guatemalan woman who grew up in Chicago. She attributed her introduction to substance use to a youth spent in and around gangs and gang activity in Chicago, as she put it "it was just a part of my life. It's just there. That's what I did. I got high. I drank." However, it was her history moving in and out of physically abusive relationships that set her on a path to a serious heroin addiction. The violence she experienced at the hands of partners was extreme. She retold the stories of episodes of

violence in a far-away, matter-of-fact tone. The father of her first two children, who she referred to as "the beast," had been brutally violent. Her second partner and father of her third child was also abusive. She described one harrowing episode of violence in which he ran over her with a car, her body, wedged between the tire and carriage of the car, was dragged several feet. Nayeli barely survived the incident. She described spending the next month in the hospital in intensive care and undergoing numerous procedures and surgeries.

> I had a trauma team of 12 doctors working on me. I had ended up with a collapsed lung, where I have the scar right here where they had to intubate me. I had a collapsed lung, I had five broken ribs. I had seven fractured vertebrae in my spine. I had a broken clavicle, a broken scapula—my scapula was broken in three different places. My clavicle was broken. There were so many bone fragments inside my eye socket that they had to go in there and scrape them out. This eye was out…they had to put it back in. And the left side of my face was fractured in so many places that they couldn't even count the fractures. (Interview, 7/14/2018)

The asymmetry in her face, retold the story as a historical presence, it was still there as a kind of remainder of the violent episode. The long and painful hospital stay was the prelude to the next chapter of substance use in Nayeli's life.

> And then you know after I got out…while I was in the hospital, I was on morphine drip. 'Cause I was in so much pain. After I got out, when I got discharged, they gave me scripts for Percocet and Dilaudid. You know, stuff like that for the pain. So, that went on for a while, getting my refills. After a while I was using them more to get high than I was for the pain anymore either. When my prescriptions ran out, I was like…I was sick. I was gettin' dope sick. I was like oh my god, I don't know what to do. What am I gonna do? I'm sick. I feel like shit. Finally, I was like I know what I can do. I was like heroin is good, it will do the trick. And that's how I started using heroin regularly. You know? So, I got on…I got on the heroin. I was in heaven. I didn't inject right away. It took a while for me to shoot up. But…I was like wow, this is life. (Interview, 7/14/2018)

Nayeli quickly developed a $200 a day habit and sustained her heavy usage with sex work. It was in this context that she learned that she was pregnant with her fourth child. Nayeli was shocked and upset when she learned she was pregnant. Given her age (early 40s), medical history, drug use history, and the fact that she hadn't had a period in some years, Nayeli didn't

think she could get pregnant. At that point in her addiction she was taking "ridiculously huge amounts of drugs" on a daily basis: "At this point, I'm basically tryin' to kill myself every night. I would be like god please let me just overdose and die. And I used to say, please god, don't let me wake up…please don't let me wake up. Every day I would wake up and I would be so mad. I'd be like you're fucking kidding!" (Interview, 7/14/2018). Nayeli neither planned for nor wanted to be pregnant: "I was like oh, I can't be pregnant again. I just can't be pregnant. 'Cause how am I gonna do this you know? I don't wanna be alive. How am I supposed to keep somebody else alive? Another baby? No…dear god. Oh my god, I didn't have a clue what I was gonna do." She continued to use after learning she was pregnant, that is, until one of her best friends died of a heroin overdose while she was with him. She recounted that the death shook her and was the turning point in her addiction. The day after his death, she walked in sub-zero winter weather to the safety net hospital to receive care.

> And it was below zero that night. I'll never forget it. I was freezing. My face was cold. I was numb. My feet were going numb. And um I'm like fuck it, ain't nothing that'll turn me around. Nothing's going to turn me around. I'm going into this. I said I want this baby. And um…but…so anyway so I'm walkin' in the cold. So, I've got two big bags with me. And I'm freezing. I looked like a bag lady. And the campus police stopped me for a second. They're like where are you going? What are you doing in this weather? They were like you need to find somewhere to go. I was like I have nowhere to go. And they were like well we can take you in. I said no…I said get me to the hospital. And they were like well, we can't take you. I was like why not? And they gave me some sob story about them being campus police…whatever. I was like look, all you gotta do is point. I'm freezing and finally I told them and I'm pregnant. They were like oh my god. But the best that they could do was they followed me to make sure I got there okay. Yeah. So, I was like oh god…I was like just let me make it to this emergency room, and I promise I will go through with this. So, I got there. And I'll never forget, I came in through the emergency room and as soon as the doors opened to emergency, I felt that warmth and I was like oh dear god, thank you…I made it. (Interview, 7/14/2018)

Trauma, violence, and death are not far from the surface in women's stories about addiction and reproduction. Nayeli's experience with violence was linked to her eventual heroin addiction by

way of the medical system which unwittingly facilitated and accelerated her opioid dependence. Her heroin addiction and reliance on sex work provided the context in which she became pregnant. Nayeli's story culminates in a kind of hero's journey with her pilgrimage to the hospital under life-threatening weather conditions, risking her safety to seek treatment, her confrontation with the campus police who refuse to help her, and the sense of purpose and promise of transformation that she experiences upon entering the hospital. Nayeli's story is both much bigger than and an example of reproductive choice and desire. The women in this sample were not naïve about the institution of motherhood and were often apprehensive to enter it. Motherhood was not always seen as a blessing or a second chance, sometimes it was experienced as just another obstacle to survive.

What to Expect, When You're Expecting

The experience of pregnancy for women in this sample often marked a moment of uncomfortable institutional confrontations. This section considers how pregnancy becomes one of the primary moments when drug using women are simultaneously exposed to expertise and rejected by experts. Historically, privileged women have had to confront expertise and prescriptions about "good" and "hygienic" mothering through 'soft' modes of governance like public health agendas, instructional manuals, and educational campaigns (Apple 2006, Ehrenreich and English 1978). Unlike the long tradition of inculcating "appropriate" motherhood in middle class women in order that they might be trusted to "self-govern," women of color, immigrant women, and poor women have experienced 'hard' forms of reproductive regulation that specifically discourage their reproduction like sterilization, child welfare intervention, and institutionalization (Solinger 2013). These findings explore this tradition of regulation among

poor, drug using women and reveals that pregnancy is a time during which this population feels the most visible to regulatory institutions and the most neglected.

Macey (white, age 31) discovered she was pregnant when she was well into her pain pill addiction. Realizing that she couldn't stop taking the pills on her own without becoming severely ill she decided that during one of her court hearings (she was also a ward of the state) she would ask the judge to incarcerate her in hopes that it might result in her being placed in a treatment facility. Once locked up, she soon recognized that the county jail was not equipped to care for pregnant women withdrawing from opioids.

> The withdrawals were so bad, they had to take me to the emergency room. And I was shackled to the bed in the hospital for five days. And you can't do anything…not even Pepto Bismal, Tylenol…nothing to help me with withdrawals. Basically, they put a diaper on me and locked me to the bed. It was horrible. Like…like all the COs (corrections officers), they look at you especially comin' in pregnant and you're locked up, and then you're dope sick. They don't wanna help you, you know. They talk bad to you. Like you did this to yourself and your kid. You wasn't worried about losing the kid when you were out there usin'. And they're just…the COs are very mean. They treat you with disrespect. Like they'll leave you on a mat, just leave you there. And they'll come in and they…like if you refuse to get up and eat or anything like that, they don't care. They'll just leave you there…like in your own waste. Just leave you there. (Interview, 7/9/2018)

Years of medical evidence demonstrates that pregnant women should not manage an addiction by quitting "cold turkey" (Terplan et al. 2018). A "cold turkey" detox approach can be life-threatening to the fetus (Haabrekke et al. 2014, Sinha et al. 2001)). In addition, there is considerable debate in the medical community regarding whether women should undergo medical detox while they are pregnant (Terplan et al. 2018). The American Society of Addiction Medicine, the American College of Obstetricians and Gynecologists, and the World Health Organization have recommended that the safest way to manage an opioid dependence during pregnancy is to follow an opioid-agonist pharmacotherapy program (e.g., methadone or buprenorphine maintenance) rather than a detoxification program. Even though maternal

addiction medicine experts promote a pharmacotherapy approach, the uptake by institutions has been dangerously slow and uneven. Macey's experience of detoxing in jail is a stark example of the life-threatening and inhumane conditions that pregnant substance users must contend with as they move in and out of institutions searching for help. The fact that some pregnant women turn to incarceration as a means of "getting clean" or in an attempt to get treatment services, reflects the failure of the healthcare system to meet the basic needs of substance using women.

Some women reported being turned away from hospitals when they revealed that were using and needed care. Gabriella (Puerto Rican, age 31) had been using heroin for several years when she learned that she was 3 months pregnant. She sought treatment options and prenatal care but was turned away from several hospitals.

> Three months pregnant, and I was using. Yeah. So, I was stuck in this…oh my god, what do I do? And then like tryin' to get help. Tryin' to go to like detox and stuff. They're like…the hospitals are like no, we don't take pregnant women. I was dumbfounded. Nobody wanted to help me. Like they just kept…like I was a hot potato. I guess 'cause I was a liability. I didn't try to detox until I was already like seven…seven and a half months pregnant. And then the shame and the…I don't want no one to know, 'cause like I saw the way they looked at me at the hospitals every time I would try to go get help. I just tried to avoid it at all costs. Like I felt like a monster. I personally—myself—felt like a monster. They were just like I was a disease. Like oh no, we don't take pregnant women. It's not like I meant for this to happen, but I wasn't going to abort her. So, I'm like I can't…I can't do this. I can't just abort her. I'm gonna have to figure it out. So, I had a really miserable pregnancy. (Interview, 7/12/2018)

The lack of integrated Medication-Assisted Treatment programs in the city of Chicago dramatically limited women's ability to find adequate care while they were pregnant. Although women are federally recognized as a "priority population" there are still significant infrastructural barriers that prevent them from receiving the care they need, including: low treatment capacity, burdensome federal regulations regarding what entities can provide medication, limited acceptance that addiction is a medical condition, and significant stigma

around pregnant women and drug use (SAMHSA 2017). Several of the women reported the ordeal of avoiding withdrawal symptoms while they were pregnant oftentimes by buying heroin on the street because they were not able to access methadone during pregnancy.

Like Gabriella, some women's experience with medical professionals left them feeling ashamed and prevented them from seeking prenatal care or substance treatment. Rose a black veteran and mother of 4, had served two deployments in Iraq and went to the VA to receive care during her pregnancy.

> I found out when I was pregnant…I was two months pregnant. And I went there to get help. And they just like they bashed me. They tell you this what you shoulda did…this what you shoulda did. And you know your kids could be this and you could turn into this person. I felt so judged…I felt so judged. And walkin' in you feel like horrible anyway. So, after they told me that, I never went back to get help at all. So yeah. People make you feel bad when you're pregnant and usin' drugs, because a person…they never know the reason you started usin'. They don't know like the things that you been through. I feel like people should um…people shouldn't you know bash you for it…judge you for it, 'cause you need help. They should like thank god you came to get help. But it's not like that at all. I was like if they don't care, why should I care? That might sound horrible. But if they don't care, why should I care? (Interview, 10/17/2018)

These moments reveal the liminal space that drug using women occupy. Even under circumstances when they seek help or presumably "do the right thing," their interactions with institutions and institutional actors discourage or prohibit further engagement with institutions as a source of help or healing. A pattern of institutional refusal to engage with women seeking help is a consistent finding of this study. Whether it was being refused methadone treatment, being refused medical care, or being refused a ride to the hospital in sub-zero weather; repeatedly, when drug using women reached out for help, they experienced rejection. I found these accounts to be particularly infuriating given that my data on medical actors revealed a pattern of doctors expending considerable energy to incriminate and collect evidence to use against their patients. Incriminating and reporting on drug using women is an institutional cover story. It is a cover

story employed by medical actors' who refuse to offer appropriate care to pregnant drug using women. It is a cover story for a broken and fragmented drug treatment system. It is a cover story that allows addicted women to take the fall for what are essentially institutional failures. The various institutional confrontations that women experienced compounded women's ambivalent feelings about reproduction and motherhood. Rose's statement, "if they don't care, why should I care?" conveys much more than feeling that one's experience is not being validated by experts. Rather, the statement reveals the experience of calling upon institutional help and instead finding social death, neglect, and abandonment.

Guilt, Shame, and Feeling Like a Mother

Motherhood is generally viewed as a primal, essential relation defined by affect and emotion. Because maternal emotions associated with bonding, caregiving, and loving children are seen as inherent and essential aspects of womanhood we do not often question their constructed-ness. However, just like all other socially recognizable feelings, emotions associated with mothering are governed by feeling rules- "rules about which feeling is or isn't appropriate to a given social setting" (Hochschild 1990:122). Donath suggests that "maternal feeling rules" guide which emotions can be expressed in the context of mothering and that guilt and self-blame are such prominent and socially powerful emotions that they have come to be associated with maternal love and "good mothering" (2015). If guilt operates as a social signifier for good mothering, I consider how expressions of guilt and shame are employed among a population of mothers whose mothering credentials are discredited.

A particularly devastating moment for drug using mothers is seeing withdrawal symptoms or the signs of neonatal abstinence syndrome (NAS) in their newborn. The symptoms can include periods of loud inconsolable crying, excessive irritability, and full body tremors. The

women in this study reported experiencing a range of feelings when seeing very demonstrable discomfort in their infants. Sharmaine was on methadone throughout her pregnancy; her baby displayed the symptoms of NAS and had difficulty latching to breastfeed after birth. Sharmaine felt both guilt and responsible for the baby's state:

> No, she didn't wanna eat. I squeezed the milk into her. They said squeeze it in there so she can get it. But she didn't even want it. She didn't wanna eat because I think it was the methadone. She was withdrawin' from the fuckin' methadone. But we wasn't able to tell yet. So, I called my pastor. I said "pastor, I'm scared 'cause she's not eatin'. She's my life. I surrender." 'Cause she wasn't eatin' and I was getting' scared. They was tryin' to get her to eat…givin' her medicine and stuff. And all she was doin' was sleepin' all day. And I was so…I was just lookin' at her like oh my gosh, she came from me. She was so little, and small, and pretty. I was like oh my God…damn, she's a pretty little baby. And she…I wanted to hear her cry. She wouldn't cry. So it was like oh, fuck…what the fuck did I do to this baby? I [had] a guilty conscience. I was kinda, you know, scared. I'm like what the fuck I did, man. I was like I fucked this baby. (Interview, 7/9/2018)

Eventually, the medical team managing her baby's care decided to insert a nasogastric feeding tube to feed Sharmaine's baby:

> But when they stuck that mother-fuckin' tube down my baby nose inside her so she'd eat…I blamed my damn self. I said take that fuckin'…. My dad was holdin' me back. I said take that fuckin' thing outta her fuckin' nose. Like mad. I just didn't…I said let her the fuck alone. I was angry as hell, like a fuckin' Incredible Hulk. Shit. It was like she…but she's okay. I can't keep beatin' myself up. (Interview, 7/9/2018)

Sharmaine experienced a range of emotions from guilt, fear, and anger in response to her infants NAS symptoms. These emotions can have a lasting impact on mothers. Sharmaine's statement implies that she still struggles with self-blame even though her baby is presently healthy. For drug using women, many of whom are struggling to enter treatment or stay clean, the emotions that they experience seeing their infants' withdrawing can push them to relapse. For example, Gabriella had been successfully completing her methadone treatment during her pregnancy but seeing her daughter's withdrawal symptoms caused her to relapse.

> I started seeing signs of withdrawals. In the baby. And it killed me. Just to see and see her doing things that I would do when I was sick, it was like yeah. So, they had to take her to the NICU and put her on methadone. And then wean her off slowly. They're like yeah, you can be here 24 hours, so I lived in the hospital with her. So, while she was in the NICU, when I wasn't there with her, I got a bag [of heroin]. I…I just couldn't…I couldn't deal with the…the…the guilt that I was putting on myself. And like her being five pounds. I'm like blaming myself for everything. And just seeing her with the withdrawals…. And then reminding that I put her through like…like her little life is just starting, and I…I didn't even give her a chance. Like I turned her into an addict before her life even began. That messed with my head a lot. But I did it to myself. (Interview, 7/12/2018)

Drug using women have the rare experience of being able to empathize with their infants when they experience withdrawal symptoms. Being able to pull from their own experiences to imagine the suffering that their newborns could be experiencing leaves some mothers so guilt-ridden that they opt not to visit their newborns in the NICU. The doctors that I interviewed would complain about such absentee mothers. However, given the profound sense of personal responsibility and the real belief that many women had that they had damaged their children for life, it is understandable that witnessing their babies suffer from pains they are all too familiar with might be too much to bear. Little to no research explores the complex emotional reactions that mothers have caring for and witnessing their newborns withdrawal (Cleveland & Bonulgi 2014). Providing resources and information to mothers about NAS symptoms could be beneficial for maternal-infant health outcomes, particularly as strong emotional reactions can be the impetus for compensatory drug seeking behavior and relapse.

Guilt is a self-focused, internalizing negative emotion that one experiences when one feels personally responsible for a loss of some kind. Guilt could be considered the definitive emotional register of the neoliberal era. As individuals are burdened with an insurmountable amount of responsibility over all manner of precarity and risk, guilt is a way by which individuals can signal that they have failed at the impossible task of shouldering such burdens.

Generally, guilt can be redemptive. For relatively privileged mothers, guilt is a way to absolve themselves of failing to live up the prescriptions of intensive mothering. However, for mothers viewed as fundamentally unworthy or undeserving of mothering, who are deemed always already guilty, guilt does not have the power to absolve, rather it is an expected way of being. Drug using women must seek absolution elsewhere, by donning the scarlet letter of bad mother, addict, monster and in performing and processing their guilt to build a new maternal identity. This was the case for Sue.

Sue was a white, 39-year-old mother of 6. She had a long career of drug use that was punctuated by periods of productivity and steady employment, what she referred to as her "functional addict" years, and moments of deep despair, shame, and suicidal ideations. Sue gave her first two children to her then partner's family who offered to take the kids while she "got her life together" however she confessed: "little did I know it wasn't gonna happen. I just kinda gave up on everything…". She spent the next several years working, living with her mother, and deep in the throes of a poly-substance addiction. Over the years she gave birth to 4 more children. For her last 3 pregnancies, she had somehow managed to hide her pregnancies from her mother.

> Then I became pregnant with my fourth child while livin' in my mom's house. I didn't tell her about the pregnancy. I went through the whole pregnancy using, drinking, smoking cigarettes… I acted like it wasn't even there. But I knew the baby was there. And in my mind—I made it up in my mind—that okay, I can't tell my mom; she's gonna kill me. I can't take care of this baby, so I'm about to give birth. I'm just gonna go to the hospital, tell 'em to take the baby and just walk away. Those were the great plans. (Interview, 7/17/2018)

Sue hid her pregnancy from her mother right up to the moment she went into labor. Once her mother realized she was going into labor she flew into a rage and threw her out.

> She threw me out the house. But I was at the hospital, and I gave birth. And I said just please take him away. I don't want him. Well, they ended up talkin' to me…you don't wanna give your baby up like that. You're just not in your right frame of mind right now. I said no, I don't have anything for this child. Just please give this baby

> to somebody else. I don't wanna see him…nothing. And no, they were just so…we need to call someone in your family. I said I don't have no family. The only family I have is my mom, and she just threw me out. So well, my mom ended up getting my son. So, they wanted me to go to rehab. I did three and a half weeks of intensive inpatient. But still the whole thing that…I don't want my son. Like I didn't. Um and it's horrible to say, but I really didn't want my son. So, uh…my mom brought him to visit I think twice, and I just looked at him and I'm just like…I don't know why they gave him to you, mom. She's like well, this is your son and you're gonna take care of him. After that I tried to commit suicide because I really wanted to kill myself. I couldn't um…I couldn't deal with all of that happened. I didn't wanna be sober anymore. (Interview, 7/17/2018)

Despite Sue's protests that she did not want the baby in her life, institutional and family forces demanded that she follow through and own up to her reproductive responsibility, forcing her into treatment. Feeling little control over her life, Sue attempted suicide. A year later, Sue became pregnant again and again hid the pregnancy from her mother, whom she was living with. She gave her 5th child to her mother to care for and spent the next several years homeless: "I hit homeless on the street. Straight junkie. Just same clothes for weeks. It was just the drugs were it." When I asked why she had gone to such lengths to hide her pregnancies from her mother she replied: "I didn't wanna face reality. Didn't really care to. I missed my children. But everything that I did …I guess I just continued to…I did continue to use for that reason. I didn't wanna get sober and face what I did. You know? I know that I could've made better choices" (Interview, 7/17/2018).

By her 6th child, Sue was ready to go into treatment where she said, "something just clicked" and she found herself receptive to the treatment and her feelings about herself started to change.

> I have to learn how to be a mother all over again. I had to learn how to be a total different person all over again, because I was shot down so far that I believed that I had no chance. I wanted to get my other kids back—you know—times I went to my mom's house, and she would say you know you're never gonna have a chance of gettin' your kids back, no matter what. They're too old. Just forget about it. So, I let her…I let myself believe that. You know? She didn't…she really didn't do

> anything to me. I let all this happen on my own. And I finally had to realize that and admit that to myself. Because nobody forced a needle into my arm. Nobody forced a bottle down my throat. Nobody forced me to walk away from my kids. And nobody forced me on the streets. I did this. (Interview, 7/17/2018)

Sue's story is one of a history of ambivalent and unwanted motherhood. It demonstrates the power of internalized stigma and guilt to shape one's relationship to others and oneself. Maternal feeling rules operate and make sense within the context of an "emotion culture" (Petersen 2006). Sue's story reveals the dark side of maternal guilt- which is maladaptive when unmoored from neoliberal notions of self-responsibility, empowerment, and a strong commitment to self-governing. Thus, neoliberal mothering (McCabe 2016) operates as a structure in and of itself which creates a hierarchy of emotional experience and validation whereby women who cannot perform empowerment must contend with shame and guilt as permanent fixtures of motherhood. The goal of rehabilitation and drug treatment is to mobilize maternal guilt to "habilitate" mothers- or create a new identity to replace the disordered one that could not appropriately self-manage (McCorkle 2004). Therefore, absolution and the reclamation of a maternal identity for women like Sue involves taking ownership over all aspects of one's failure to live a normative, reproductive and productive life. Oddly enough, empowerment involves removing an individual's ability to situate their strife outside of themselves and requires that they view all manner of failure and loss as internally generated and resolved. Sue, like numerous other women in this study, assumed ownership over her life circumstances embracing a "damaging and painful" discourse of "no legitimate dependency" whereby "dependency of almost any sort was disavowed" and neoliberal logics of self-responsibility "become naturalized and unquestioned as the individual level" (Peacock et al. 2014). In many ways, empowerment is the ultimate cover story. However, empowerment is an inclusionary performance (Cruikshank 1999, Decoteau 2013, Reich 2005) that offers a sense of civic recognition and social belonging for those who can

demonstrate it. Thus, Sue's story offers a redemptive arc that is traded on the ability for one to absorb and claim ownership over socially and structurally generated suffering.

I did not encounter many stories like Sue's while conducting this research. In some ways it was phenomenal that she was afforded multiple "second chances" to rear her children, despite her protestations that she wanted to give them up for adoption. It is likely that race-privilege contributed to the ways in which institutional actors responded to Sue. Research suggests that women of color are exposed to institutional "narratives of empowerment" that discourage them from viewing redemption via the lens of motherhood and child rearing and rather encourage them to envision progress through a lens that de-emphasizes parenthood (McKim 2008). While my sample is not large enough to reflect these racial variations in institutional responses, I suspect that women of color and white women must contend with and are differentially shaped by neoliberal metrics of success, suggesting that even among a population of similarly marginalized women (by reproductive status and as substance users) that race plays is a definitive role in demarcating opportunities for reproductive and maternal redemption.

Conclusion

This chapter explores the reproductive experiences of marginalized women. It considers how we assign value to lives that do not conform to our notions of respectable reproduction. The framework of reproductive "choice" has been hoarded by reproductive rights and reproductive health groups and consequently narrowly defines intentionality and reproductive desire. This research helps reveal the thread of ambivalence that runs through women's narratives of reproductive desire. Rather than sitting on opposite sides of a binary, ambivalence and desire are experienced simultaneously and can shape maternal feelings and behaviors in equal measure. In

addition, this chapter has sought to capture the ways that the "institution of motherhood" is experienced by women whose reproduction is considered deviant.

Neoliberalism restructures both institutions and subjectivities. Lauren Berlant contends that affect is inherently reproductive and passes through one attachment to another transmitting certain "fantasy-practices." She argues that the "fantasy of security becomes a practice," in which neoliberal subjects contend with the myriad "unreliable dependencies" of life (interpersonal, political, and institutional) by creating certain narratives about progress, human worth and deservedness, merit and reward, shame and indebtedness which ultimately hook individuals into particular relationships with capitalist production (2011). As social institutions increasingly signal to the growing segment of those living on the socio-economic margins that they do not serve their needs and instead reinforce their social death, these groups are left to contend, not only with the material effects, but with the symbolic and affective effects of desertion. Maternal feeling rules and affective experience are embroiled in these various neoliberal maneuvers. Drug using women's feelings of maternal guilt and self-blame are not avenues by which they can be read as righteous and loving mothers. For this population, maternal feeling rules are mobilized to feel one's way through to a new maternal identity one that suggests a neoliberal ideology of social change contingent upon the adoption of an individualized epistemology of agency and will.

CHAPTER SIX: CONCLUSION

Child abuse and neglect laws that punish behavior during pregnancy effectively codify fetuses as children in state statutes. While child welfare interventions at birth are not often viewed as a part of an anti-reproductive rights agenda, these findings reveal that laws like these do, in fact, infringe on the basic human rights of people based on their reproductive status. In response to these laws medical providers assume the role of state enforcers, setting aside their responsibilities as healers, caretakers, and patient advocates, and actively pursue incriminating their most vulnerable patients at the state's behest. One might argue that providers abdicate their role as caretakers because of a culture of defensive medicine. In a risk averse obstetric culture, "high-risk" drug using patients are viewed as liabilities to be shunted out the door and onto other institutional actors that can effectively manage their riskiness. Another possible explanation is that the fetus has increasingly come to be viewed as *the* patient in maternal-fetal medicine and reproductive medicine writ large (Casper 1999, Holc 2004, McCulloch 2012). The possible risks to fetuses are often placed above risks posed to the patients carrying them (Lyerly et al. 2007). As fetuses come to assume a prominent and visible role in medicine, the needs and visibility of the women carrying them recede into the background.

However, another possibility is that providers are *not* responding primarily as rational self-interested actors, calculating risks and potential liabilities, but rather the actions of providers reflect the long tradition of racist practices in reproductive medicine. Black life becomes especially vulnerable in medical settings. Numbers that track racial disparities in healthcare reflect apartheid like conditions (Feagin & Bennefield 2015, Washington 2006). Reproductive medicine in the US has a long history of perpetuating violence against black women and exploiting their reproductive and biological processes for scientific advancement (Washington

2006, Skloot 2017). In *The Health and Physique of the Negro American* (1906), W.E.B. DuBois uses demographic data from the 1900 census to explore health disparities between black and white populations and found that the infant mortality rate for blacks was 2.3 times higher than that of whites. Today, African Americans have 2.2 times the infant mortality rate as whites (U.S Department of Health and Human Services Office of Minority Health, 2018) and black women are up to four times more likely to die during or after giving birth to a child compared to white women (Roeder 2019). These figures demonstrate that over 100 years of biotechnological advancement and over a half a century of civil and legal protections have not effectively shielded black women from the structures that secure their premature death (Davis 2006).

Merely half a century ago, it was not uncommon for large hospitals to have two labor and delivery wards, two newborn nurseries. The reproductive experiences of black and white women were not only spatially partitioned but on one side of the partition was subpar care, medical neglect, and death (Byrd & Clayton 2012). Today, these partitions, while less visible, still exist. This research documents the ways in which medical actors establish *a threshold in care.* A *threshold in care* is a biopolitical cut that establishes the boundary between life worth preserving and life marked for death (Agamben 1998). When physicians employ surveillance technologies (drug testing) and seemingly race-neutral medical rationalities (prenatal care utilization as a risk factor for drug use) to mark women for state intervention, they are reifying historical technologies of state racism and bringing them into the contemporary era where they take on novel more covert forms. This research demonstrates that medical providers are imbued with state powers to make life and death decisions (beyond the medical scope) and that carceral logics flow through medical practices and transform and expand the jurisdiction of medical social control while seeming to mark a delimitation of medical powers (i.e., in refusing to treat

substance using women as patients they are in fact expanding the ways in which medicine exercises power over people's lives and bodies). This dissertation reveals that this new hybrid form of *carceral health governance,* while expansive, multi-institutional, and diffuse, is highly fragmented and riddled with fissures which allow for numerous exceptions whereby marginalized populations are dispossessed of basic rights and protections.

Since these technologies are shaped by anti-black racism and the racial responses calcified during the height of the War on Drugs and "crack" panic, they operate in ways that sharply and distinctly burden black women, even though they also effect other racial-ethnic groups. The emerging response to the opioid epidemic, which has been coded as a racially white crisis, portends a shift in responses to substance use during pregnancy (Netherland & Hansen 2016). It is yet to be seen how and if these changes will affect substance using pregnant women. Will addiction (to all substances and among all demographics) become more medicalized and treated primarily as a medical condition or will the addictions of some (classed, raced, and sexed-privileged communities) be treated medically while the drug use of everyone else continues to be policed and surveilled? The case of responses to substance use in Chicago suggests some uptake of a medicalized approach (evident by the perinatal network initiative on maternal opioid use) but mostly reveals a pattern of continuity in responses (e.g., intervention, coercion, and surveillance) for low-resourced, racialized drug users. What is new about this response, is that it is increasingly obscured within a privatized social service complex and unlike the maneuvers made during the crack cocaine era, the current system disavows racial logics and thus, allows them to persist.

I have argued that private-public, carceral-welfare collaborations constitute a *re-privatization* of gendered and racial dependency. Dependency is no longer constructed solely as

a social burden, or a sapping of the vitality of the productive citizenry but rather dependency is made "active" (Rose 2000) and is essential to the operation of private agencies. The neoliberal, biopowerful state (unlike the biopowerful, welfare state) invests in risk, not for the purposes of normalizing and regularizing it, but for the purposes of sustaining the immobility of risky subjects within the social service sector and slowly administering their social abandonment (Willse 2015). Substance using mothers are valued in this system of social management *because* they are deemed to have several "risk factors" which can be dispersed among multiple agencies (e.g., substance treatment, behavioral therapy, parental education, mental health services, etc.).

The women that I spoke to in these agencies were openly confused about the purpose these programs served. They, like myself, mistakenly believed that these programs were intended to reinforce and encourage their mobility and civic inclusion (even if it is was towards low-wage, low-skill, dead-end employment opportunities). I was surprised to learn that instead the programs were fatally hollow and provided a bare minimum of material and instrumental support, while supplying a steady supply of life lessons about "going it alone," self-sustainment, and performing empowerment (Reich 2005). In addition to offering little in the form of supportive services, programs like Keeping Families Together wield state-like powers without offering civil protections for clients. Moreover, the "gender-responsive" nature of these programs target maternal status as a mode of punishment and a means to attain compliance from clients, effectively alienating them from the "potential relationship of any woman with her powers of reproduction and to children" (Rich 1995:13).

This research demonstrates that substance using women live in a state of in-betweenness; between public and private, between patient and offender, between medical and carceral, and between legal and illegal. This liminal space is a space of rightlessness and abandonment. It is a

space in which their mobility is defined by a series of violent, institutional handoffs. Medical research over the past two decades has documented the danger of handoffs and patient transitions within medical settings, citing an increase in medical errors, poor patient outcomes, and patient deaths (Riveria-Rodriguez & Karsh 2010, Sutcliffe et al. 2004). This study extends these insights to the realm outside of the clinic; as medical actors handoff patients to state-actors who handoff "clients" to private, semi-carceral agencies who then circulate and handoff clients to numerous experts and institutions within the semi-carceral, therapeutic social service complex.

Scholars that contend that the therapeutic state and institutions of social control target marginalized populations for civic *inclusion* (Rose 1999), fail to recognize that technologies of abandonment and death are etched into the blueprints of these institutions. Rather than "circuits of inclusion" this research documents a pattern of *endless circulation.* Multiply marginalized surplus populations move, by way of coercion, in and between multiple institutions. Each institution makes some claim or promise to improve their lives, requires some disproportionate sacrifice in return (e.g., freedom of mobility, freedom from surveillance, bodily autonomy, reproductive and parental rights, economic stability, etc.), and yet offers little in the form of life-enhancing or life-saving resources in exchange. This pattern of endless inter-institutional circulation enacts violence and demonstrates a "zone of indistinction" between letting and making die, a power that invests in reproduction as a wearing down of marginalized populations.

The specter of death was ever-present in these stripped-down, hollowed out social service organizations. For example, at no point in my data collection did I encounter respondents in these semi-carceral systems (neither workers, nor clients) discuss or promote harm reduction strategies. Granted, harm reduction strategies are often portrayed as the pie in the sky, enabling, and overly permissive (for example, conservative states historically resist clean needle exchange

programs based on the misconception that they promote drug use). However, even widely accepted harm reduction strategies such as making Naloxone- a life-saving overdose reversal medication, accessible to long-term heroin and opioid users- were not mentioned by providers in substance treatment centers or their clients. Rather, these institutions promoted an abstinence-only, resilience-centered, "go it alone" approach that left women who were already vulnerable, exponentially vulnerable to death and fatal overdose once they left the confines of these programs.

This study demonstrates that for substance using women, reproduction and pregnancy are moments of in which they are "socially included" (via a carceral social service complex) and legally and medically abandoned. A moment in which their fetuses are granted rights and they subsequently surrender their own. All pregnant and potentially pregnant women are in some ways regarded as "competing sovereigns" by the state (Deutscher 2008) whose reproductive choices (the ability to "take life" or terminate a pregnancy) pose a threat to the state's claims over the fetus. Yet, marginalized, drug using women's reproduction is viewed as distinctly risky and threatening to the fetus, and later child, relative to women who elect to have abortions. Rather, racially marginalized, drug using women's reproduction is viewed as a threat to the "futurity" of the social order. During the crack cocaine era this threat was heightened to a fever pitch and was publicly and visible managed with violent strong-arm techniques (incarceration, child removals, and media hysteria). This research demonstrates that today those techniques, while still deployed, have been strategically muted and that the neglect, punishment, and surveillance of this population have been relocated to the seemingly benign social service sector where their treatment is obscured from public view.

Over the past three years of conducting this research I have read and heard exclaimed by well-meaning individuals in policy, conducting research, and carrying out advocacy work that the reason we should not punish pregnant substance users with criminalization or child welfare interventions is because it deters them from seeking prenatal care. Even I have used similar rationalizations when explaining my research to family members and acquaintances who are confused as to why I am studying such a topic and such a population (*why those women?)*. In an attempt to explain why these women matter, we (individuals who consider themselves maternal advocates) often fall back upon the value of the children they may soon or already have.

These sorts of rationalizations that place the value of children and fetuses over and above those of the women who carry them, are of a piece of the larger anti-abortion movement that seeks to displace women's rights by affording personhood rights to their fetuses. This dissertation documents the myriad ways in which women's fundamental human rights (patients' rights, privacy rights, and legal rights) are violated in the name of securing the supposed health and safety of the fetus/child but also points to the "sliding scales of subordination and dispossession" (Sparke 2017) of women based on their social positionality.

CITED LITERATURE

Abel, Ernest L., and Michael Kruger. "Physician attitudes concerning legal coercion of pregnant alcohol and drug abusers." *American journal of obstetrics and gynecology* 186, no. 4 (2002): 768-772.

Abused and Neglected Child Reporting Act of 1975, 325 ILCS 5/4.4.

ACOG Committee Opinion No. 524: Opioid abuse, dependence, and addiction in pregnancy.

ACOG Committee on Health Care for Underserved Women., American Society of Addiction Medicine.Obstet Gynecol. 2012 May; 119(5):1070-6.

ACOG Committee Opinion No. 554. “Reproductive and sexual coercion.” American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:411–5.

ACOG Committee Opinion No. 439. “Informed consent.” American College of Obstetricians and Gynecologists. Obstet Gynecol 2009; 114:401–8.

AFCARS Data 2000-2016. Accessed May 30, 2019. https://ncsacw.samhsa.gov/resources/child-welfare-and-treatment-statistics.aspx

Agamben, Giorgio. *Homo sacer: Sovereign power and bare life*. Stanford University Press, 1998.

Agar, Michael. *Ripping and running: A formal ethnography of urban heroin addicts*. Vol. 1. Academic Press, 1973.

Alexander, Michelle. The New Jim Crow: Mass incarceration in the age of colorblindness. The New Press, 2010.

Amar, Paul. *The Security Archipelago: human-security States, sexuality politics, and the end of neoliberalism*. Duke University Press, 2013.

American Society of Addiction Medicine (2017). *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids.*

Apple, Rima D. "Constructing mothers: Scientific motherhood in the nineteenth and twentieth centuries." *Social history of medicine* 8, no. 2 (1995): 161-178.

Appleton, Susan Frelich. "Reproduction and regret." *Yale JL & Feminism* 23 (2011): 255.

Armstrong, David. "The rise of surveillance medicine." *Sociology of health & illness* 17, no. 3 (1995): 393-404.

Austin, Michael J. "The changing relationship between nonprofit organizations and public social service agencies in the era of welfare reform." *Nonprofit and Voluntary Sector Quarterly* 32, no. 1 (2003): 97-114.

Baker, Phyllis L., and Amy Carson. "“I take care of my kids” mothering practices of substance-abusing women." Gender & society 13, no. 3 (1999): 347-363.

Bartholet, Elizabeth. *Nobody's children: Abuse and neglect, foster drift, and the adoption alternative*. Beacon Press, 1999.

Bartholet, Elizabeth. “Parental Custody? Not if They’re Addicts,” *Boston Globe*, April 17, 2014. https://www.bostonglobe.com/opinion/columns/2014/04/16/parental-custody-not-they-addicts/bxv08D20cH87AUQd0ZeepO/story.html

Bauchner, Howard, Barry Zuckerman, Mary McClain, Deborah Frank, Lise E. Fried, and Herb Kayne. "Risk of sudden infant death syndrome among infants with in utero exposure to cocaine." *The Journal of pediatrics* 113, no. 5 (1988): 831-834.

Bechteler, S.S. & Kane-Willis, K. (2017). Whitewashed: The African American Opioid Crisis. Chicago Urban League, Research and Policy Center.

Beck, Ulrich. *Risk society: Towards a new modernity*. Vol. 17. sage, 1992.

Behnke, Marylou, Vincent C. Smith, and Committee on Substance Abuse. "Prenatal substance abuse: short-and long-term effects on the exposed fetus." *Pediatrics* 131, no. 3 (2013): e1009-e1024.

Berlant, Lauren. "Intimacy: A special issue." *Critical Inquiry* 24, no. 2 (1998): 281-288.

Berlant, Lauren Gail. *Cruel optimism*. Duke University Press, 2011.

Bernstein, Elizabeth. "Carceral politics as gender justice? The "traffic in women" and neoliberal circuits of crime, sex, and rights." *Theory and Society* 41, no. 3 (2012): 233-259.

Branum, Amy M., and Katherine A. Ahrens. "Trends in timing of pregnancy awareness among US women." *Maternal and child health journal* 21, no. 4 (2017): 715-726.

Briggs, Laura. *Reproducing empire: Race, sex, science, and US imperialism in Puerto Rico*. Vol. 11. Univ of California Press, 2002.

Briggs, Laura. *Somebody's children: The politics of transnational and transracial adoption*. Duke University Press, 2012.

Browne, Simone. *Dark matters: On the surveillance of blackness*. Duke University Press, 2015.

Brown, Phil, Mercedes Lyson, and Tania Jenkins. "From diagnosis to social diagnosis." *Social science & medicine* 73, no. 6 (2011): 939-943.

Budde, S., and A. Harden. "Substance-exposed infants in Illinois (1998-2001): Trends in caseloads, placement, and subsequent maltreatment." *Unpublished manuscript* (2003).

Burke, Sheila, "Doctors Applaud the End of Tennessee's Fetal Assault Law" *Salon.* April 1, 2016. http://www.salon.com/2016/04/01/doctors_applaud_the_end_of_tennessees_fetal_assault_law/

Byrd, W. Michael, and Linda A. Clayton. *An American health dilemma: a medical history of African Americans and the problem of race: beginnings to 1900*. Routledge, 2012.

Cacho, Lisa Marie. "“You Just Don't Know How Much He Meant”: Deviancy, Death, and Devaluation." *Latino Studies* 5, no. 2 (2007): 182-208.

Cacho, Lisa Marie. *Social death: Racialized rightlessness and the criminalization of the unprotected*. NYU Press, 2012.

Campbell, Nancy D. "The construction of pregnant drug-using women as criminal perpetrators." *Fordham Urb. LJ* 33 (2005): 463.

Campbell, Nancy. *Using women: Gender, drug policy, and social justice*. Routledge, 2002.

Campbell, Nancy D. *Discovering addiction: The science and politics of substance abuse research*. University of Michigan Press, 2007.

Campbell, Nancy D. "When Should Screening and Surveillance Be Used during Pregnancy?." AMA journal of ethics 20, no. 3 (2018): 288-295.

Casper, Monica J. "The making of the unborn patient." *The Lancet* 353, no. 9158 (1999): 1103-1104.

Casper, Monica J., and William P. Simmons. "Accounting for death: Infant mortality, the MDGs, and women’s (dis) empowerment." *Counting on Marilyn Waring: New advances in feminist economics* (2014): 89-104.

Castel, Robert. "From dangerousness to risk. Pp, 281–298 in G. Burchell, C. Gordon and P. Miller, eds." *The Foucault Effect: Studies in Governmentality* (1991).

Carr, E. Summerson. "Signs of sobriety: Rescripting American addiction counseling." *Addiction trajectories* (2013): 160-87.

CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2018. https://wonder.cdc.gov/.

Charmaz, Kathy. *Constructing grounded theory: A practical guide through qualitative analysis*. Sage, 2007.

Chasnoff, Ira J., William J. Burns, Sidney H. Schnoll, and Kayreen A. Burns. "Cocaine use in pregnancy." *New England Journal of Medicine* 313, no. 11 (1985): 666-669.

Chasnoff, Ira J., Harvey J. Landress, and Mark E. Barrett. "The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida." *New England Journal of Medicine* 322, no. 17 (1990): 1202-1206.

Chicago Reporter. “Losing Their Children: As State Cracks Down on Parents, Black Families Splinter” (1997). Published online April 6. 2011. https://www.chicagoreporter.com/losing-their-children-state-cracks-down-parents-black-families-splinter/

Child Abuse and Prevention Treatment Act of 2003. Public Law 114-198, s 106(b)(2)(B)(ii) and (iii) (2003).

Clarke, Adele E., Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman. "Biomedicalization: Technoscientific transformations of health, illness, and US biomedicine." *Biomedicalization: Technoscience, health, and illness in the US* (2010): 47-87.

Clarke, Adele. *Situational analysis: Grounded theory after the postmodern turn*. Sage, 2005.

Cleveland, Lis M., and Rebecca Bonugli. "Experiences of mothers of infants with neonatal abstinence syndrome in the neonatal intensive care unit." *Journal of Obstetric, Gynecologic & Neonatal Nursing* 43, no. 3 (2014): 318-329.

Conrad, Peter. "Medicalization and social control." *Annual review of Sociology* 18, no. 1 (1992): 209-232.

Conrad, Peter, and Joseph W. Schneider. *Deviance and medicalization: From badness to sickness*. Temple University Press, 1980.

Conrad, Peter. "The shifting engines of medicalization." *Journal of health and social behavior* 46, no. 1 (2005): 3-14.

Copeland, L. "Oxytots." *Slate Online publication.* Published December 7, 2016. https://slate.com/human-interest/2014/12/oxytots-and-meth-babies-are-the-new-crack-babies-bad-science-and-the-rush-to-demonize-the-most-vulnerable-pregnant-women.html

Courtwright, David T. "The NIDA brain disease paradigm: History, resistance and spinoffs." *BioSocieties* 5, no. 1 (2010): 137-147.

Couvrette, Amélie, Serge Brochu, and Chantal Plourde. "The “deviant good mother” motherhood experiences of substance using and lawbreaking women." *Journal of drug issues* 46, no. 4 (2016): 292-307.

Collins, Patricia Hill. *Black sexual politics: African Americans, gender, and the new racism*. Routledge, 2004.

Crawford, Robert. "Health as a meaningful social practice." *Health:* 10, no. 4 (2006): 401-420.

Cruikshank, B. (1999). *The will to empower: Democratic citizens and other subjects*. Cornell university press.

Dasugpta, Amitava. “Chain of Custody for Urine Drugs of Abuse Testing.” *Clinical Laboratory News.* American Association of Clinical Chemistry (2019). https://www.aacc.org/publications/cln/articles/2019/janfeb/chain-of-custody-for-urine-drugs-of-abuse-testing

Davis, Angela Y., and Cassandra Shaylor. "Race, gender, and the prison industrial complex: California and beyond." *Meridians* 2, no. 1 (2001): 1-25

Davis, Dana-Ain. *Battered Black women and welfare reform: Between a rock and a hard place*. SUNY Press, 2006.

Davis, Dana-Ain. "Narrating the mute: Racializing and racism in a neoliberal moment." *Souls* 9, no. 4 (2007): 346-360.

Decoteau, Claire Laurier. "Exclusionary inclusion and the normalization of biomedical culture." *American Journal of Cultural Sociology* 1, no. 3 (2013): 403-430.

De Lissovoy, Noah. "Conceptualizing the carceral turn: Neoliberalism, racism, and violation." *Critical Sociology* (2012): 0896920512452162.

DePanfilis, Diane. "Social isolation of neglectful families: A review of social support assessment and intervention models." *Child Maltreatment* 1, no. 1 (1996): 37-52.

De Bortoli, Lillian, Jan Coles, and Mairead Dolan. "Linking illicit substance misuse during pregnancy and child abuse: what is the quality of the evidence?." *Child & Family Social Work* 19, no. 2 (2014): 136-148.

Deutscher, Penelope. "The inversion of exceptionality: Foucault, Agamben, and “reproductive rights”." *South Atlantic Quarterly* 107, no. 1 (2008): 55-70.

DiFranza, Joseph R., C. Andrew Aligne, and Michael Weitzman. "Prenatal and postnatal environmental tobacco smoke exposure and children’s health." *Pediatrics* 113, no. Supplement 3 (2004): 1007-1015.

Donath, Orna. *Regretting motherhood: A study*. North Atlantic Books, 2017.

Drescher-Burke, K., & Price, A. (2005). Responding to substance-exposed newborns: An exploratory study of policies and practices.*National Abandoned Infants Assistance Resource Center, University of California at Berkeley, Berkeley, CA*.

Du Bois, William Edward Burghardt, ed. *The Health and Physique of the Negro American: Report of a Social Study Made Under the Direction of Atlanta University, Together with the Proceedings of the Eleventh Conference for the Study of the Negro Problems, Held at Atlanta University, on May the 29th, 1906*. No. 11. Atlanta University Press, 1906.

Ehrenreich, Barbara, and Deirdre English. *For her own good: Two centuries of the experts advice to women*. Anchor, 1978.

Ellsworth, Marc A., Timothy P. Stevens, and Carl T. D'Angio. "Infant race affects application of clinical guidelines when screening for drugs of abuse in newborns." *Pediatrics* 125, no. 6 (2010): e1379-e1385.

Ettorre, Elizabeth M. *Women and substance use*. Macmillan International Higher Education, 1992.

Farmer, Paul. *Infections and inequalities: The modern plagues*. Univ of California Press, 2001.

Fassin, Didier. "Another politics of life is possible." *Theory, culture & society* 26, no. 5 (2009): 44-60.

Feagin, Joe, and Zinobia Bennefield. "Systemic racism and US health care." *Social science & medicine* 103 (2014): 7-14.

Federici, Silvia. *Caliban and the Witch*. Autonomedia, 2004.

Flacks, S. (2018). Dangerous drugs, dangerous mothers: Gender, responsibility and the problematisation of parental substance use. *Critical Social Policy*, 0261018318795573.

Frank, Deborah A., Marilyn Augustyn, and Barry S. Zuckerman. "Neonatal neurobehavioral and neuroanatomic correlates of prenatal cocaine exposure: problems of dose and confounding." *Annals of the New York Academy of Sciences* 846, no. 1 (1998): 40-50.

Fraser, Nancy, and Linda Gordon. "A genealogy of dependency: Tracing a keyword of the US welfare state." *Signs* 19, no. 2 (1994): 309-336.

Friedman, Jennifer, and Marisa Alicea. "Women and heroin: The path of resistance and its consequences." *Gender & society* 9, no. 4 (1995): 432-449.

Foucault, Michel, Mauro Bertani, Alessandro Fontana, François Ewald, and David Macey. 2003. *"Society must be defended": lectures at the Collège de France, 1975-76*.

Foucault, Michel. "The History of Sexuality, vol. 1, An Introduction, trans. Robert Hurley." *New York: Pantheon* (1978).

Gilmore, Ruth Wilson. "Globalisation and US prison growth: From military Keynesianism to post-Keynesian militarism." *Race & Class* 40, no. 2-3 (1999): 171-188.

Giroux, Henry A. "Reading Hurricane Katrina: Race, class, and the biopolitics of disposability." *College Literature* (2006): 171-196.

Goffman, Erving. *Stigma: Notes on the management of spoiled identity*. Simon and Schuster, 1963.

Gowan, Teresa, and Sarah Whetstone. "Making the criminal addict: Subjectivity and social control in a strong-arm rehab." *Punishment & Society* 14, no. 1 (2012): 69-93.

Gray, Mel, Mitchell Dean, Kylie Agllias, Amanda Howard, and Leanne Schubert. "Perspectives on neoliberalism for human service professionals." *Social Service Review* 89, no. 2 (2015): 368-392.

Grundetjern, Heidi. "Negotiating Motherhood: Variations of Maternal Identities among Women in the Illegal Drug Economy." *Gender & Society* 32, no. 3 (2018): 395-416.

Gurr, Barbara. "Complex Intersections: Reproductive Justice and Native American Women." *Sociology Compass* 5, no. 8 (2011): 721-735.

Gutiérrez, Elena R. *Fertile matters: The politics of Mexican-origin women's reproduction*. University of Texas Press, 2009.

Guttmacher Institute. *Substance Use During Pregnancy.* Updated May 1, 2019. https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy

Griffin, Christine. "Fear of a Black (and working-class) planet: Young women and the racialization of reproductive politics." *Feminism & psychology* 2, no. 3 (1992): 491-494.

Haabrekke, Kristin Johanne, Kari Slinning, Kristine Beate Walhovd, Tore Wentzel-Larsen, and Vibeke Moe. "The perinatal outcome of children born to women with substance dependence detoxified in residential treatment during pregnancy." *Journal of addictive diseases* 33, no. 2 (2014): 114-123.

Haney, Lynne. "Introduction: Gender, welfare, and states of punishment." *Social Politics: International Studies in Gender, State & Society* 11, no. 3 (2004): 333-362.

Haney, Lynne Allison. *Offending women: Power, punishment, and the regulation of desire*. Univ of California Press, 2010.

Haney, Lynne. "Motherhood as punishment: The case of parenting in prison." *Signs: Journal of Women in Culture and Society* 39, no. 1 (2013): 105-130.

Hannah-Moffat, Kelly. "Sacrosanct or flawed: Risk, accountability and gender-responsive penal politics." *Current Issues in Criminal Justice* 22, no. 2 (2010): 193-215.

Haraway, Donna. "Situated knowledges: The science question in feminism and the privilege of partial perspective." *Feminist studies* 14, no. 3 (1988): 575-599.

Harris, Marian S., and Wanda Hackett. "Decision points in child welfare: An action research model to address disproportionality." *Children and Youth Services Review* 30, no. 2 (2008): 199-215.

Harvey, David. *A brief history of neoliberalism*. OUP Oxford, 2005.

Hendrixson, Anne. "Population control in the troubled present: the '120 by 20'target and Implant Access Program." *Development and Change* 50, no. 3 (2019): 786-804.

Hensley, Erica, and Michelle Liu. "Delivering Justice." *Mississippi Today*. May 12, 2019. https://mississippitoday.org/2019/05/11/delivering-justice/

Hill, Robert B. "Institutional racism in child welfare." *Race and Society* 7, no. 1 (2004): 17-33.

Hines, Alice M., Kathy Lemon, Paige Wyatt, and Joan Merdinger. "Factors related to the disproportionate involvement of children of color in the child welfare system: A review and emerging themes." *Children and youth services review* 26, no. 6 (2004): 507-527.

Hoggart, Lesley. "'I'm pregnant… what am I going to do?'An examination of value judgements and moral frameworks in teenage pregnancy decision making." *Health, risk & society* 14, no. 6 (2012): 533-549.

Holc, Janine P. "The purest democrat: fetal citizenship and subjectivity in the construction of democracy in Poland." *Signs: Journal of Women in Culture and Society* 29, no. 3 (2004): 755-782.

Hong, Grace Kyungwon. *The ruptures of American capital: Women of color feminism and the culture of immigrant labor*. U of Minnesota Press, 2006.

Hoppe, Trevor. *Punishing disease: HIV and the criminalization of sickness*. Univ of California Press, 2017.

Hurt, Hallam, Elsa Malmud, Laura Betancourt, Leonard E. Braitman, Nancy L. Brodsky, and Joan Giannetta. "Children with in utero cocaine exposure do not differ from control subjects on intelligence testing." *Archives of Pediatrics & Adolescent Medicine* 151, no. 12 (1997): 1237-1241.

Hurt, Hallam, Nancy L. Brodsky, Hallam Roth, Elsa Malmud, and Joan M. Giannetta. "School performance of children with gestational cocaine exposure." *Neurotoxicology and Teratology* 27, no. 2 (2005): 203-211.

Hurt, Hallam, Laura M. Betancourt, Elsa K. Malmud, David M. Shera, Joan M. Giannetta, Nancy L. Brodsky, and Martha J. Farah. "Children with and without gestational cocaine exposure: a neurocognitive systems analysis."*Neurotoxicology and Teratology* 31, no. 6 (2009): 334-341.

Illinois Department of Public Health. *Opioid Use Treatment Resources for Pregnant Women with Medicaid in Illinois.* Last updated May 5, 2018. http://www.dph.illinois.gov/sites/default/files/publications/publicationsowhopioid-use-treatment-resource-manual-ab.pdf

Illinois Department of Children and Family Services. “Annual Progress and Services Report.” Fiscal Year 2018. https://www2.illinois.gov/dcfs/aboutus/newsandreports/Documents/APSR_FY18.pdf

Inciardi, James A., Dorothy Lockwood, and Anne E. Pottieger. *Women and crack-cocaine*. Macmillan Coll Div, 1993.

Jequier, Anne M. "Vasectomy related infertility: a major and costly medical problem." *Human reproduction (Oxford, England)* 13, no. 7 (1998): 1757-1759.

Králová, Jana, and Tony Walter, eds. *Social Death: Questioning the life-death boundary*. Routledge, 2018.

Katz, Cindi. "The state goes home: Local hyper-vigilance of children and the global retreat from social reproduction." *Social justice* 28, no. 3 (85 (2001): 47-56.

Klinenberg, E. (2001). Bodies that don't matter: death and dereliction in Chicago. *Body & Society*,*7*(2-3), 121-136.

Kunins, Hillary Veda, Eran Bellin, Cynthia Chazotte, Evelyn Du, and Julia Hope Arnsten. "The effect of race on provider decisions to test for illicit drug use in the peripartum setting." *Journal of Women's Health* 16, no. 2 (2007): 245-255.

Land, D. B., and R. Kushner. "Drug abuse during pregnancy in an inner-city hospital: prevalence and patterns." *The Journal of the American Osteopathic Association* 90, no. 5 (1990): 421-426.

Latimer, Heather. "Bio-reproductive futurism: bare life and the pregnant refugee in Alfonso Cuarón's Children of Men." *Social Text* 29, no. 3 (108) (2011): 51-72.

Link, Bruce G., and Jo Phelan. "Social conditions as fundamental causes of disease." *Journal of health and social behavior* (1995): 80-94.

Luna, Zakiya, and Kristin Luker. "Reproductive justice." *Annual Review of Law and Social Science*9 (2013): 327-352.

Lucken, Karol. "Privatizing discretion: "Rehabilitating" treatment in community corrections." *Crime & Delinquency* 43, no. 3 (1997): 243-259.

Lupton, Deborah. "'Precious cargo': Foetal subjects, risk and reproductive citizenship." *Critical public health* 22, no. 3 (2012): 329-340.

Lyerly, Anne Drapkin, Lisa M. Mitchell, Elizabeth M. Armstrong, Lisa H. Harris, Rebecca Kukla, Miriam Kuppermann, and Margaret Olivia Little. "Risks, values, and decision making surrounding pregnancy." *Obstetrics & Gynecology* 109, no. 4 (2007): 979-984.

Mackendrick, Norah. "More work for mother: Chemical body burdens as a maternal responsibility." *Gender & Society* 28, no. 5 (2014): 705-728.

MacGregor, Scott N., Louis G. Keith, Jay A. Bachicha, and Ira J. Chasnoff. "Cocaine abuse during pregnancy: correlation between prenatal care and perinatal outcome." *Obstetrics and Gynecology* 74, no. 6 (1989): 882-885.

Mahan, Sue. *Crack cocaine, crime, and women*. Vol. 4. Sage, 1996.

Mamo, Laura. *Queering reproduction*. Duke University Press, 2007.

Marcus, George E. "Ethnography in/of the world system: The emergence of multi-sited ethnography." *Annual review of anthropology* 24, no. 1 (1995): 95-117.

Markens, Susan, Carole H. Browner, and Nancy Press. "Feeding the fetus: on interrogating the notion of maternal-fetal conflict." *Feminist studies* (1997): 351-372.

Marsh, Jeanne C., Joseph P. Ryan, Sam Choi, and Mark F. Testa. "Integrated services for families with multiple problems: Obstacles to family reunification." Children and Youth Services Review28, no. 9 (2006): 1074-1087.

Martin, M. Louise, Muin J. Khoury, José F. Cordero, and Grady D. Waters. "Trends in rates of multiple vascular disruption defects, Atlanta, 1968–1989: Is there evidence of a cocaine teratogenic epidemic?." *Teratology* 45, no. 6 (1992): 647-653.

Martin, Nina. “How Some Alabama Hospitals Quietly Drug Test Mothers- Without their Consent.” *Propublica.* Published September 30, 2013. https://www.propublica.org/article/how-some-alabama-hospitals-drug-test-new-mothers-without-their-consent

Martins, Silvia S., Julian Santaella-Tenorio, Brandon DL Marshall, Adriana Maldonado, and Magdalena Cerdá. "Racial/ethnic differences in trends in heroin use and heroin-related risk behaviors among nonmedical prescription opioid users." *Drug and alcohol dependence* 151 (2015): 278-283.

Mbembé, J-A., and Libby Meintjes. "Necropolitics." *Public culture* 15, no. 1 (2003): 11-40.

McCabe, Katharine. "Mothercraft: Birth work and the making of neoliberal mothers." *Social Science & Medicine* 162 (2016): 177-184.

McClain, Dani. “The Murder of Black Youth is a Reproductive Justice Issue”, *The Nation,* August 13, 2014.

McCorkel, Jill A. *Breaking women: Gender, race, and the new politics of imprisonment*. NYU Press, 2013.

McCulloch, Alison. "The rise of the fetal citizen." *Women's Studies Journal* 26, no. 2 (2012).

McKim, Allison. "“Getting gut-level” punishment, gender, and therapeutic governance." *Gender & Society* 22, no. 3 (2008): 303-323.

Melnikow, Joy, Sonia A. Alemagno, Carol Rottman, and Steven J. Zyzanski. "Characteristics of inner-city women giving birth with little or no prenatal care: a case-control study." *Journal of Family Practice* 32, no. 3 (1991): 283-289.

Metzl, Jonathan M., JuLeigh Petty, and Oluwatunmise V. Olowojoba. "Using a structural competency framework to teach structural racism in pre-health education." *Social Science & Medicine* 199 (2018): 189-201.

Michalsen, Venezia, and Jeanne Flavin. "Not all women are mothers: Addressing the invisibility of women under the control of the criminal justice system who do not have children." *The Prison Journal* 94, no. 3 (2014): 328-346.

Miller, Christry L., Lewis H. Margolis, Bettina Schwethelm, and Sheila Smith. "Barriers to implementation of a prenatal care program for low income women." *American Journal of Public Health* 79, no. 1 (1989): 62-64.

Miller, Jody. "Gender and power on the streets: Street prostitution in the era of crack cocaine." *Journal of Contemporary Ethnography* 23, no. 4 (1995): 427-452.

Moeller, Karen E., Julie C. Kissack, Rabia S. Atayee, and Kelly C. Lee. "Clinical interpretation of urine drug tests: what clinicians need to know about urine drug screens." In *Mayo Clinic Proceedings*, vol. 92, no. 5, pp. 774-796. Elsevier, 2017.

Moynihan, Daniel Patrick, Lee Rainwater, and William L. Yancey. *The Negro family: The case for national action*. Cambridge, MA:: MIT Press, 1967.

Murphy, Michelle. "Distributed reproduction, chemical violence, and latency." *S&F Online* 11, no. 3 (2013).

Nelson, Alondra. *Body and soul: The Black Panther Party and the fight against medical discrimination*. U of Minnesota Press, 2011.

Nelson HD, Fu R, Cantor A, Pappas M, Daeges M, Humphrey L. Effectiveness of breast cancer screening: systematic review and meta-analysis to update the 2009 U.S. Preventive Services Task Force Recommendation. Ann Intern Med. 164(4):244-55, 2016.

Netherland, Julie, and Helena Hansen. "White opioids: Pharmaceutical race and the war on drugs that wasn't." *BioSocieties* 12, no. 2 (2017): 217-238.

Neubeck, Kenneth J., and Noel A. Cazenave. *Welfare racism: Playing the race card against America's poor*. Routledge, 2002.

Neuspiel, Daniel R., Terry Martin Zingman, Virginia H. Templeton, Paula DiStabile, and Ernest Drucker. "Custody of cocaine-exposed newborns: determinants of discharge decisions." *American Journal of Public Health* 83, no. 12 (1993): 1726-1729.

NWHN and SisterSong (n.d.) 'Long-acting Reversible Contraception: Statement of Principles'. National Women's Health Network and SisterSong: Women of Color Reproductive Justice Collective. www.tinyurl.com/LARCprinciples

Osterman MJK, Martin JA. Timing and adequacy of prenatal care in the United States, 2016. National Vital Statistics Reports, vol 67 no 3. Hyattsville, MD: National Center for Health Statistics. 2018.

Paltrow, Lynn M., and Jeanne Flavin. "Arrests of and forced interventions on pregnant women in the United States, 1973–2005: Implications for women's legal status and public health." *Journal of Health Politics, Policy and Law* 38, no. 2 (2013): 299-343.

Patterson, Orlando. *Slavery and Social Death: A Comparative Study, With a New Preface*. Harvard University Press, 2018.

Paul-Emile, Kimani. "The Charleston Policy: Substance or Abuse?." *Michigan Journal of Race and Law* 4, no. 2 (1999): 325-387.

Peacock, Marian, Paul Bissell, and Jenny Owen. "Dependency denied: health inequalities in the neo-liberal era." *Social Science & Medicine* 118 (2014): 173-180.

Petersen, Alan R. "Risk and the regulated self: the discourse of health promotion as politics of uncertainty." *The Australian and New Zealand Journal of Sociology* 32, no. 1 (1996): 44-57.

Peterson, Gretchen. "Cultural theory and emotions." In *Handbook of the Sociology of Emotions*, pp. 114-134. Springer, Boston, MA, 2006.

Petr, Christopher G., and Ivy C. Johnson. "Privatization of foster care in Kansas: A cautionary tale." *Social Work* 44, no. 3 (1999): 263-267.

Pew Research Center, April 2014, "America's Changing Drug Policy Landscape"

Piven, Frances Fox, and Richard Cloward. *Regulating the poor: The functions of public welfare*. Vintage, 1993.

Pollack, Harold A., Sheldon Danziger, Rukmalie Jayakody, and Kristin S. Seefeldt. "Drug testing welfare recipients—false positives, false negatives, unanticipated opportunities." *Women's Health Issues* 12, no. 1 (2002): 23-31.

Pollack, Shoshana. "Labelling clients 'risky': Social work and the neo-liberal welfare state." *British Journal of Social Work* 40, no. 4 (2010): 1263-1278.

Povinelli, Elizabeth. "Economies of abandonment." *Social Belonging and Endurance in Late Liberalism* (2011).

Preble, Edward, and John J. Casey. "Taking care of business—the heroin user's life on the street." *International journal of the addictions* 4, no. 1 (1969): 1-24.

Quadagno, Jill S. *The color of welfare: How racism undermined the war on poverty*. Oxford University Press, 1994.

Ramanathan, Mala, and U. S. Mishra. "Correlates of female sterilization regret in the southern states of India." *Journal of Biosocial Science* 32, no. 4 (2000): 547-558.

Rapp, Rayna. *Testing women, testing the fetus: The social impact of amniocentesis in America*. Routledge, 2004.

Ratner, Mitchell S., ed. *Crack pipe as pimp: An ethnographic investigation of sex-for-crack exchanges*. New York: Lexington Books, 1993.

Reich, Jennifer A. *Fixing families: Parents, power, and the child welfare system*. Taylor & Francis, 2005.

Reinarman, Craig. "Addiction as accomplishment: The discursive construction of disease." *Addiction Research & Theory* 13, no. 4 (2005): 307-320.

Rich, Adrienne. *Of woman born: Motherhood as experience and institution*. WW Norton & Company, 1995.

Richie, Beth. *Arrested justice: Black women, violence, and America's prison nation*. NYU Press, 2012.

Rivera-Rodriguez, A. J., and Ben-Tzion Karsh. "Interruptions and distractions in healthcare: review and reappraisal." *BMJ Quality & Safety* 19, no. 4 (2010): 304-312.

Roberts, Dorothy E. *Killing the black body: Race, reproduction, and the meaning of liberty*. Vintage Books, 1999.

Roberts, Dorothy E. "Child welfare's paradox." *Wm. & Mary L. Rev.* 49 (2007): 881.

Roberts, Dorothy. *Shattered bonds: The color of child welfare*. Civitas Books, 2009.

Roberts, Dorothy E. "Prison, foster care, and the systemic punishment of black mothers." *Ucla L. Rev.* 59 (2011): 1474.

Roeder, Amy. “America is Failing Its Black Mothers.” *Harvard Public Health Magazine*. Winter 2019. https://www.hsph.harvard.edu/magazine/magazine_article/america-is-failing-its-black-mothers/

Rose, Nikolas, and Peter Miller. "Political power beyond the state: Problematics of government." *British journal of sociology* (1992): 173-205.

Rose, Nikolas. *Powers of freedom: Reframing political thought*. Cambridge university press, 1999.

Rose, Nikolas. "Government and control." *British journal of criminology* 40, no. 2 (2000): 321-339.

Rose, Nikolas. "The politics of life itself." *Theory, culture & society* 18, no. 6 (2001): 1-30.

Rose, Nikolas, and Carlos Novas. "Biological citizenship." *Global assemblages: Technology, politics, and ethics as anthropological problems.* (2005): 439-463.

Rosenbaum, Marsha. *Women on heroin*. Rutgers University Press, 1981.

Ross, Loretta. "Understanding reproductive justice: Transforming the pro-choice movement." *Off our backs* 36, no. 4 (2006): 14-19.

Rothwell, Jonathan. "How the war on drugs damages Black social mobility." *Brookings Institution* (2014).

Ruhl, Lealle. "Liberal governance and prenatal care: risk and regulation in pregnancy." *Economy and society* 28, no. 1 (1999): 95-117.

Ruhl, Lealle. "Dilemmas of the will: Uncertainty, reproduction, and the rhetoric of control." *Signs: Journal of Women in Culture and Society* 27, no. 3 (2002): 641-663.

Saitman, Alec, Hyung-Doo Park, and Robert L. Fitzgerald. "False-positive interferences of common urine drug screen immunoassays: a review." *Journal of analytical toxicology* 38, no. 7 (2014): 387-396.

Salmon, Amy. "Aboriginal mothering, FASD prevention and the contestations of neoliberal citizenship." *Critical Public Health* 21, no. 2 (2011): 165-178.

Silliman, Jael Miriam. *Undivided rights: Women of color organize for reproductive justice*. South End Press, 2004.

Sinha, C., P. Ohadike, P. Carrick, P. Pairaudeau, D. Armstrong, and S. W. Lindow. "Neonatal outcome following maternal opiate use in late pregnancy." *International Journal of Gynecology & Obstetrics*74, no. 3 (2001): 241-246.

Schram, Sanford F. "Neoliberalizing the Welfare State: Marketizing Social Policy/Disciplining Clients." *The SAGE Handbook of Neoliberalism* (2018): 308.

Schoen, Johanna. *Choice & coercion: Birth control, sterilization, and abortion in public health and welfare*. Univ of North Carolina Press, 2005.

Shim, J. K. (2010). Cultural health capital: a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior*, *51*(1), 1-15.

Skloot, Rebecca. *The immortal life of Henrietta Lacks*. Broadway Books, 2017.

Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

Sutcliffe, Kathleen M., Elizabeth Lewton, and Marilynn M. Rosenthal. "Communication failures: an insidious contributor to medical mishaps." *Academic medicine* 79, no. 2 (2004): 186-194.

Smith, Brenda D., and Mark F. Testa. "The risk of subsequent maltreatment allegations in families with substance-exposed infants" *Child Abuse & Neglect* 26, no. 1 (2002): 97-114.

Solinger, Rickie. *Abortion wars: A half century of struggle, 1950-2000*. Univ of California Press, 1998.

Solinger, Rickie. *Pregnancy and power: A short history of reproductive politics in America*. NYU Press, 2005.

Sparke, Matthew. "Austerity and the embodiment of neoliberalism as ill-health: towards a theory of biological sub-citizenship." *Social Science & Medicine* 187 (2017): 287-295.

Stoler, Ann Laura. *Race and the education of desire: Foucault's history of sexuality and the colonial order of things*. Duke University Press, 1995.

Szott, Kelly. "Contingencies of the will: uses of harm reduction and the disease model of addiction among health care practitioners." *Health:* 19, no. 5 (2015): 507-522.

Terplan, Mishka, Hollis J. Laird, Dennis J. Hand, Tricia E. Wright, Ashish Premkumar, Caitlin E. Martin, Marjorie C. Meyer, Hendrée E. Jones, and Elizabeth E. Krans. "Opioid detoxification during pregnancy: a systematic review." *Obstetrics and gynecology* 131, no. 5 (2018): 803.

Timmermans, Stefan. "When death isn't dead: implicit social rationing during resuscitative efforts." *Sociological Inquiry* 69, no. 1 (1999): 51-75.

Timmermans, Stefan, and Jonathan Gabe. "Introduction: Connecting criminology and sociology of health and illness." *Sociology of Health & Illness* 24, no. 5 (2002): 501-516.

U.S Department of Health and Human Services Office of Minority Health, “Infant Mortality and African Americans,” https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23

Van Boekel, Leonieke C., Evelien PM Brouwers, Jaap Van Weeghel, and Henk FL Garretsen. "Stigma among health professionals towards patients with substance use disorders and its

consequences for healthcare delivery: systematic review." *Drug and alcohol dependence* 131, no. 1-2 (2013): 23-35.

Volkow, Nora D., George F. Koob, and A. Thomas McLellan. "Neurobiologic advances from the brain disease model of addiction." *New England Journal of Medicine* 374, no. 4 (2016): 363-371.

Wacquant, Loïc. *Punishing the poor: The neoliberal government of social insecurity*. duke university Press, 2009.

Wang, Jackie. *Carceral capitalism*. Vol. 21. MIT Press, 2018.

Warner, Elizabeth A., Robert M. Walker, and Peter D. Friedmann. "Should informed consent be required for laboratory testing for drugs of abuse in medical settings?." *The American journal of medicine* 115, no. 1 (2003): 54-58.

Washington, Harriet A. *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Doubleday Books, 2006.

Waggoner, Miranda. *The Zero Trimester: Pre-Pregnancy Care and the Politics of Reproductive Risk*. Univ of California Press, 2017.

Weheliye, Alexander G. *Habeas viscus: Racializing assemblages, biopolitics, and black feminist theories of the human*. Duke University Press, 2014.

Williams, Clare. "Framing the fetus in medical work: rituals and practices." *Social Science & Medicine* 60, no. 9 (2005): 2085-2095.

Williams, Terry Moses. "Crackhouse: Notes from the End of the Line." (1992): 493-513.

Willse, Craig. *The value of homelessness: Managing surplus life in the United States*. U of Minnesota Press, 2015.

Wulczyn, Fred. "Closing the gap: Are changing exit patterns reducing the time African American children spend in foster care relative to Caucasian children?." *Children and youth services review* 25, no. 5-6 (2003): 431-46

Tiger, Rebecca. Judging addicts: Drug courts and coercion in the justice system. NYU Press, 2013.

Tracy, Elizabeth M., and James K. Whittaker. "The social network map: Assessing social support in clinical practice." *Families in Society* 71, no. 8 (1990): 461-470.

Yang, Kaifeng, and Gary VanLandingham. "How hollow can we go? A case study of the Florida's efforts to outsource oversight of privatized child welfare services." *The American Review of Public Administration* 42, no. 5 (2012): 543-561.

VITA

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Education

2019	*University of Illinois*	*Chicago*
	Ph.D. | Sociology
2015	Certificate in Gender and Women's Studies
2011	*M.A. Sociology; Fordham University*
2007	B.A. Southern Methodist University
	Summa Cum Laude | Major: Psychology

Research Interests

Medical sociology; risk and risk theory; reproduction and pregnancy; crime, deviance, and the law; addiction and substance use; critical race theory; feminist epistemology; sexuality and gender; biopolitics; qualitative research methods

Publications

Peer-Reviewed

McCabe, Katharine. "Mothercraft: Birth work and the making of neoliberal mothers." *Social Science & Medicine* 162 (2016): 177-184.

Everett, Bethany G., Katharine F. McCabe, and Tonda L. Hughes. "Unintended pregnancy, depression, and hazardous drinking in a community-based sample of sexual minority women." *Journal of Women's Health* 25, no. 9 (2016): 904-911.

Everett, Bethany G., Katharine F. McCabe, and Tonda L. Hughes. "Sexual orientation disparities in mistimed and unwanted pregnancy among adult women." *Perspectives on sexual and reproductive health* 49.3 (2017): 157-165.

McCabe, Katharine, and J. E. Sumerau. "Reproductive Vocabularies: Interrogating Intersections of Reproduction, Sexualities, and Religion among US Cisgender College Women." *Sex Roles* 78.5-6 (2018): 352-366.

Under-review

McCabe, Katharine. "Pulling Herself Up by the Umbilical Cord: Risk, Responsibility, and Rugged Empowerment in Mothers' and Birth Workers' Birthing Narratives." *Sociology of Health and Medicine.*

Book Chapters

Bethany Everett, Oluwatitofunmi O. Apatira, and Katharine McCabe "Changing Times: How is Same-Sex Relationship Equality Impacting the Fertility Landscape." in *Fertility and Assisted Reproductive Technology (ART)Theory, Research, Policy and Practice for Health Care Practitioners (2016).*

Katharine McCabe. (Invited) "Stratification in Reproductive Healthcare." in *Advances in Medical Sociology, Reproduction, Health and Medicine, Vol 20.* Eds. M. Waggoner, S. Markens, E. Armstrong. (forthcoming).

In Progress

McCabe, Katharine, Meggan Lee, Johnathan Stoltman, Mishka Terplan. "A Systematic Review of Research on the Relationship between Substance Abuse during Pregnancy and Subsequent Child Abuse"

Hirshfield, Laura, Katharine McCabe. "Understanding the Role of Emotion and Emotion Work in Standardized Patients' Interactions with Medical Students"

Grants and Fellowships

2017-2018	NSF- Doctoral Dissertation Research Improvement Award $11,000
2017-2018	Travel Awards- UIC $550
2017	Provost Award – UIC $2000
2017	Chancellor's Award – UIC $5000
2009-2010	Presidential Scholarship – Fordham University
2005-2007	Academic Honor Transfer Scholarship

Honor and Awards

2018	SSSP/SWS- Beth B. Hess Memorial Scholarship Honorable Mention
2018	Graduate Student Teaching Award- UIC Sociology
2007	Excellence in Psychology Award- Southern Methodist University
2005, 2006	Honor's List with High Distinction- Southern Methodist University

Positions

2017- present: Research Assistant for Dr. Laura Hirshfield, University of Illinois at Chicago, Department of Medical Education; Project: *Experiences of Standardized Patients*

2017-present: Teaching Appointment, Sociology, DePaul University,
Courses: Introduction to the US Healthcare System; Sociology of Sexuality

2016-present: Teaching Appointment, Sociology, University of Illinois at Chicago,
Courses: Human Sexuality: Social Perspectives, Social Problems, Health and Medicine

2015-2016: Student Associate Editor, *Social Problems*

2013-2015: Research Assistant for Dr. Bethany Everett, University of Illinois at Chicago; Department of Sociology; Project: *Sexual Minority Fertility Study*

2012-2015: Teaching Assistant, Sociology, University of Illinois at Chicago,
Courses: Introduction to Sociological Theory; Introduction to Sociological Research Methods; Introductory Sociological Statistics; Introduction to Sociology; Gender and Society

2010-2012: Research and Policy Analyst, National Advocates for Pregnant Women, New York, NY

2009-2010: Presidential Scholarship, Fordham University

2007-2009: Community Educator, New Beginning Center Domestic Violence Agency, Dallas, TX

Teaching Experience

Courses Taught
Sociology of Sexuality –(300 level)
Introduction to the US Healthcare System –(200 level)
Health and Medicine –(200 level)
Social Problems –(100 level)
Human Sexuality: Social Perspectives – (200 level)

Teaching Assistantships
Introduction to Sociological Theory– (300 level)
Introduction to Sociological Research Methods – (300 level)
Introductory Sociological Statistics – (200 level)
Introduction to Sociology – (100 level)
Gender and Society – (200 level)

Presentations

Eastern Sociological Society 2019. Annual Meeting: Facts and Fictions: Narratives of Inequality and Difference, Boston, MA. March 14-17, 2019.

> Panel: Health Professions Education in the 21st Century: VII. Diverse Providers in HPE, Presentation: Making the Subjective, Objective?: Assessing Decision-Making and Evaluation Among Standardized Patients Katharine Faye McCabe, University of Illinois - Chicago; Kelly Underman, Drexel University; Laura E. Hirshfield, University of Illinois – Chicago, March 16, 2019.
>
> Panel: Sociology of Reproduction: XI. Policy, Advocacy, and Public Reproductive Health

Presentation: Searching for the Opioid Epidemic: A Study of Responses to Substance Using Pregnant Women and the Special Case of Opioids Katharine Faye McCabe, University of Illinois – Chicago, March 17, 2019.

American Sociology Association 2018. Annual Meeting: Feeling Race: An Invitation to Explore Racialized Emotions, Philadelphia, PA. August 10-15, 2018.

Regular Session Panel: Reproductive Control and Decision-Making
Presentation: Risk, Responsibility, and Rugged Empowerment in Mothers' and Birth Workers' Birth Narratives, August 11, 2018.

Southern Sociological Society 2018. Annual Meeting: Racial Theory, Analysis, and Politics in Trump America. New Orleans, LA. April 4-7, 2018.

Presentation: "Abusive Wombs: How policymakers create and respond to the problem of substance using pregnant women." April 5, 2018.

Southern Sociological Society 2016. Annual Meeting*: The Politics of Marriage from Intimacy to Public Policy.* Atlanta GA. April 13-16, 2015.

Presentation: "Expanding Notions of Maternal Responsibility: Risk Discourses among Birth Workers and the Women Who Use Them." April 14, 2016.

Presentation: Research and Teaching About Relationship Trauma: A "Write Where It Hurts" Panel. "Birth Trauma: Trauma Narratives that Heal and Harm." April 16, 2016

Sociologists for Women in Society 2015 Winter Meeting: *Feminism in Theory and Practice.* Washington D.C. February 19-22, 2015.

Presentation: 'Good Mothers' Resist Medicalization: Lessons on the Limits of Agency in Midwives Work Narratives, February 21, 2015.

Sociologists for Women in Society 2014 Winter Meeting: *Gender and Multi-Institutional Politics. Nashville, TN, February 6-9, 2014.*

Presentation: Pregnancy, Bodies & Birth, Katharine McCabe and Emilie Glass. "Mapping Non-Biomedical Terrains: Voices of Midwives, Doulas, and the Women Who Use Their Services," February 7, 2014.

Presentation: Health Inequalities, Bethany Everett, Camille Li, and Katharine McCabe. "Sexual Orientation Disparities in Perinatal Health," February 8, 2014.

2013 IMPACT Chicago LGBTQ Health and Wellness Conference. Poster: Everett, Bethany, Camille Li, Katharine McCabe. "Sexual Orientation Differences in Perinatal Health Behaviors," Feinberg School of Medicine, Northwestern University, Chicago, IL, November 20, 2013.

Midwestern Sociological Society's 76th Annual Meeting: *Integrating the Sociology Eclectic: Research, Teaching and Activism.* Panel: Gender-based Violence, Formal Paper

Session. Title: *Responding to Dating Violence on Campus: The Role of Informal Social Control.* Chicago, IL, March 27-30, 2013.

American Society of Criminology's 2011 Annual Meeting: *Breaking the Mold: Innovations and Bold Ventures in Criminology*, Panel: Crime on College Campuses, Title: "University and Student Responses to Dating Violence on Campus," Washington, D.C., November 16-19, 2011.

Eastern Sociological Society's 81st Annual Meeting: *Intersectionalities and Complex Inequalities*, Panel: Criminal Justice and Society, Formal Paper Session. Title: "Theories of Community Organization: A Model for Understanding Intimate Partner Violence," Philadelphia, PA, February 24-27, 2011.

Committees and Professional Service

Professional Memberships: American Sociological Association, Sections: Science, Knowledge, and Technology, Bodies and Embodiment, Medical Sociology; Sociologists for Women in Society (SWS); Society for the Study of Social Problems (SSSP)

Independent Study Hours: Special Topics in Reproductive Health, Undergraduate Mentorship (2 students). Spring 2018

President. Sociology Graduate Student Organization. May 2015 – May 2016

Student Editorial Board. Social Problems. June 2015 – June 2016

Manuscript Reviewer: *Social Inquiry, Social Science and Medicine*

Chicago Ethnography Conference, Abstract Committee. December 2016- March 2017

Engendering Change Conference, Abstract Committee. September 2015-May 2016

Engendering Change Conference, Discussant Committee. September 2012-March 2013

Sociology Department Recruitment Committee. 2013

Global Footprint Project, UIC Office of International Affairs. 2013