“LEFT HIM IN THE DUST:”

FATHER EXCLUSION FROM MATERNAL HARM REDUCTION SERVICES

by

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Abstract

This study was conducted in Vancouver, B.C., Canada, with former patients of a harm reduction maternity ward serving pregnant women who use illicit drugs in Vancouver’s downtown eastside. This district is one of Canada’s poorest urban neighbourhoods. The purpose of this study was to build theory, based on how fathers and mothers were affected by father exclusion, to inform development of more effective services for substance-using parents.

The study demonstrates how father exclusion from services offered at a harm reduction hospital maternity unit affects fathers and mothers struggling with problematic drug use. A qualitative approach, constructivist grounded theory, was used. A purposeful sampling method was employed to recruit 20 parents, 10 mothers and 10 fathers, for individual interviews and a focus group. Grounded theory method highlighted how structural conditions of addictions services recursively interact with experiences of fathers and mothers, amplifying obstacles experienced by parents using illicit drugs, such as poverty, stigma, racism and homelessness.

Fathers’ gender-based exclusion compounded feelings of exclusion based on race and class, and negatively affected mothers. The study findings: contest the tenets of ‘difference’ feminist theory that underpin contemporary addictions services for women; demonstrate the importance of including fathers in antenatal, natal and postnatal addictions services; and contribute to theory aimed at disrupting and destabilizing gender norms.
Preface

Sydney Weaver identified the research problem; designed and conducted the study; analyzed the data; and produced this manuscript. The study was supervised by Dr. Paule McNicoll and approved by the Behavioural Research Ethics Board of the University of British Columbia (Certificate number H10-02863).
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1 Introduction

“Society incurs the greatest costs from social policy based on biological views about the origins of political equality, poverty and equal opportunity and the (im)possibility of social change.” (Fausto-Sterling, 1985, p. 207)

1.1 Background to the study

This work must begin with a major caveat: were it not for drug law and policy in Canada, making the use of certain substances illegal, the study may not have taken place. The classification of certain substances as illicit spawns a profusion of circumstances, consequences and industries. These laws and policies situate the lives of people like these study participants squarely and continually within a myriad of overtly or subtly oppressive structures: jails, detoxes, treatment centres, clinics, hospitals.

The behaviours users of illicit drugs are compelled to perform to obtain these substances (prostitution, drug dealing, robbery, fraud, etc.) place them not only at personal risk, but also in a continually despised position: scapegoats for social ills. Were these substances legal, these behaviours, the subsequent vilification and penalization of illicit drug users, the growth of treatment and criminal justice industries, may not exist.

Catastrophic drug laws aside, I know from personal experience the toll that problematic drug use takes: it robs us of our spirit and our health. Watching my own suicidal drug use, or that of my partner or friends, has taken a serious toll. Legal or not, “I’ve seen
the needle and the damage done.”¹ This all being said, I will now move on to discuss the current reality for these study participants, and the institutions that have developed around them.

Interest in the study grew from personal and professional experience: as a former intravenous illicit drug user; as a client of outpatient and residential addictions services; and as a social worker in British Columbia, Canada, for over 25 years. In my three years working at Fir Square Combined Care Unit, B.C. Women’s Hospital, I became concerned that we lacked the capacity to help mothers’ partners, the fathers of their babies. I observed mothers leave Fir Square to be with partners through their pregnancy. This resulted in pregnant mothers, and their partners, remaining in situations characterized by poverty and risk; services were available, but only to mothers. I realized fathers had also been absent in my child welfare work, largely invisible, and written off as ‘deadbeat dads.’ Yet these fathers were also marginalized, and likely to benefit from services. Why were they excluded? What happened to children with absent fathers?

I noticed that in residential and outpatient addictions treatment couples were often encouraged to separate in order to ‘focus on their own recovery,’ regardless of whether the couple had children together, and/or were in a long term relationship. The assumptions underlying this direction seemed problematic; the result was division, control and exclusion of marginalized peoples. To find out more about this phenomenon as it related to fathers, and its implications for mothers, fathers and families, I conducted a literature survey, and

¹ Neil Young
designed a mixed methods (qualitative and quantitative) pilot study of the current study (Weaver, 2009a).

I found very little research pertaining to fathers using illicit drugs (Collins, Grella & Hser, 2003; McMahon & Rounsaville, 2002a, 2002b; McMahon, Winkel, Suchman & Rounsaville, 2007). Yet research on illicit drug-using fathers seems imperative in view of how fathers’ problematic drug use can affect health and social outcomes for mothers, fathers and children (Collins et al., 2003; Laudet, Magura, Furst & Kumar, 1999; McMahon & Rounsaville, 2002a).

Father exclusion in child welfare practice has had significant consequences, including mothers’ concealment of continued relationships with partners due to “concern about loss of benefits and services,” and fathers’ re-creation of problematic family situations with successive partners (Strega, Brown, Callahan, Dominelli & Walmsley, 2009, p. 713). Klee (2002) found that mothers using illicit drugs identify relationships with partners as important. Other studies found these relationships can also be “relatively long lasting (M=49 months; 59% reported 24 months or more)” (Kissin, Svikis, Morgan, & Haug, 2001, p. 32). Father involvement therefore seems well-advised.

Perhaps fathers’ absence from mothers’ addictions services seemed prudent in view of literature that describes many of these relationships as violent (van Wormer & Davis, 2003). Yet women’s continued involvement with partners suggests an opposite conclusion, that is, the necessity of identifying and engaging fathers in substance use services, particularly since “the use of alcohol and drugs has consistently been found to be a major factor in intimate partner violence” (van Wormer & Davis, 2003, p. 348). The fact that
fathers continue to affect mothers and children, absent or not (McMahon & Rounsaville, 2002a), in itself compels us to conduct further research with this population.

Engaging fathers in addictions services may improve women’s retention in treatment and reduce incidence of factors linked with domestic violence, such as drug use and psychological distress (Collins et al., 2003). In their study of 52 cocaine users in the U.S., Higgins, Budney, Bickel and Badger (1994) found that “having a significant other participate in treatment was a robust predictor of cocaine abstinence” (p. 51). In fact, Higgins et al. (1994) report that the “odds of achieving a criterion level of cocaine abstinence were approximately 20 times greater for subjects who had a significant other participate in treatment” (p. 48). Laudet et al. (1999) note, in their discussion of the Higgins et al. (1994) study, that this result was “particularly strong for women clients” (p. 608). Fischer (2000), pointing out that pregnancy and childbirth “may present an ideal opportunity to treat both partners for their dependence” (p. 1143), underscores the opportunity for recovery that presents in childbirth for both parents. Fischer (2000) recommends “treatment services… make provision for this and attempt to involve both partners” (p. 1142).

Thus far, most analyses of addictions services have neglected to deconstruct underlying assumptions of services in reference to family, gender, race and class (Barker & Hunt, 2004; Boyd, 1999, 2004; Campbell, 2000). As Barker and Hunt (2004) comment in respect to the alcohol and drug literature to date:

Family is treated essentially as a ‘black box’ that is left ‘unpacked.’ This leads to the creation and imposition of social services and public policies aimed at alleviating or
eradicating (problem) substance use, without...insight into the coercive or oppressive potential of the state...(p. 350).

Barker and Hunt’s (2004) analysis is particularly apropos here; with normative family ideals largely uncontested in the literature, a substantive component of the social context of problematic drug use is concealed. Mothers and fathers using illicit drugs are implicated as inherently deviant and ‘at risk.’

Existing literature largely omits consideration of race, class and colonization (Boyd, 2004; hooks, 2005); discussions of gender have focused almost exclusively on women/mothers and their purported need for separate services (e.g. Finkelstein, 1994; Kandall, 1996; Murphy & Rosenbaum, 1999). These omissions have resulted in short sighted views culminating in theoretical limitations (Boyd, 2004; Campbell, 2000) and unintended consequences for mothers, fathers and families, such as separation of couples and separation of fathers from partners and children. Some of these consequences are prominent in the findings of this study.

Excluding race and class from analytical frameworks becomes acutely relevant in respect to the population of illicit substance users served by harm reduction services in Vancouver’s Downtown Eastside, the focus of the present study. The City of Vancouver reports, “while two per cent of Vancouver’s population is Aboriginal, the DTES has an Aboriginal population of 10 per cent” (City of Vancouver, 2012, p. 9). Race and class may thus figure prominently in identity constructions among this area’s residents. Poverty also forms a pivotal intersectional axis: “In 2006, the median household income in the DTES was
$13,691, less than 30 per cent of the city’s median household income figure ($47,299)” (City of Vancouver, 2012, p.31).

In respect to gender, in his discussion of “multiple masculinities,” Connell (2005) emphasizes the centrality of class and race in configuration of masculinities, calling for a “three-fold model of the structure of gender,” including considerations of power, production and “cathexis (emotional attachment)” (p. 73). Within Connell’s (2005) dynamic framework, the identity configurations of illicit drug-using fathers from Vancouver’s Downtown Eastside fall under the rubric of marginalized, not hegemonic, masculinity, foregrounding issues of poverty, stigma, and colonialism. This demarcation highlights the ways that marginalized men, like these father participants, are excluded from the privileges and power experienced by White, middle class men. Fathers lacking access to privileges popularly ascribed to ‘men’ as a category experience a sense of failure. Positioned as powerful, they are virtually powerless.

Also relevant here is Connell’s (2005) argument for a “degendered rights-based politics of social justice” (p. 232); a project aimed at developing capacities “of male bodies other than those developed in war, sport or industrial labour,” including those capacities to care for infants (p. 233). This is central to a true gender-based analysis, calling for promotion and development of the currently curtailed relational capacities of men and fathers. While addictions treatment services do exist for men, they are based on out-dated gender roles, do not reflect the “gender multiculturalism” described by Connell as a possible goal (2005, p. 234), and do not address fathering. By ‘gender multiculturalism’ Connell is referring to a paradigm that calls for deconstructing stereotypical gender traits, and gender flexibility of
each sex. In contrast, the gendered nature of addictions treatment services appears as essentialized, reflected prominently in the Minnesota model of treatment, a model “designed primarily by men for male clients...their approaches have been informed by research conducted on male substance-abusing populations” (Nelson-Zlupko, Kauffman & Dore, 1995, p. 49).

Nelson-Zlupko et al. (1995) explain how “confrontational approaches, which serve to enhance guilt and shame, have been found to be counter-productive with female substance abusers” (p. 49). Yet the confrontational model has yielded “adverse evidence from outcome research” in studies conducted with both female and male clients (Miller, 2003, p. 395). Miller’s (2003) evidence suggests that shaming, confrontational models are least efficacious for men as well. Shifting the focus from men to Western patriarchy is critical in a project that seeks to reveal challenges for those oppressed by race, class and illicit substance use.

Numerous assumptions based on gender pervade addictions theory. Shame and stigma, identified as core features of substance-using mothers’ emotional landscape (Weaver, 2007a, 2007b) are viewed as a gender difference in social and media views of substance-using mothers (Greaves & Poole, 2007). Preliminary studies of substance-using fathers identify a similar theme among fathers (McMahon & Rounsaville, 2002a), demonstrating a need to acknowledge potential barriers for fathers accessing substance use services.

Similarly, damaging stereotypes identified in respect to substance-using mothers (Boyd, 1999, 2004; Greaves & Poole, 2002, 2007; Weaver, 2007a, 2007b), which vilify women who use substances “in ways that interfere with their roles as mothers” (Greaves &
Poole, 2007, p. 220), may also exist for substance-using fathers. McMahon and Rounsaville (2002) cite research findings that demonstrate how negative stereotypes and concomitant “systemic issues...discourage greater involvement” in parenting for fathers, remarking also that “empirical study of substance-abusing fathers may produce findings that contradict popular stereotypes, highlight bias and identify systemic issues that discourage change in father–child relationships that may benefit fathers, mothers and children” (p. 1111).

McMahon and Rounsaville (2002) also predict the emergence, in empirical studies, of findings that contradict popular stereotypes of drug-using fathers.

The importance of a strengths-based approach to substance-using mothers (Weaver, 2007a) is echoed in the few studies that do exist relating to substance-using fathers (Collins et al., 2003; McMahon, Winkel & Rounsaville, 2007). A strengths perspective is ‘client-centred;’ focused on hope and resources rather than pathology; and views people in their social, family and community context. As with mothers (Weaver, 2007a), the social context of fathers’ substance use may also be important; there is “virtually no information about ways other factors may mediate and moderate the impact of substance abuse on fathering” (Rounsaville, 2002a, p. 1111). These factors could include challenges associated with race and class; access to resources such as education and community involvement; birth family parental presence and parenting style; birth family resources and social location; and fathers’ capacity to achieve success as defined by the dominant culture. Finally, I chose a woman-centred service, leading the reader to ask, how can fathers not be excluded here? The study participants informed us that father inclusion is not only possible but urgent.
1.2 Statement of the research problem

To find out how father exclusion from services offered at Fir Square Combined Care Unit affected substance-using mothers and fathers, this study built on a pilot study I conducted in 2009, funded by Mitacs-Accelerate B.C. in partnership with BC Mental Health and Addictions Research Network (Weaver, 2009a). While the pilot study sought to determine whether and how father exclusion affected mothers’ engagement in maternal harm reduction services, the present study expanded the research question, aiming to find out in a broader sense how mothers and fathers were affected by father exclusion from these maternal harm reduction services.

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2 Pregnant and post-partum mothers who use illicit substances, and illicit substance-using fathers, partners of these mothers, were the research participants of both studies; mothers were former patients of Fir Square Combined Care Unit. The forms that comprise mothers’ charts at Fir Square, at B.C. Women’s Hospital, the site of both studies, solicit virtually no information about fathers. This in itself suggests that fathers are ‘left out.’ A robust quantitative analysis of fathers’ demographics and engagement in services offered at the unit could only be conducted if such data were, for the purposes of the study, collected by the hospital. Based on my analysis of the scant data available, from a sample of 40 mothers’ charts, I did find that mother engagement was positively correlated with father engagement; the qualitative data from the pilot study supported this quantitative finding. Gender, race and class issues formed a strong and consistent thread through the data; multiple structural systems combined to thwart efforts of these marginalized fathers to engage with mothers, infants and services. Data from a focus group with 8 service providers revealed institutional barriers to their efforts to work with fathers. These data also reflected how service providers both take up and contest the dominant discourse relating to fathers; service providers expressed clearly that their mandate did not include engaging fathers, primarily due to lack of institutional support (capacity). Service providers expressed that a history of violence should not necessarily preclude offering services to fathers.
1.3 Location of the study

Fir Square Combined Care Unit

Fir Square Combined Care Unit (Fir Square) is a harm reduction maternity unit, located within B.C. Women’s Hospital, in Vancouver, B.C., Canada. Fir Square is a unique service in North America. It is exemplary in that it provides harm reduction services to mothers using illicit drugs, reflecting a non-judgmental philosophy firmly grounded in a structural analysis, counter to the individualistic, abstinence-based trends reflected in the bulk of addictions theory and practice. Fir Square offers services aimed at reducing women’s substance use; improving perinatal outcomes; increasing the number of mothers able to safely retain custody of their infants; and increasing women’s readiness for treatment. The unit’s staff consists of a multidisciplinary team of physicians; a senior nurse practice leader; nurses; a social worker; an addictions counsellor; a nutritionist and a life skills/parenting counsellor. The unit’s philosophy is to offer non-judgmental care to pregnant women struggling with problematic substance use.

Fir Square was chosen as a site for this study because of the opportunity pregnancy and childbirth may present for fathers, as well as for mothers, to enter recovery from problematic use of illicit drugs. Although this unit is considered atypical of most addictions treatment, reflecting a model free of many of the problems with addictions theory and practice described below, it cannot escape certain oppressive constraints. Fir Square is situated in a maternity hospital, whose patients include wealthy, middle-class women; the hospital is located a significant distance away from the neighbourhood it serves, Vancouver’s
Downtown Eastside, in one of the city’s wealthiest neighborhoods. These factors may result in decreased access and comfort for patients of this unit.

Currently, fathers are largely, though not entirely, excluded from the unit’s services. Citing internal and external institutional impediments, service providers in the pilot study (Weaver, 2009a) explained that “many [fathers] have been really interested in parenting...but...we don’t offer what they need and the Ministry (i.e., Ministry for Children and Family Development, Vancouver’s child protection services) will be involved and they tend to separate them...” (p. 15). Service providers, while recognizing the need for and importance of engaging fathers, described not having the institutional “capacity” to work with fathers (Weaver, 2009a, p. 16). This sentiment highlights Ball & Daly’s (2012) observation that “Practitioners in health and social services find themselves on uncertain ground as their understandings, skills, and program models seem inadequate to reach out to fathers in ways that fathers respond to and find helpful” (p. 1).

In terms of policy as it relates to father exclusion, because Fir Square is located in BC Women’s Hospital, it is subject to overall hospital policy; it is hospital policy that fathers are not allowed to reside with mothers overnight at the hospital until after the baby is born. There is one exception to this policy: Evergreen unit provides care for women with very high-risk pregnancies (excluding women using illicit drugs). In most maternity units at the hospital, stays are relatively short and most fathers, it is assumed, have housing and food, so policy has very different implications for partners of most of the women delivering at BC Women’s, than it does for the marginalized fathers with partners at Fir Square. The hospital
does not provide food for women’s partners; again, it is assumed, that for most partners, this would not be a problem.

In terms of Fir Square’s policy in respect to services, fathers have traditionally not been and are still not allowed in to the alcohol and drug-counseling group. Fathers have always been allowed into the parenting group, which is conducted by the Infant Development Worker, and this is still the case. Fir Square service providers are not expected to provide any individual services for counseling, assessment, referrals, or infant care/parenting to fathers. Nor are they expected to provide any health services for fathers. As stated, they lack the capacity to provide these services; with severe health and social service cuts occurring in British Columbia over the last decade, understaffing is part of the landscape at most, if not all, hospitals in the province (Baines, 2004; Layton, 2008).

Part of Fir Square’s mandate is to advocate for mothers to retain custody of their infants; this is substantial work, as most of these babies, born to mothers using illicit drugs, would be removed at birth by child welfare workers. Weekly care plan meetings involve representatives of the Ministry for Children and Family Development (MCFD) or Vancouver Aboriginal Child and Family Services Society (VACFSS). Fir Square is unrelenting in its advocacy for mothers, sometimes keeping mothers on the ward for months, until suitable housing and supports are in place. This is at times a formidable piece of work, drawing on all service providers to document and speak for mothers’ strengths.

Despite the challenges inherent in its advocacy-focused involvement with child protective services, its location, institutional setting, and staffing constraints, the unit remains committed to effectively serving the marginalized population of pregnant users of
illicit drug users, continually struggling to overcome existing barriers, and to improve service delivery. The unit’s Medical Director, Dr. Ron Abrahams, supports the current study, and its focus on engaging fathers.

**Sheway**

Fir Square is closely linked to Sheway; participants in this study, like many patients of Fir Square, used both services. Sheway\(^3\) is a ‘sister resource’ to Fir Square. Sheway is located in Vancouver’s Downtown Eastside, making it highly accessible to the women it serves. Sheway “provides health and social service supports to pregnant women and women with infants under eighteen months who are dealing with drug and alcohol issues” ([http://sheway.vcn.bc.ca](http://sheway.vcn.bc.ca)). Like Fir Square, Sheway is committed to providing non-judgmental health services and support to pregnant women struggling with problematic drug use. Sheway offers a number of services, including a medical clinic; advocacy; financial aid assistance; food services; housing; infant development program; and music therapy. Staff includes an alcohol and drug counsellor; nurses; social workers; nutritionist; infant development consultants; physicians; outreach and housing support workers; a cook; Aboriginal community support worker; family support worker and administrative support staff.

Fathers/male partners are allowed into the space at Sheway dependent upon the wishes of mothers, who are Sheway’s clients. This includes fathers’ attending groups, lunch, or simply ‘hanging out.’ All of fathers’ participation is at the discretion of their women

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\(^3\) [http://sheway.vcn.bc.ca](http://sheway.vcn.bc.ca)
partners/friends. This includes fathers who may have assumed custody and care of children when mothers have left the home; in these situations, fathers can use the services very much like mothers, if the mother approves.

Sheway also provides space for both mothers and fathers to have supervised visits with their children (i.e., with children in state care). Sheway’s Coordinator, Dr. Amy Salmon, cautions that Sheway must be mindful about the extent to which they provide services to male partners; as Dr. Salmon points out, the woman can change her mind about fathers’ presence at Sheway at any time, leaving fathers suddenly bereft of services. Currently, Sheway is exploring possibilities in relation to a fathers’ group, but again, as an agency that serves women, fathers’ presence in the space is dependent upon the wishes of the involved mother, making this a somewhat complex process. Apart from mother clients’ approval, decisions about fathers’ presence or receipt of services are made on a ‘case by case’ basis. Behaviour, rather than illicit drug use, is also a determining factor.

Dr. Salmon shared an interesting story about how service providers view men; a young woman’s father, an older man, was accompanying his daughter to Sheway for various services. Dr. Salmon reports that he was viewed suspiciously by staff, but for no apparent reason. This phenomenon was discussed and debriefed in the agency’s staff meetings, as they struggled to identify the source of their vague concerns. Doucet (2006) remarks that the “‘social gaze’ at men’s movements with children as they inhabit female-dominated community spaces is made all the more penetrating because it is tinged with suspicion and surveillance” (p. 41). This story demonstrates the extent to which our views of the embodied male are both troubled and troubling; it also goes toward explaining the deep
feelings of exclusion experienced by these marginalized fathers as they courageously, consistently attempt to ‘live in’ these spaces.

1.4 Preface to the literature review

To place this study in context I offer a critical analysis of theory relating to women and addiction as this historical and theoretical background shapes the emergence of the maternal harm reduction unit. I demonstrate both the necessity of these developments and their flaws, which have led to the current situation of father exclusion in maternal harm reduction services.

This is followed by a structural analysis of policies and practices of addictions services for women and mothers, with specific attention paid to class and race. These services form a continuum and include: harm reduction services, outpatient counselling, support recovery homes and residential treatment; I primarily address residential services. I locate this analysis within the province of British Columbia, Canada, and argue that the construction of women’s and mothers’ treatment needs in respect to problematic substance use is shaped by a feminist analysis that omits consideration of class and race. This omission supports the dominant ideology of neoliberal patriarchy in North America; undermines mothers’ agency and effectively divides marginalized peoples by imposing theory, policy and practice that, through a sustained focus on gender differences, effectively cloaks class differences and the effects of structural violence. I use critical structural theory to explicate the ways that mothers are regulated and oppressed through contemporary addictions services.
To further explore how gender binaries manifest as restrictive and divisive in addictions theory and models of intervention, I examined *concepts of men and masculinity within addictions theory*. I further explore these concepts through a discussion of *colonialism, dislocation theory and violence*, cohabiting factors in contemporary social constructions of men and masculinity. This intertwining appears as a cogent political force in the addictions discourse; questions of gender and sex require penetration rather than superficial excavation. Finally I turn to the newer *fathering literature*, which has begun to excavate historical omissions relating to men and fathers. I then provide a summary of the literature review before moving into the research method, data analysis and findings of the present study.
2 Theoretical framework and literature review: mothers

2.1 Women and addictions theory

Postcolonial feminists have challenged mainstream feminist ideology in respect to its neglect of race and class (hooks, 2000; Lawrence, 2003; Hare-Mustin, 1998); this criticism is called for in assessing contemporary theory and practice in respect to mothers’ problematic substance use. Yet critiques that point to the “marginal role of fathers” (Lewis, 2002, p. 33); the lack of ethnographic studies of women substance users (Boyd, 1999); and racial profiling in addictions theory and practice (Boyd, 2004; Campbell, 2000) have not informed the structuring of addictions services.

In response to increased concern that “treatment programs were ill-equipped to help women,” feminist research identified gender differences in relation to substance use (Green, 2006, p. 55) that resulted in women-specific services. As Green (2006) suggests, these shifts in addictions research and service design occurred in a context of women’s “increased participation in the workforce” and a higher public profile of drug use and its consequences (p. 56).

Yet aspects of women’s experience can be viewed, not as gender or sex differences, but as reflective of gender norms (Boyd, 2004; Campbell, 2000; Rutman, Field, Jackson, Lundquist & Callahan, 2005). These normative ideals, positioned within a false paradigm of gender “differences,” are starkly revealed in deconstructing women’s allegedly different treatment needs. For instance, women’s role as primary or solitary caregiver is a norm, not a gender or sex difference (see Doucet, 2006). Yet in posing mothers’ carer identities as
absolute, as a gender ‘difference’ and treatment need, addictions theorists (e.g. Poole & Greaves, 2007) reify, rather than disrupt, the gendering of care.

Doucet (2009b) describes Ruddick’s (1995) aim: to “challenge and disrupt the binary distinction between mothers and fathers and the taken-for-granted ideological and discursive lapse between mother/carer/homemaker and father/provider/breadwinner” (p. 107). Of particular import is Ruddick’s (1995) project to develop a “broad social critique” aimed at disturbing gendered patterns of care (Doucet, 2009b, p. 107). This deeper analysis is, as Doucet (2006) points out, reflective of an ‘equality’ rather than a ‘difference’ feminism. ‘Difference’ feminism operates repressively and exclusively in addictions theory for women that has emerged over the past 15 years (e.g. Finkelstein, 1994; Greaves & Poole, 2007). The necessity of disturbing, rather than shoring up, gendered patterns of responsibility, goes toward “getting beyond the constraining binary of mothering and fathering” (Ball & Daly, 2012, p. 15).

Another instance of reifying gender norms can be located in the emerging body of literature relating to women and shame, in which women’s shame is identified as an outcome of puritanical idealizations of motherhood (Brown, 2006; Klee, 2002a, 2002b; Poole & Isaac, 2001; Weaver, 2007a). Brown (2006) theorizes a three-dimensional concept of women’s shame, composed of powerlessness, isolation and a sense of being “trapped” (p. 46). Brown (2006) found that the “cultural component points to the very prevalent role of cultural expectations and the relationship between shame and the real or perceived failure of meeting cultural expectations” (p. 45). This failure to meet cultural expectations is also experienced by men/fathers and may be tied to their problematic drug use.
Another stream of women’s addictions literature poses histories of trauma as unique to women, requiring gender-specific addictions treatment (Covington, 1998; Najavits, 1997). Yet marginalized men with problematic drug use histories also carry histories of trauma, experience isolation, and struggle with identity and normative cultural ideals (Ball, 2009; Ball & Daly, 2012; Najavits, Schmitz, Johnson et al., 2009). Within this literature, structural conditions, such as poverty and racism, which shape these ‘needs,’ are obscured; problems are constructed as gender-unique and focus on individual or familial pathology.

In her complex analyses of sex and gender, Butler (1990) reveals how we are trapped by our language and conceptualization. To shake up, to “trouble” the discourse that perpetuates the male/female dichotomy, to “destabilize” power relations Butler (1990) proposes identifying sites where these repressive categories can be both identified and questioned (p. 201). In questioning the essentialist nature of feminist theory within the addictions discourse, Butler’s (1990) work is instructive.

Butler (1990, 2004) explicates how oppression is introduced the moment that women are identified as subject; subject requiring intervention; subject apart; subject whose identity is configured in opposition to male. This ‘othering’ Butler (1990, 2004) discusses is intrinsic to ‘difference’ feminism, which has been instrumental in informing women’s addiction treatment services. Butler’s (1990) polemic reminds us that “within the sex/gender distinction, sex poses as ‘the real’ and the ‘factic,’ the material or corporeal ground upon which gender operates as an act of cultural inscription” (p. 199). In other words we need to question the foundation of our signification of ‘substance-using women/mothers,’ our identification and setting apart of women, whether through an
essentialist framework, separating by ‘sex,’ or a cultural framework that separates by ‘gender.’

Through Butler’s lens, we can begin to question the ground upon which gender-specific addictions services are built. ‘Othering’ women by signifying them as uniquely traumatized; uniquely shamed and as primary or sole caregivers, has the unintended consequence of cementing, rather than destabilizing, damaging gender norms. Armed with a more intense lens, and a wider scope, we begin to see that the ‘factic’ is actually comprised of socially constructed norms which divide by race and class; gender differences become the veil that obscures the similarities of marginalized, mostly non-White, men and women.

Some feminist addictions theory may have contributed to the very practices and modes of thought it sought to subvert, through reifying both sex and gender as immutably located ‘in subject,’ curtailing rather than enhancing an emancipatory framework. The ‘treatment needs’ of substance-using mothers, identified by the ‘difference’ feminist ideology underpinning the discourse of women and addictions, are not intrinsic needs inextricably intertwined with gender, or with sex, the body upon which gender becomes signified. Rather, these alleged ‘needs’ of women and mothers result from a patriarchal ideology and economy; they are related to hegemonic masculinity, as discussed below.

2.2 A structural analysis of women’s addiction services

Structural theory renders visible the multiplicity of factors at play in both problematic substance use and the responses of health and social institutions to it. The purpose of
applying structural theory to social problems is transformative and liberatory; as a ‘subset’ of critical social theory, structural theory encompasses a socialist ideology, a social change perspective inclusive of “all forms of oppression” (Mullaly, 2007, p. 204). A structural perspective is helpful in illuminating the impact of institutions designed to address behaviours constructed as health problems, in which cause is attributed individually rather than socially.

A tendency to ignore structural contributions, such as poverty and colonization has, until recently, plagued historical and contemporary views of addictions policy and practice responding to women’s problematic substance use. Structural theory in social work is “always making the connection between the personal and the political” (Mullaly, 2007, p. 212); thus this theoretical approach facilitates useful critiques of both policy and practice. Structural social work theory stems from the observation that “professional practice is profoundly influenced by a society’s economic and political forces,” making it useful in analysing both addictions practice and policy aimed at mothers (Carniol, 1992, p. 2).

Governmentality theory is closely related to structural theory and is equally useful in examining addictions services. Foucault (1980) identifies connections between poverty and governmentality, in the form of health-related “assistance,” (1980) as occurring as early as the eighteenth century. By the term governmentality, Foucault (1980) is referring to the “ensemble formed by the institutions, procedures, analyses and reflections, the calculation and tactics” based on political economy and actualized by “apparatuses of security” (p. 102). As McKim explains, governmentality describes how moral regulation of the population is effected through “shaping others’ actions, rather than by force” (McKim, 2008, p. 305).
Governmentality includes the “formation of a whole series of specific governmental apparatuses” (Foucault, 1980, p. 103). For women’s addictions services, these apparatuses can be located in, for example, the criteria for entry; expectations in relation to the use of illicit drugs and/or alcohol; the exclusion of women’s partners; periods of no contact with outside family or friends; dress codes; behavioural codes; imposition of the therapeutic approaches of individual counsellors; the adoption of a specific discourse that frames women’s histories in a particular way.

Women’s addictions services in British Columbia constitute multiple sites of governmentality, which serve to regulate and ‘shape’ women’s relationships to self, drugs, family and community. These gender-specific services are primarily government-funded and adhere to models based on literature demonstrated as problematic. As a public health service, these services are subject to approval by government funding bodies.

2.3 Economics, neoliberalism and the production of health

In Canada, alongside entrenched, legislated colonialism and racism (Lawrence, 2003), we have experienced, as part of the neoliberal regime, a “dramatic rise in income disparities” and the “dismantling of social services” within a climate of increasing globalization in the form of free trade agreements and increased facilitation of foreign investment (Carroll and Little, 2001, p. 35). As Carroll and Little (2001) illustrate, “cultural conditions” form a vital part of the neoliberal package. Among these conditions, of relevance to the current discussion is the “development of mechanisms of control which indirectly channel the free decision-making capacities of individuals” (Carroll et al., 2001, p.
47). Women’s addictions services exercise mechanisms of control that function to profoundly influence women’s decision-making in respect to their relationship to drugs and their relationships with family and community.

Under the rubric of encouraging “active citizenship,” or freedom of choice, the state assigns to members of every socio-economic class the same task: to participate, “choose and ‘consume’” (Carroll & Little, 2001, p. 49). However, mothers’ poverty is excluded from the equation for measuring the accomplishment of active citizenship; failure to take up active citizenship earns individuals the status of moral failure. Mothers using illicit substances fit neatly into this latter category. Having established mothers’ deviance, the state then claims the opportunity to ‘help,’ inducting this population of marginalized mothers into the health industry, subjugating them to forms of ‘treatment’ in response to their ‘disease.’ In this way the neoliberal state continues to “locate communities and individual members of society who require ‘special attention’ “(Carroll & Little, 2001, p. 51). These categories invariably include the poor and non-White.

The “increasingly coordinated surveillance” to which Carroll and Little (2001, p. 51) refer in respect to Ontario’s welfare recipients, takes a subtler, more heinous form when disguised as a health intervention. Under this umbrella, mothers’ agency becomes a veritable façade, as they take up new identities within a therapeutic milieu structured by terms such as ‘empowerment,’ ‘healing,’ and ‘connection.’ Yet these terms, constituting a therapeutic discourse suggestive of freedom and agency, are deceiving. As McKim (2008) details in her study of a women’s addictions treatment centre in the United States, therapeutic discourse is employed in addictions treatment settings to accomplish social and
moral regulation of women (McKim, 2008). In practice, resistance to the structure of the treatment program is not tolerated; women may be encouraged to sever connections with significant others; women’s routines of healing are structured and prescribed. For instance, for the first two weeks women are in residence at a local residential treatment centre, they are not to have any contact with family members, including children.

Foucault (1980) describes how “medical service was provided mainly thanks to charitable foundations” (p. 168). This trend continues today in addictions services for mothers, with some religiously based organizations offering various forms of treatment⁴. The development of an increasingly sophisticated array of women’s addiction services characterized by ‘expert’ knowledge, incorporating an apparently benign but normalizing discourse, is of even greater concern (see McKim, 2008).

Rituals are conducted within both residential and outpatient addictions treatment settings; participation in normalizing rituals is commonly required by child welfare authorities for mothers to be able to retain or regain custody of their own children (Boyd, 1999, 2004; Klee, 2002; Weaver, 2007b). These rituals, constituting the therapeutic treatment regime, are based on contemporary theoretical interpretations of mothers’ ascribed ‘pathology’ and exclude structural factors. For instance, in one residential treatment centre in British Columbia (now closed), part of the treatment program required women to write their ‘alcohol and drug use history,’ a kind of ‘lifeline,’ and share this in their

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⁴ For example, the Salvation Army’s Vancouver Homestead, a residential support recovery home for women.
small group. The intent of this exercise is to facilitate women’s awareness of what drugs they used, how much, and when.

Yet the influence of external/structural factors influenced patterns of illicit drug use, such as racism, poverty or homophobia were unaddressed. Were women isolated, coping with social exclusion as a result of poverty? Did being lesbian in a homophobic community play a role in the woman’s substance use? What was the social context, what were the structural factors, in women’s problematic substance use? Excluding structural factors multiplies women’s guilt and shame.

Methods of intervention, tied to the political economy, construct both mothers’ problematic substance use and the solutions to it (Boyd, 2004; Duran, Firehammer & Gonzales, 2008; hooks, 2004). For instance, current addictions theory relating to women reflects a focus on trauma (Covington, 1998; Covington and Bloom, 2003; Najavits, 2002); constructing mothers’ histories as ‘traumatic’ creates conditions for mothers to assume victimhood and deny agency. Neither Najavits’ (2002) nor Covington’s (1998) models of treatment identify and address structural factors such as poverty, racism and other forms of oppression.

Contemporary therapeutic responses employed in residential and other treatment centres for women also fail to identify instances and sites of resistance in respect to women’s experiences of structural violence (Bungay, Johnson, Varcoe & Boyd, 2010; Reynolds, 2010). Yet there are other possibilities; Reynolds (2010) has developed a model she terms “supervision of solidarity” in her work with trauma (Reynolds, 2010). Reynolds’ (2010) work reflects a “personal is political” model in which she collaborates with survivors
to identify instances in which they resisted violence and oppression. Building on those instances of resistance is authentically both collaborative and empowering.

Fraser and Valentine (2008) discuss the “power of identity categories, expert knowledge and biomedical technologies in forming individual experience” (p. 115). Although Fraser and Valentine (2008) emphasize the “feedback effect” in the relationship between ‘patients’ and treatment structure, citing the emergence of user advocacy groups, such groups do not exist within abstinence-based services. Within residential treatment settings, “service providers do view clients as asocial and deviant, in need of surveillance and discipline. These repertoires work towards reproducing the effects of treatment that other repertoires, such as value-neutral policy language, can mask” (Fraser & Valentine, 2008, p. 119). Theory and policy in women’s addiction services employ a simultaneously liberatory and expert discourse that masks the regulating nature of addictions treatment.

The continual refinement and development of new models of residential and other treatment for substance-using mothers provides an opportunity for addictions service providers to further their careers and sense of importance as providers of health services. By creating a perception of increased indispensability, this group of professionals ensures the perpetuation of both the treatment industry, and the social regulation of deviant women/mothers (see De Leeuw et al., 2009). The disease model provides a sound basis to accommodate problematic substance use comfortably within the governmental regime of health production in which professional expertise is commandeered to structure mothers’ experience within a pathological framework (see Boyd, 2004; Foucault, 1980). On the
positive side, the disease model also provides mothers with an opportunity to rename alleged moral failing as a health issue.

Therapeutic techniques employed in addictions services for women are revealed as divisive in respect to families and communities, and as complicit in imputing pathology to mothers. In the same residential treatment centre for women discussed above, neither women’s partners nor any other family members were involved in the treatment process at all. While women were taught about relationships ("Boundaries/Healthy Relationships), communication skills, sexuality and intimacy, their partners did not receive this information. This could result in fractured relationships and families; as women developed new sets of beliefs and behaviours, their partners remained uninformed about what these new beliefs and behaviours were about. Compounded with their exclusion from the treatment experience, partners could well become confused, distant, and reactive to the new insights, understandings and knowledge of the women.

Families of origin were subtly or overtly designated problematic and blameworthy; the source of women’s problems. Yet intra-familial abuse also takes place within a context; what were the influences of poverty and racism? In what context did the abuse take place? Demonizing family members by assigning blame to them may well result in women’s increased isolation as family members, rather than the state, are identified as intrinsically pathological. For example, this can occur when partners, with whom the women have used

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5 Aurora Treatment Manual
drugs, and who might still be using, are identified as ‘dangerous’ to women’s recovery. This can result in encouraging mothers to stop all contact with her partner.

In other cases, family members may have been abusive to women in the past, due to their own experiences of oppression; these family members may be constructed as inherently ‘destructive’ for women. In both cases, women may be encouraged to stop contact with these family members, rather than, for example, invite them to participate in healing. These situations can be framed with greater compassion for women’s family members; other potential solutions could be developed aimed at healing, rather than severing, these important relationships. In the case of Canadian Aboriginal peoples in particular, this process is tantamount to furthering colonization; the victim is blamed and the role of the state in perpetuating abuse is obscured.

This form of ‘treatment’ for women fits neatly into Foucault’s paradigm; such institutions conduct “in some cases the surveillance of ‘unstable’ or ‘troublesome’ elements“ (Foucault, 1980, p. 168). Foucault (1980) explains how normalizing techniques and surveillance are inextricably linked to the economy, to the production of a healthy population, “to set the ‘able-bodied poor to work…and to assure the self-financing by the poor themselves of the cost of their sickness” (Foucault, 1980, p. 169).

The production and maintenance of population health, monitored by “police” is tied not to benevolence, but to the economy and to “political power” (Foucault, 1980, p. 170). Treatment modalities that infer pathology solely to the individual and their family members neatly exculpate the state from responsibility, weakening community bonds and disempowering those struggling with problematic illicit drug use. The intent of such
modalities is to impute responsibility and a sense of individualism to its residents, with the expectation that they will, upon completion of treatment, be able to abstain from illicit drug use, and become ‘productive’ members of society.

Personalizing, rather than politicizing, problematic substance use distracts attention from the ways the state is complicit in producing problematic substance use through the perpetuation of both poverty and colonization. Drug prohibition, and its concomitant cycle of arrest and imprisonment, also forms a substantive part of the state’s role in the perpetuation of illicit drug use and its consequences (Boyd, 2009; Weaver, in press). As Foucault (1980) suggests, these technologies of power are increasingly subtle; in the case of addictions services for substance-using mothers they also perform the task of managing ‘risk,’ working with child welfare authorities to achieve mothers’ regulation. This is accomplished primarily through surveillance and documentation, rather than collaboratively with mothers; neither the role of drug prohibition, poverty nor colonization are acknowledged or addressed in substantive ways by counsellors or child welfare workers in discussions with women, or in discussions between workers and counsellors (Weaver, 2007b).

Through the structural theoretical framework proposed by Moreau, as described by Carniol (1992), addictions services can be viewed as “secondary structures” that “express and perpetuate the supremacy of the primary structures of oppression” (p. 5). The contrived professionalism of service providers in addictions services facilitates a distanced relationship between consumer and service provider that constitutes a form of oppression, whether disguised as a sympathetic, therapeutic service or not. The commodification of
therapeutic interventions itself constitutes a capitalist, patriarchal form of governmentality; the medical model from which these emanate “effectively psychologize[s] problems which are essentially political in nature” (Carniol, 1992, p. 10). A counter-approach, described by Carniol (1992) as both feminist and consistent with First Nations philosophies, is to work to reduce the distance between service provider and consumer of service, in which professionals acknowledge the limits of their expertise and knowledge.

By inscribing this population with co-existing identities of ‘addict’ and mother, mothers’ deviance and therefore the need for government health intervention is established (Fraser & Valentine, 2009; Boyd, 2004). Structural factors such as poverty and social isolation recede as the substance-using mother is confined within a medical or quasi-medical setting, despite research demonstrating that “models of individual-level change are self-evidently limited in their capacity to explain, encourage or sustain sufficient change” (Rhodes, 2009, p. 194). Rhodes (2009) argues for a risk environment approach in theorizing harm reduction, which “shifts the focus for change from individuals alone to the social situations and structures in which they find themselves” (p. 194). This shift towards a structural approach in harm reduction theory has yet to ‘filter up’ to addictions treatment for mothers.

Residential and other forms of addiction treatment constitute ‘models of individual-level change’ at the level of technical modes of government surveillance. Here, mothers’ lives are re-and co-constructed within the therapeutic milieu. Mothers’ experiences are transformed into stories consistent with contemporary addictions theory. Participants in treatment are not simply asked: what is your story, and what meaning do you make of it?
Instead, mothers’ experiences are transformed according to the theoretical treatment framework endorsed by the institution. These stories form the foundation of mothers’ new and altered identities; as theory shifts in tandem with political agendas, so too do configurations of mothers’ stories. Pathologizing substance use strips mothers of agency through inculcation within a treatment setting, rather than working with mothers, their families and communities to address the structural factors that impact on all of these relationships.

Alternatively, Fir Square Combined Care Unit, from which participants were recruited for the current study provides primary health services; advocacy-focused social work services; supportive psycho-educational counselling; art therapy and infant care education for pregnant women. The unit’s mandate is to provide non-judgmental care in a harm reduction setting. This model demonstrates an approach that de-constructs pathology and facilitates shame reduction for mothers.

Pregnant women who continue to use illicit drugs are treated with respect, care and concern; while structural factors may not be discussed with patients per se, the level and nature of advocacy for pregnant women on the unit is consistent and significant. The primary mechanism of advocacy includes weekly meetings with the patients’ identified personal and professional ‘supports,’ including child protection social workers. In these meetings, staff present a strengths-based assessment of the woman and her baby. Education of child protection social workers is key in these case conferences, in respect to illicit drug use, pregnancy and parenting. At times the unit will extend women’s hospital stays until suitable housing and supports are put in place for the woman and her baby; staff
hold child welfare workers accountable in terms of providing supports to the woman, to facilitate the woman’s capacity to parent and to retain custody.

Abstinence is not a measuring stick of women’s ‘success;’ the unit offers women a refuge from the intense stigma they endure anywhere else, as pregnant women using illicit drugs. Women’s poverty is named as causal in discussions with child welfare professionals; the state is actively called upon to provide monetary, practical support to women to facilitate their ability to retain custody of their infants. Illicit drug use is viewed as only one of many challenges faced by the women, and is named as a self-medicating in response to the trauma resulting from chronic poverty, racism and colonialism. The unit also has a ‘sister’ community resource, Sheway, so ties to the community are facilitated for patients from their initial involvement. Sheway provides health and social service supports to pregnant women and women with infants under 18 months with drug and alcohol issues. This program aims to assist women in Vancouver’s Downtown Eastside to have healthy pregnancies and “positive early parenting experiences.”6 Like Fir Square, Sheway provides an array of health services that address health, nutrition, problematic drug use, parenting and infant development.

2.4 Gendered theory: obscuring race and class

Canada’s history and political context, as described above, suggests the necessity of considering race, yet contemporary addictions theory appears to have focused on gender to

6 http://www.vch.ca/403/7676/?program_id=13389
the exclusion of both race and class. The body of White, liberal feminist theory appropriately and not entirely unhelpfully emerged in response to previous addiction treatment theory based on research with White males (Finkelstein, 1994; Kandall, 1996; Murphy & Rosenbaum, 1999); yet this gendered, feminist focus “remains colonial” (Lawrence, 2003, p. 5, quoting Monture-Angus). Further, this body of theory generated what has been termed a ‘gender-based’ analysis in Canadian health research; upon examination, however, a ‘gender-based analysis’ appears to constitute a woman-centred analysis.

This discourse has also been co-opted into women’s penal reform, where it effectively serves to mask and enhance existing power relations between women and institutions (Hannah-Moffat, 2004; McKim, 2008). Specifically, Hannah-Moffat (2004) demonstrates how the penal system in Canada has co-opted the concept of ‘empowerment’ to “reinforce pre-existing relations of power” (p.510). Utilizing ‘emancipatory’ language to mask increased state control is a tactic also identified by McKim (2008), in her deconstruction of the therapeutic discourse employed to effectively regulate women and compromise their agency.

The focus on gender and exclusion of class and race as structural factors contributing to problematic substance use facilitates increased surveillance, control and regulation of women and mothers. Just as colonization developed means to identify the “Indian” as deviant (Quintero, 2001), and created restricted and separate spaces for “Indians”(Lawrence, 2003), a physical enactment of ‘othering’, so too has the development of residential treatment for women created spaces for increased surveillance and regulation
of women. In creating separate spaces for women and mothers struggling with problematic
substance use, the state can more easily fulfill its goal of increased production of a healthy
population that will contribute to maintaining a robust, disparate neoliberal economy
through techniques of surveillance, regulation and moral inculcation (Foucault, 1980).

Within the framework of British Columbia’s neoliberal politics, Teghtsoonian (2003)
states that “organizational and discursive changes within government” have “reduced the
institutional spaces within which a gendered understanding of public policy and its impacts
might be articulated and made visible” (2003, p. 28). Pointing to the steady elimination of
women’s representation and forms of support and assistance, Teghtsoonian (2003) exposes
the decimation of “illegitimate and unrepresentative expression of ‘special interests’” in a
ccontext of neoliberal ideology (2003, p. 29). While it is true, and concerning, that formal
recognition of women’s interests has been eroded within this framework, with significant
consequences for marginalized groups, including substance-using mothers, a political focus
on gender is accomplished at the cost of the more relevant claims of those ‘special interests’
based on class and race.

Teghtsoonian (2003) points out that women are a “highly diverse group distributed
across widely varying social and economic locations;” (p. 31) nevertheless she defends the
championing of women’s interests per se. In doing so, Teghtsoonian (2003) glosses over the
obfuscating nature of gender-based politics, which obscure class and race differences.
Paying only lip service to these fundamental forms of oppression, Teghtsoonian (2003)
argues that damage to marginalized women constitutes damage to all women. This position
evades, and therefore perpetuates, critical issues relating to class and colonization.
Realistically, in any group in which there is a ‘normal distribution’ of the socioeconomic status variable, particularly within a neoliberal ideological framework, the predominant interests served are those of the upper class.

As Procacci (1991) explains in his discussion of poverty, “transformation of the social domain” is composed of “a multiplicity of social islands dealt with at a local level, a plurality of diverse modes of behavior needing to be combated, encouraged or promoted...” (p. 152). The ‘social islands’ to which Procacci (1991) refers are difficult to pinpoint and require a structural analysis. By adopting a framework in which gender supersedes class, these sites of the “grafting of morality onto economics” are masked (Procacci, 1991, p. 157). Division by gender facilitates conquering by class: “Why does poverty itself, as the effect of social inequality, the existence in society of the rich and poor, not become the object of attack for this discourse?” (Procacci, 1991, p. 159). While arguing that the government of British Columbia has failed to “address the intersections among multiple dimensions of marginalization,” Teghtsoonian (2003) herself maintains a steadfast focus on gender, obfuscating those dimensions of marginalization that form the structural conditions that spawn numerous forms of violence, i.e., class and race (Teghtsoonian, 2003, p. 36).

As explained by Moore and Fraser (2006), “feminist political action outside the academy (in party politics, business and the public sector, for example) is predominantly liberal” (p. 3043) and it is this liberal feminism that has shaped addictions policy and practice for women. The point made by Moore and Fraser (2006) that the categories of ‘women’ and ‘drug users’ are ‘othered’ within the neoliberal context can be extended to include ‘poor’ and ‘colonized.’ Considering the intersectional nature of these structural elements is
critical in analyzing how addictions services respond to mothers who are using illicit substances: “Revisions in health service delivery must also be accompanied by addressing underlying structural social and economic inequities...” (Bungay et al., 2010, p. 7).

Bungay et al. (2010) emphasize the necessity of responding to women crack user’s lack of safety, “historical trauma, continuing everyday violence, poverty and structural inequalities” (Bungay et al., 2010, p. 7). The structural violence experienced by mothers using illicit drugs is produced not only by male partners and clients, but also by “forces such as the economy, politics, law and geographical locale” (Bungay et al., 2010, p. 3). Yet these locations of violence are rarely referenced in policy and practice that guides addictions treatment services for women; the “unequal circumstances under with [drug users] attempt to approximate the neoliberal ideal” are not addressed in most addictions treatment services for women or for men (Moore & Fraser, 2006, p. 3045).

An exclusive focus on gender in women’s addictions services is problematic for other reasons, relating to identity and agency:

Butler (1990) excavates notions of gender at the deepest level, arguing that at the moment we adopt the category of ‘gender’ we employ a limiting discourse that aims, consciously or not, to establish a fixed and reified gender identity. In so doing the possibilities for a kind of gender freedom are extinguished, and we perpetuate that which we rally against: “Feminist critique ought to explore the totalizing claims of a masculinist signifying economy, but also remain self-critical with respect to the totalizing gestures of feminism” (Butler, 1990, p. 18)” (Weaver, 2009b, p. 15).
The category of ‘woman’ is increasingly and appropriately subject to a range of interpretations; through a persistent focus on discourse that aims to contain and limit gender, we subjugate ‘people’ to a fixed identity. In so doing, policy and practice are developed that reflect this focus. Given the significant influence of liberal feminism in addictions theory relating to women, and its lack of ‘self-criticism,’ services have developed that reflect this ‘reified gender identity.’

The importance of including structural aspects of substance-using mothers’ experience beyond that of gender becomes prominent in deconstructing the ways that poverty and colonialism shape institutional constructions of risk relating to mothers and substance use. Feminist addictions theory has leaned heavily into gender differences in constructing treatment needs for mothers, inadvertently resulting in mothers’ isolation from family and community (see Weaver, 2009a). Meanwhile, the structural conditions of poverty, colonialism and dislocation\(^7\) increasingly contribute to the production and perception of substance-using mothers’ children as ‘at risk.’

### 2.5 Risk, identity and agency

The concept of risk forms a subtle yet powerful weapon in rationalizing techniques of surveillance aimed at regulating substance-using mothers. Addictions treatment services for mothers form a central location for surveillance of risk perceived to surround substance-using mothers. Indeed, addictions services for mothers form a substantial part of the

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\(^7\) Dislocation “denotes psychological and social separation from one’s society...it refers to an enduring lack of psychosocial integration, no matter how it comes about” (Alexander, 2007, p. 59).
“broader cultural project through which neoliberal practices teach and promote certain forms of agency and autonomy that then tie individuals, organizations, government ministries, and communities to expectations of performance” (Carroll & Little, 2001, p. 51). As Carroll and Little (2001) suggest, the “neoliberal marketization of society” relies on a “model of risk management” (p. 51). This model of ‘governmentality’ has developed increasingly sophisticated and actuarial measures of risk in an attempt to contain and manage risk, within a paradigm exclusive of material circumstances and other structural factors.

Positioning risk associated with illicit drug use at the individual level imputes the substance user with both agency and responsibility. In harm reduction policy and theory, the notion of risk is under critical examination (Rhodes, 2009; Moore & Fraser, 2006). These discussions have relevance here because the ways that illicit drug use behaviours are conceptualized in harm reduction policy and practice may contribute towards shaping policy and practice in addictions services for mothers. While discussion of risk in harm reduction theory addresses physical health risks involved in illicit drug use, for substance-using mothers these risks extend beyond behaviours associated with the body and disease, to encompass mothers’ behaviours in relation to parenting. Within this paradigm, the assessment and measurement of risk has evolved into a sophisticated technology incorporated into child welfare discourse, working frequently in tandem with addictions services (Boyd, 2004; Klee, 2002a, 2002b; Swift & Callahan, 2009). In health and social work discourse, theoretical and political configurations of risk directly relate to issues of agency, identity, responsibility, and freedom.
As explained by Moore and Fraser (2006), in addictions and other fields of ‘medicine,’ responsibility for and management of risk has been “redistributed from the state to individuals” (p. 3037). This realignment of responsibility for managing risk has important implications for users' agency and suggests the necessity of an intersectional structural analysis. Both class and race can and do limit agency: “the citizen–as-(healthy)-consumer rationality does not acknowledge constraints on ‘choice’” (Moore & Fraser, 2006, p. 3037). Moore and Fraser (2006) cite “statements of agency and responsibility” emanating from qualitative research with participants in methadone maintenance programs that, in their estimation, “suggest the productive sense of personal empowerment and resilience that adopting a neo-liberal view may confer upon drug users” (Moore & Fraser, 2006, p. 3037).

Although Moore and Fraser (2006) suggest potential increases in agency as users adopt aspects of a neoliberal identity, the ways that neoliberal paradigms function in addictions treatment services for women may constrain agency and impose rather than co-construct identity.

Rhodes (2009) discusses “envisaging a risk environment as comprising types of environment (physical, social, economic, policy) interacting with levels of environmental influence (micro, macro)” (p. 193). This is a model that can be adapted to “give primacy to context” not only in the milieu of active problematic illicit substance use (Rhodes, 2009), but in a structural analysis of health services designed to meet the needs of substance-using mothers. The physical and social environments of women’s addictions services are constructed within the purview of health services and are bound and shaped by economics, the dominant political ideology and its concomitant relevant policy.
As observed by Bourgois (2003), in reference to Vancouver, British Columbia, the “left arm of the state attempts to soften the repression of the right arm via inconsistently administered high-tech health and social services” (p. 35). This tension between neoliberalism and numerous, disconnected harm reduction services has perhaps distracted the attention of the public and of researchers from abstinence-based services for women and mothers in British Columbia.

The risk environment analysis can be extended to assess the ways that women’s addictions services contribute to the risk environment. Along Rhodes’ (2009) social axis, “social and peer group ‘risk’ norms” can be responded to with “social network and peer-based interventions” (p. 194). Peer-based interventions support mothers’ agency; neither outpatient settings nor residential treatment constitute peer-based intervention. Instead, these services rely on a model of ‘expert’ and ‘client’ that undermines mothers’ agency.

Further, the social network that may be cultivated within the institutional setting is artificially constructed, within a therapeutic milieu, and mothers may not be able to integrate this network into their lives upon leaving the residential centre. Neither will their structural conditions (housing, income, communities) have changed. Along the policy axis, “access to low-threshold housing” is listed as a risk; in British Columbia, only one addictions program inclusive of mothers addresses this risk 8 (Rhodes, 2009, p. 194). Rhodes’ (2009) economic axis indicates cost of living, and lack of income generation and employment, as risks; neither of these are addressed in residential or outpatient treatment services for

8 The Addiction Recovery Program, Vancouver Coastal Health in partnership with B.C. Housing.
mothers, although there is one program for women in recovery (abstinent) that facilitates their return to the workforce.⁹

### 2.6 Race, colonization and agency

Thobani argues that Canada’s sovereign power is “institutionalized through the law” and that “colonial sovereignty relies on very ‘particular’ kinds of violence” (2007, p. 38). This racial violence provides the foundation of identity reduction of Aboriginal peoples to a single and opaque identity as ‘Indian’ (Lawrence, 2003; Thobani, 2007). Within this framework, Aboriginal mothers struggling with problematic substance use are automatically and intrinsically bereft of the opportunity to access successfully the identity of neoliberal subject, to participate in ‘active citizenship.’

To compound this identity disruption, addictions treatment for women offers Aboriginal women a White, liberal, feminist framework. This framework, with its focus on gender and omission of considerations of race, class and colonization, has excluded First Nations’ philosophies, traditions and values. The “claims of religious, racial and cultural superiority” that shaped the conquest of First Nations people by the French and English have become incorporated, in the most subtle forms of surveillance, into the government ‘apparatuses’ that constitute women’s addictions treatment (Thobani, 2007, p. 42). As Thobani (2007) explains, we have turned the “violence of conquest into authorizing authority” (p. 43).

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⁹ Vancouver Eastside Educational Enrichment Society’s newStart program
Despite the rhetoric that shapes addictions services for women, brandishing phrases such as: “We emphasize individual empowerment;” 10 “It is important to support the empowerment of women;” 11 and “We use many different approaches... and empowerment models” 12 are misleading. In fact, theoretical models dictate meaning making of women’s stories; women’s agency is constrained by confinement to designated physical spaces and stringent daily schedules of activities designed to promote abstinence from illicit drug use. Failure to comply to the daily regime, or with the imposed theoretical constructs, renders the client “deviant or resistant” (Moore & valentine, 2007, p. 8). As Hannah-Moffat (2000) explains, words such as ‘empowerment’ are easily co-opted by technologies of surveillance and moral regulation that exist within correctional services; the same can be said of the health industry.

As Fraser and valentine clearly state (2007), “[d]rug treatment itself is linked to the control of deviance, the making docile of unruly bodies” (p. 138). The methods identified by Thobani (2007) in her description of the means employed to conquer Aboriginal peoples in Canada are reflected in the methods used to conduct surveillance and control within the addictions treatment system. These include “coercion, trickery and deception” (p. 42). This is reflected in the professionalization of addictions treatment services;

10 From the website of a support recovery society for women in Vancouver, B.C.
11 From the website of a women’s residential treatment centre in Vancouver B.C.
12 From the website of a support recovery home in Burnaby, B.C.
... professional counselors are too often trained to further pathologize the members of such communities by refusing to address the historical context, injustices and subsequent soul wounds that underlie much of their psychological distress. Consequently, Native American clients are often labeled as resistant when they do not demonstrate an interest in continuing to participate in the counseling process. (Duran, Firehammer and Gonzalez, 2008, p. 290)

As Duran et al. (2008) point out, the Diagnostic and Statistical Manual of Mental Disorders “serves to alienate Native people and persons from other cultural groups who do not understand or accept a Eurocentric worldview of mental health and psychopathology” (p. 291). I would argue that this mode of classification fails to serve White women or women of colour; the ever-expanding DSM is representative of how the medicalized subject is isolated from structural conditions and constructed as deficient. The DSM is also a tool used to justify increasingly prescribed licit drugs to women in addictions treatment services, a significant form of social control, and a practice that is on the rise (Boyd, 2004; Currie, 2007).

For Aboriginal women, addictions treatment that fails to account for structural violence related to colonization, class and race can only be viewed as oppressive. As explained in British Columbia Centre of Excellence for Women’s Health’s *Gendering the National Framework: Trauma-informed Approaches in Addictions Treatment* (2009), the “literature over the past decade has emphasized the centrality of the experience of interpersonal victimization including childhood abuse, sexual abuse, and intimate partner violence for women with mental health problems and addictions “(p. 2). This statement is representative of the ways that addictions discourse relevant to women continues to
construct women’s identities as victimized by personal, not political or social, circumstances. The statement locates violence only within the woman’s family; yet as Ball (2009) documents in her work on fathering, a history of colonialism has worked to divide Indigenous families since colonization began, and many Indigenous men now lack a frame of reference for fathering and the development of healthy relationships.

The document goes on to note the “greater risk” that women face, as compared to men, for “interpersonal victimization” (B.C. Centre of Excellence for Women’s Health, 2009, p. 2). Yet, framing this risk and victimization in terms of colonization and structural violence would position all Aboriginal people as affected and traumatized, locating the problem not interpersonally but politically and socially. This positioning would go towards efforts to heal families through addressing environmental risks and histories of colonization, rather than divide families by gender.

Hooks (2004) and others (see Ball, 2009) illuminate the effect of colonization and racism on men. As Hill and Sprague (1999) write: “Racial discrimination and exclusion, on the other hand, presented significant barriers to Black men in their attempt to become the sole economic provider for their families, and their inability to fulfill this role diminished their power, esteem, and participation in families” (p. 482). Thus the intersections of gender and race constitute central and critical dimensions in viewing problematic substance use as an adaptive response. The focus on gender, as previously stated, excludes men, many of whom women value, and with whom women would like to participate in healing (see Weaver, 2009a).
As Duran et al. (2008) document, policy and practice are tied to “funding sources...[which have] empirically tested best counseling and therapy practices...that have passed the Western empirical test” (p. 293). The corporate structure of health, as deconstructed by Foucault (1980) and others develops an increasingly seductive discourse that enshrines addictions treatment as a commodity, and its recipients as deficient. Although health services in British Columbia may be perceived to be responding to Aboriginal women’s addictions treatment needs, the motive for doing so is well encapsulated in this quote:

Aboriginal people are the fastest growing population in Canada, and will be an important part of our economy in the coming decades. It is imperative that we do all that we can to support initiatives that help Aboriginal communities to improve the health status of their members. (Vancouver Coastal Health President & CEO)\(^\text{13}\)

This speaks to the production of a healthy population for purposes of economics as explicated by Foucault (1980) and described above. The arrogance and lack of respect in this statement is appalling; the colonizer now describes the colonized as the “fastest growing population” in the country. The burden of Aboriginal health forms a motive for governmental prevention and control of ill health. The burden of ill health is shifted to the population; the structural conditions that gave rise to, and continue to propagate, health disparities between Aboriginals and non-Aboriginals remain unacknowledged.

The neoliberal state clearly would not support a document that encourages addressing colonization, racism and poverty in addictions treatment. In British Columbia’s Centre of Excellence for Women’s Health’s *Gendering the National Framework: Trauma-informed Approaches in Addictions Treatment* (2009), the word “colonization” is mentioned only once (in this 12 page document), as is the word “poverty;” the word “mental health,” however, is mentioned 16 times. Subtly, within this discourse, structural factors are permutated to become individual failings; individuals are constructed as victims; trauma is situated within the family. Yet the violent behaviours of the colonized against each other can be viewed as intended consequences of colonization, i.e., ‘divide and conquer’ techniques, and reproduce colonizing conditions (see hooks, 2005; Fanon, 1963). This ‘gendered’ framework and discourse is divisive of families and communities, an issue taken up by hooks (2004) and Ball (2009).

Fanon (1963) is also instructive in examining how systems of health technology perpetuate racism and colonialism; he describes colonization as the “great purveyor of psychiatric hospitals” (p. 181). Fanon (1963) describes the “defensive positions” taken by the colonized, and how these behavioural manifestations, responses to structural violence, form a protective stance (p. 182). Fanon (1963) refers to the “harmful stimulants” of colonization, which, unresisted, result in the psychological collapse of the colonized subject. Consistent with the moral endeavor of addictions treatment for women, Fanon (1963) sees as the “final aim” of colonization “to convince the indigenous population it would save them from darkness” (p. 149). This observation supports similar claims made by DeLeeuw, Greenwood and Cameron (2009) that describe the self-serving and self-perpetuating aim of
White professional ‘helping’ culture to make itself indispensable, posing as a supportive agent of change.

2.7 Poverty, class and addictions treatment

According to Fanon (1963), “[w]hat matters today, the issue that blocks the horizon, is the need for a redistribution of wealth” (p. 55). Also lacking is an acknowledgement of the violence of the state in respect to colonization, which First Nations groups are currently contesting through the Idle No More movement14 in Canada. A structural analysis of women’s addictions treatment services reveals the profound truth of Fanon’s identification of poverty as the issues; as the state extends and refines systems of surveillance and regulation, perhaps none of society’s members are more vulnerable than poor mothers of colour (Boyd, 1999, 2004; Campbell, 2000; Klee, 2002). In spite of the relationship between poverty and problematic substance use of illicit drugs, very little addictions literature, policy or practice address the interconnectedness of these structural factors.

Yet important exceptions are found in the harm reduction literature. Bourgois (2003) links poverty to crack use, discussing the connections between the political economy, race, class and choice of drug, outlining the costs, in human lives, of neoliberal policies. Although Rhodes (2009) points out that a structural or political-economic analysis may be viewed as impractical because “large-scale transformation” is implied, this is not necessarily the case. Nor do the implications of such an analysis position individuals as lacking agency; in

14 http://idlenomore.ca
fact, systemic changes based on qualitative research actualize agency of service users. The reciprocity of structural determinants of health and human agency can be accommodated and enhanced incrementally within the existing neoliberal framework, by paying more than lip service to consumers’ voiced needs. Although the “redistribution of wealth” to which Fanon (1963) refers would be the ideal, the potential to effect changes that address structural factors does exist.

**Summary**

In subtle yet powerful ways, women’s addictions treatment has evolved into an institution that perpetuates, rather than contests, oppressive structural conditions for mothers. This is accomplished through an opaque persistence in gendering that presents as a liberatory claim, obfuscating structural factors such as poverty, racism and colonization. Locating both cause and solutions to problematic substance use individually rather than socially produces a false sense of agency, named “empowerment,” in mothers; in reality the oppressive structures that compromise mothers’ agency remain unchallenged by the treatment industry and therefore by participating mothers. Neither is the treatment industry itself contested; as stated, user advocacy groups are absent from the abstinence end of the treatment continuum. This obfuscating paradigm works to not only subdue mothers’ agency, but to perpetuate dislocation, as mothers come to identify family and community members, rather than structural factors, as causal in respect to their problematic substance use, resulting in their increased isolation, rather than healing with and within family and community resources.
3 Theoretical framework and literature review: Fathers

3.1 Men, masculinity and addiction theory

The restrictive binary thinking that characterizes the development of women’s addictions services also functions to demonize male partners in addictions discourse. Perpetuating “the belief that the self is formed in opposition to an other” (hooks, 2000, p. 31). Health Canada’s ‘Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems’ (2001) provides an example of this discourse, suggesting a shift from mother-blaming to male partner-blaming: “Partners are sometimes abusive and women often get into drugs with a male partner and the male is still using and may not want her to get treatment” (Health Canada, 2001, p. 13). Although this statement employs modifiers such as ‘often’ and ‘may,’ male partners are clearly implicated. While well intentionened, perpetuating a binary bifurcation may result in unintended consequences for mothers, fathers and children. As hooks (2000) states:

We wish to affirm the primacy of family life because we know that family ties are the only sustained support system for exploited and oppressed peoples. We wish to rid family life of the abusive dimensions created by sexist oppression without devaluing it. Devaluation of family life in feminist discussion often reflects the class nature of the movement (p. 38).

hooks (2000) calls on feminists to “graphically address links between sexist oppression and family disintegration,” (p. 40) rather than constructing men as the enemy. Western discourse relating to women’s problematic substance use has consistently failed in this
regard. The same exclusionary effect that resulted in alienating black women from the feminist movement may have, indeed may still be, alienating women in relationships with men from ‘treatment’ services: “an anti-male stance” has not been viewed as a “sound basis for action” (hooks, 2000, p. 71). In fact this approach may be counterproductive, serving to “intensify sexism by adding to the antagonism which already exists between women and men” (hooks, 2000, p. 71). “Problematising masculinity rather than men” (Dominelli, 2002, p. 29) could result in strengthening, rather than separating, families.

To excavate how the needs of fathers are obfuscated and excluded from addictions theory, practice and program design, the concept of hegemonic masculinity provides a larger backdrop in which to situate the anomaly of father exclusion. As explained by Connell and Messerschmidt (2005), the concept of ‘hegemony,’ was adopted from Gramsci and “reduced to a simple model of cultural control” in its pairing with masculinity (p. 831). Yet this term, hegemonic masculinity, is useful in describing the “normative” “practice” of a “patriarchal gender system” (Connell & Messerschmidt, 2005, p. 832). The term hegemonic masculinity “names issues...about power and political leadership, public and private violence, and changes in families and sexuality” (Connell & Messerschmidt, 2005, p. 830); it implicates acts rather than persons, so has emancipatory utility.

Hegemonic masculinity cultivates men’s emotional suffocation, resulting in increased expression of the one legitimised emotion for men: anger. hooks (2004) contends that “women are the targets for displaced male rage at the failure of patriarchy to make good on its promise of fulfillment” (p. 84). In discussing how hegemonic masculinity has curtailed men’s capacity and opportunity for experiencing and expressing a multi-faceted
constellation of emotions, rather than anger alone, hooks (2004) contextualizes male violence in stating that: “The first act of violence that patriarchy demands of males is not violence toward women...Instead patriarchy demands...that they kill off the emotional parts of themselves” (p. 66). This silencing of the complexity of men’s emotional landscape has damaging implications and consequences for men, women and families. Essentialist views reflected in divisive discourse such as descriptions of the “characteristics of addicted women,” posed in opposition to those of men (Nelson-Zlupko et al., 1995, p. 48), contribute to shoring up, rather than dismantling, hegemonic masculinity and its fertile soil of neoliberal policies.

Positioning learned differences in gender behaviours as innate characteristics serves to maintain the status quo, resulting in weakening or disappearing opportunities for shucking off these constraints. Gender troubling, as Butler describes, is a route towards troubling entrenched neoliberal policies aimed at domination and control of non-traditional groups. This brand of politics walks hand in hand with hegemonic masculinity; indeed they are intricately intertwined.

3.2 Colonization, dislocation and addictions services

Colonization, dislocation and hegemonic masculinity perpetuate both addiction and violence. The cultural and physical ransacking that results from colonization has a well-documented impact. As Alexander (2008) explains, both colonization and dislocation can trigger a self-medicating response in its targets. Hegemonic masculinity can also be viewed as complicit in the process of activating both compulsive self-medication, and violence.
Contemporary and historical addictions services appear to subtly perpetuate, rather than deconstruct, this status quo. This is not to say that immediate needs of victims of violence and problematic substance use are never met within the current complex of the addictions health services industry. Yet, through divisive practice, based on theory that has yet to thoroughly mine the recesses of structural conditions, dislocation is perpetuated rather than addressed in addictions theory and ‘treatment.’ Fanon (1963) describes methods of capitalist society that:

...instill in the exploited a mood of submission and inhibition which considerably eases the task of the agents of law and order. In capitalist countries a multitude of sermonizers, counselors, and ‘confusion-mongers’ intervene between the exploited and the authorities (p. 4).

This “mood of submission and inhibition” is ripe for exploitation when the ‘shamed addict’ approaches and becomes inculcated within the treatment industry. Foucault (1963, 1999) describes the emergence of psychiatry, the construction and medicalization of the “abnormal,” which spawns innumerable ‘counselors and confusion-mongers’15 who engage in mediating relationships of social control. Fanon’s use of the word ‘confusion’ connotes the perpetuation of ‘therapeutic’ discourse used to reframe circumstances, thoughts and feelings of ‘the exploited’ (in this case, marginalized drug users). The power of this discourse

15 ‘Monger’ is defined as “denoting a dealer or trader in a specific commodity…a person who promotes a specified activity, situation or feeling, esp. one that is undesirable or discreditable” (New Oxford American Dictionary)
re-shapes the drug user’s paradigm of despair and relief, re-positioning this cathexis in ways that may be intolerable to the respondent (Garcia, 2008).

The “mood” to which Fanon (1963) refers is engendered through processes of colonization and dislocation. Alexander’s (2008) detailed framework of the conditions that produce problematic substance use, and other addictions, is useful in relocating the problem from the individual to social conditions. Alexander’s (2008) thesis is based on the concept of psychosocial integration and its disintegration through processes of dislocation.

Psychosocial integration is defined as a “profound interdependence between individual and society ... [p]sychosocial integration reconciles people’s vital needs for social belonging with their equally vital needs for individual autonomy and achievement” (Alexander, 2008, p. 58). Alexander (2008) describes this integration as being “experienced as a sense of identity...a sense of oneness with nature...a connection with the divine” (p. 58). A sense of connectedness to people and to nature is central to psychosocial integration. Autonomy is not positioned as paramount, as superseding the importance of relationships, but is situated within the context of family and community.

Alexander (2008) draws on Polanyi’s term “dislocation” to denote “psychological and social separation from one’s society, which can befall people who never leave home, as well as those who have been geographically displaced” (p. 59). Dislocation has also been referred to as “alienation” (Alexander, p. 59). This severing of community, connections and sustained meaningful relationships can lead to profound despair (Alexander, 2008, p. 50). It is this despair, Alexander (2008) argues, that culminates in substitutive activities such as problematic substance use and other addictive behaviours. Contrary to dominant feminist
ideologies, needs for belonging and connection are universal, not ascribed as unique to the female sex.

Alexander’s (2008) dislocation theory is supported by both historical and contemporary research (Garcia, 2008; Hare-Mustin, 1998). Hare-Mustin (1998) reminds us of Durkheim’s observations that “when farmers moved to London with the dislocations of the Industrial Revolution there was a tremendous increase in homicide, suicide, battering and abuse” (p. 41). Linking dislocation to patriarchy and globalization, Hare-Mustin (1998) describes how connections formed and fostered in families and communities diminished in response to the proliferation of commerce and industry (Hare-Mustin, 1998). This burgeoning emphasis on individualism is reinforced by, and marks the “goal” of, “much of psychotherapeutic treatment (Hare-Mustin, 1998, p. 41). Yet this individualism “presumes middle class privileges of social power as well as educational and financial resources to all,” rendering outcasts those whose culture or life circumstances do not support this dehumanized model of being (Hare-Mustin, 1998, p. 41).

Hare-Mustin (1998) connects dislocation to both gender and class, noting “many men do not experience themselves as powerful” particularly those who occupy oppressed places in the hierarchy due to race or class (p. 44). Hare-Mustin (1998) explores what mechanisms continue to reproduce gendered discourse despite evidence that “differences within genders are as great as differences between them;” she argues for a postmodern therapeutic approach that focuses on destabilizing gender binaries, social context, and cultivating consciousness of power relations (Hare-Mustin, 1998, p. 46).
Recent post-colonial Indigenous literature more specifically addresses domestic violence, and father exclusion from “community programs supporting families and child development” (Manahan & Ball, 2007, p. 43). As discussed by Lawrence (2003), a feminist ideology lacking an intersectional analysis, which forms the theoretical backbone of contemporary women’s addictions services, is inadequate in explaining colonization, and does not address divisive colonial frameworks; a broader view is required to reveal the sources of domestic violence among the dislocated:

I take very seriously the warning of Mohawk scholar Patricia Monture-Angus that for Native women in Canada, "feminism as an ideology remains colonial" (1995,171). Monture-Angus has noted in particular that the concept of "patriarchy" alone is inadequate for explaining the many levels of violence that Native women face within their communities...(Lawrence, 2003, p. 5)

Contributing to the exploration of the nuanced nature and multiple levels of colonialism and violence, the Aboriginal Fathers Project, explored the “impact of colonialism and assimilation processes on the roles of Aboriginal fathers” and recommends culturally specific means to engage Aboriginal fathers in fathering (Manahan & Ball, 2007, p. 43).

Other work, emerging from New Zealand, explicates how the dominant Western view of domestic violence is “narrower than the concept of family violence embedded in a social context of colonization, loss of culture and poverty” (Taylor, Cheers, Weetra & Gentile, 2004, p. 72). Consistent with Alexander’s (2001, 2008) depiction of the processes of dislocation, emanating from principles of Western free-market society, these authors note that the common understanding of domestic violence “isolates” adult intimate relationships
from the context of family and community relationships (Taylor et al., 2004, p. 72). Like hooks (2004), Taylor et al. (2004) criticize the “white women’s movement grounded in feminist theory” which excluded Indigenous perspectives on family violence (Taylor et al., 2004, p. 74). Their observations of the individualistic and divisive “Western approach” and its resulting exclusion of community are echoed by Hamby (2005) and Ball (2009).

I propose that the community context of interpersonal violence is equally important in considering non-Aboriginal marginalized fathers. As Ball (2009) explains, “Extreme socioeconomic exclusion...and mother-centric biases in parenting and childcare programs” contribute to ‘divide and conquer’ effects of the dominant ideology (p. 44). Ball (2009) makes recommendations for change that include recognition of circumstances that plague ‘dislocated’ fathers, such as homelessness and incarceration. Ball’s (2009) study reveals numerous barriers to fathering, and identifies the impact of hegemonic masculinity on Aboriginal fathers. Ball’s (2009) contrast between Indigenous “collectivist communities” and the “nuclear unit of care characteristic of Western European family life” suggests the importance of relationships and connections to men, and potential solutions to dislocation and the resulting incidence of domestic violence (p. 44).

3.3 Fathering: Situating risk, drug use and violence

In this section I investigate how fathers are represented in the family addictions literature, and the implications of these representations for mothers’ and fathers’ addictions services. I specifically examine the theoretical assumptions that underlie these representations and how they might impact research, policy and practice with the aim of
considering the possibility and implications of substance-using fathers’ participation in addictions treatment with their partners and/or children.

I also examine how assumptions about interpersonal violence may present an obstacle to engaging fathers in addictions treatment with mothers and children, and consider the complexity of the relationship between substance-using fathers and interpersonal violence; how this relationship is depicted in the literature; the consequences of these interpretations and alternative perspectives. As both Rhodes (2009) and Boyd (2004) point out, structural factors such as racism, sexism, colonialism, and the unequal distribution of wealth (poverty) contribute to interpersonal violence; “the larger question which is rarely asked is how can violent social conditions be transformed?” (Boyd, 2004, p. 165). Next I analyse the representations of fathers in the fathering literature, noting how shifts in this new literature, paired with critical masculinity literature, are contributing to a wider, more realistic view of fathers.

### 3.4 Responses to interpersonal violence and substance dependence

There is an emerging body of work that recommends counselling for couples involved in interpersonal violence and problematic substance use, specifically Behavioural Couples Therapy (BCT) (Fals-Stewart, Kelley, Fincham, Golden, Logsdon & Kelley, 2004; Kelley & Fals-Stewart, 2002; Stuart, O’Farrell & Temple, 2009). Although thus far evaluations of this model have been limited to couples in which only the male partner is substance-using, findings of reduced interpersonal violence and substance use, improvements in partner relationships and in children’s physical, mental and emotional health compel the pursuit of
further research with this model (Fals-Stewart et al., 2004; Kelley & Fals-Stewart, 2002; Stuart et al., 2009). Investigating other options is critical given the documented inefficacy of current batter interventions, and the link between interpersonal violence and problematic substance use (Featherstone, Rivett & Scourfield, 2007; Humphreys, Regan, River & Thiara, 2005; Stuart et al., 2009). A weakness of the BCT model is that it does not attend to structural factors that impinge on families’ mental, physical and emotional health.

Referring to the Duluth model, the standard treatment for perpetrators of interpersonal violence, Featherstone, Rivett and Scourfield (2007) note that “Western pro-feminist models should not be seen as the automatic template for interventions, regardless of ‘race’ and class” (p. 110). The inefficacy of this model is well-documented: “Results of meta-analytic reviews revealed little or no effects for these programs (e.g., Babcock, Green, & Robie, 2004), a conclusion supported by recently completed experimental studies (e.g., Dunford, 2000)” (Fals-Stewart & Kennedy, 2005, p. 10). This model obscures the heterogeneous nature of the population of men who perpetrate violence, adopting a ‘one size fits all’ approach that eclipses the particularities of men’s situations, tendencies and underlying issues.

For substance-using fathers, particularly Aboriginal fathers, this model may not address “the experience of these men which is far from one of feeling `powerful’” (Featherstone, Rivett & Scourfield, 2007, p. 104). Further, Milner (2004) argues that workers facilitating the Duluth model “totalize violent men to such an extent that they not only describe how they are but also presume to know what they think” (p. 80). By making such
presumptions, men’s genuine issues and concerns may remain unresolved, resulting in continued interpersonal violence.

The underlying mechanisms of this model are remarkably similar to those associated with the Minnesota model, a standard in addictions treatment: “Feelings of responsibility, shame and guilt are starting points in the process of self-reflection” (Milner, 2004, p. 81). Yet shame and confrontation are contraindicated in work with violent men, resulting in “reduced women’s choices” (Milner, 2004, p. 83). Shame and confrontation techniques are also ineffective and potentially damaging in work with substance users (Collins, 2002; O’Connor, Berry, Inaba, Weiss & Morrison, 1994). This approach is reminiscent of Fanon’s (1963) descriptions of the subordinated subject: “The first thing the colonial subject learns is to remain in his place and not overstep its limits” (p. 14). Shame-based models of ‘treatment’ for substance dependence have been eschewed for women substance users; I argue that these models are equally damaging for men, in both substance dependence and violence interventions.

It is crucial for contemporary research to better inform treatment models. In her qualitative study with Indigenous fathers, Ball (2009), applying a grounded theory analysis, identified six “key ecological and psychological factors that combine to account for Indigenous men’s experiences of fatherhood” (p. 29). These include “personal wellness, learning fathering, socioeconomic inclusion, social support, legislative and policy support, and cultural continuity” (Ball, 2009, p. 29). Contrary to popular images of fathers in the addictions literature, “few Indigenous fathers in this study blamed women for barriers to being effectively involved fathers;” rather, they cited “colonial legacies [that] had exerted
different but equal challenges for Indigenous women” (Ball, 2009, p. 38). Ball’s (2009) work illuminates the multiple dimensions of fathers’ experiences and needs, suggesting the utility of a much broader spectrum of understanding and meeting the needs of families that struggle with problematic substance use.

Fathers in Ball’s (2009) study described involvement in child care as healing, and a need for traditional healing to recover their “Indigenous knowledge and their capacities to parent and live together as families (p. 38). Oppressed by race and class, these marginalized fathers “underscored the need for long term investments in policy reform and programs to reduce structural, personal and social barriers to Indigenous fathers’ involvement” (Ball, 2009, p. 44). Compounding Indigenous and other fathers’ marginalization are the “mother-centric biases in parenting and childcare program and in child welfare,” also extant in the ‘difference’ feminist discourse in addictions theory, policy and practice (Ball, 2009, p. 44). A broader view implicates structural conditions, not fathers.

3.5 Images of substance-using fathers in family addictions literature

Fathers are conspicuously absent from the addictions literature (Berridge, 2002; Fals-Stewart et al., 2004; Rounsaville, 2002a, 2002b; Scaife, 2008; Twomey, 2007); yet the importance of working with families and couples where problematic substance use exists is well-documented (Barnard, 2007; Barker & Hunt, 2004; Csiernik, 2002; Copello & Orford, 2002). Fathers have also been ignored in child welfare literature, policy and practice (Strega et al, 2009; Strega et al., 2012) and from child and adolescent psychology literature (Phares, 2007). What data or literature does exist in respect to fathers in addictions literature
appears to be primarily based on mothers’ accounts, and depicts fathers as absent, distant, ‘drunken’ or violent (Twomey, 2007). The lack of studies exploring the complexities of substance-using fathers and fathering exists despite the identified importance of fathers’ influence in the lives of their children, whether substance-using or not (Fals-Stewart et al., 2004; Nurco, Blatchley, Hanlon, O’Grady & McCarren, 1998; Phares, 1992).

Barker and Hunt (2004), arguing for a more complex, contemporary analysis, describe a “single stolid vision of family” that pervades the addictions literature (p. 348). Barker and Hunt’s (2004) review of the literature reveals a division between alcohol and illicit drugs. Barker and Hunt (2004) describe the historical positioning of alcohol versus drug research; alcohol research is subsumed within medical literature and illicit drug use research in criminology literature. Illicit drug use, unlike alcohol, is conceptualized as deviant, immediately implicating the substance user, compelling both “secrecy” and “isolation” (Fals-Stewart et al., 2004). Contesting drug users’ constructed deviance, a recent yet substantial body of work in health epidemiology, centred on reducing health risks associated with problematic substance use, is now emerging (Rhodes, 2009).

Until recently, drug use literature in relation to the family has focused on familial (parental) contributions to adolescent drug use and adolescents’ concomitant ‘deviance’ (Barker & Hunt, 2004). Demarcation of the ways that drug policy has been complicit in producing lifestyles of ‘risk’ for substance-using fathers and mothers has been absent from the literature until recently (e.g. see Boyd, 1999; Boyd, 2004). A shift in the family and addictions discourse, focused on mothers’ substance use, has emerged in the last decade (Barker & Hunt, 2004; McMahon & Rounsaville, 2002a; Scaife 2008). Fathers, however,
continue to be under-studied and largely under-represented (Phares, 2002). Also lacking in the family addictions literature is a structural and ecological analysis that would ground research in the social context in which families function (Barker & Hunt, 2004). As explained by Velleman and Orford (1999), much of the research relating to parenting and problematic substance use depicts a “passive and one-way picture, whereby parental behaviour exerts a blanket and deterministic effect on the offspring” (1999, p. 67). Service recommendations are aimed at the individual, not the family (Copello & Orford, 2002).

Fathers are described as ‘absent,’ ‘enmeshed’ (Kaufman, 1985; Ripple & Luthar, 1996), ‘distant’ (Barnard, 2007; Stanton & Todd, 1982; Nurco et al., 1998), ‘resistant to treatment’ (Boyd & Guthrie, 1996) and more difficult to engage or recruit (Laudet, Magura, Furst & Kumar, 1999; Osborn & Berger, 2009; Velleman & Orford, 1999). In the alcohol literature, “nearly all studies [included] more male than female problem drinkers and many consisting entirely of men, leading to less being known about the impact of maternal problem drinking” on children (Velleman & Orford, 1999, p. 26). While fathers were positioned centrally in the alcohol literature, mothers, or ‘wives’ were positioned as ‘co-dependent’ or ‘enablers;’ this discourse continues (e.g. Rotunda, West & O’Farrell, 2004).

Much of the discourse relating to drug-using fathers demonizes fathers, contributing to fathers’ shame and stigma (McMahon, Winkel, Suchman & Rounsaville, 2007). Shame and stigma have been identified as core features of substance-using mothers’ emotional landscape (Weaver, 2007a). Greaves et al. (2007) cite shame and stigma as a gender difference, evidenced in theoretical, social and media views of substance-using mothers; yet
preliminary studies identify a similar theme among drug-using fathers (McMahon & Rounsaville, 2002a).

Fathers’ problematic alcohol use is viewed in some of the literature as more harmful to children than mothers’ (Velleman & Orford, 1999). Other reports conclude that fathers are more likely to use substances, but children have more exposure to mothers, so mothers (the non-using parent, by implication) could benefit from “additional public supports” (Osborn & Berger, 2009, p. 368). In a substantial number of studies, fathers’ absence “is rarely investigated further” (Barker & Hunt, 2004), perhaps because this absence is constructed as positive for both children and mothers:

Presumably, a mother’s best means of protecting her child from the negative outcomes associated with paternal substance abuse is by limiting or preventing the father’s access to the child...mothers who allow substance-abusing fathers to live in their households may constitute a select, high-risk group of mothers who have other characteristics that are also associated with poor developmental outcomes for children (Osborn & Berger, 2009, p. 344).

This analysis constructs both parents as a risk; father’s absence is recommended as a means of protecting children from the effects of fathers’ substance use; mothers are equally implicated if they continue a relationship between children and their fathers.

An alternative analysis suggests that exploration of the relationship between fathers’ problematic substance use and their parenting is warranted. As explained by McMahon et al. (2005), “Assuming chronic drug abuse compromises ability to function effectively as a father, there is also need to better document how that occurs over time and how failure to
function as a parent affects the psychological state of drug-abusing men” (italics mine) (p. 88). Discussions of how substance-using fathers are affected by their perceived or actual failure to parent is atypical in the literature; concern with fathers’ problematic substance use rarely translates into speculation or research into how fathers’ improved functioning as parents might be facilitated.

This inadequate response to perceptions of fathering issues for substance-using men exists despite salient and well-documented points pertaining to fathers: the importance of fathers in children’s development (Phares, 1992; Scaife, 2008) and awareness that “fathering is a socially generative experience that has the potential to transform individuals“ (Parke, 2002, p. 1118). This theoretical bias constitutes a significant omission with substantial implications for fathers, mothers and children; it translates into ‘father neglect’ in both policy and practice. Attention to fathers in research and practice has historically been one-dimensional, opaque and limited, primarily concerned with fathers’ absence or dangerousness. The recursive relationship suggested by McMahon et al. (2005) has yet to be explored: how do fathers’ feelings about themselves as fathers relate to their problematic drug/alcohol use? How are we facilitating the development and exploration of fathers’ fathering?

Contesting assertions that men and fathers are reluctant to engage in treatment, one study found that although more fathers than mothers struggle with problematic substance use, “men seeking treatment outnumbered women more than 2 to 1” (McMahon et al., 2005, p. 84). Further, Fals-Stewart et al. (2004) cite the “success of well-known family-based intervention programs for substance abuse” as evidence that engaging parents in family
treatment with their children is possible (p. 666). Recruitment and engagement difficulties may be overestimated; Phares (1992) found that “fathers were no more difficult to recruit than mothers” (1992, p. 658); while participants in Phares’ (1992) study were not substance users, McMahon et al. (2007) were able to engage 106 substance-using fathers who were in methadone treatment.

Substance-using fathers may experience numerous stresses that negatively impact their self-esteem; these may include issues relating to class (ability to provide for the family) and race (discrimination), structural factors that intersect together with hegemonic masculinity and Western neoliberal ideology to produce a sense of failure in substance-using fathers. This combination of factors may form the basis of fathers’ identified feelings of dissatisfaction with their own parenting abilities (McMahon et al, 2007). As Laudet et al. (1999) explain engagement of male partners may require determining “any possible motive for the man to become engaged in the process (such as children-related issues, improvement of the relationship with his partner)” (p. 624). The responsibility to make a conscious and informed effort to engage fathers is echoed by Stanton and Todd (1982) who described strategies for “countering the father’s resistance” almost 30 years ago (p. 72).

Stanton and Todd (1982) also contest the assertion that fathers are difficult to engage in treatment. In cases where fathers are perceived to be ‘resistant’ to engagement in treatment or in research, the fault may lie with researchers and service providers, not with fathers. In a study of young fathers, Bunting and McAuley (2004) found that “service providers are viewed by fathers not only as unsupportive but as constituting an additional barrier to paternal involvement “(p. 302). This finding is not surprising given the lack of
research with fathers, and a propensity in the existing research to denigrate or dismiss substance-using fathers.

In fact, the absence of positive views of substance-using fathers in the literature, and their exclusion from families, compel a re-examination of the factors that contribute to this absence (Twomey, 2007). Rather than conceptualizing men and fathers as dangerous, inadequate or responsible for women’s problematic substance use (Krestan, 2000, p. 22; Gordon, 2002), efforts can be redirected to deconstruct and address structural and other factors that contribute to how and why these behaviours may exist (McMahon et al., 2007; Twomey, 2007). Family violence and fathers’ role in it are considered priority among described behaviours of concern; these must be considered in context. Boyd describes the negative implications and health consequences of drug law and policy for users of illicit substances (Boyd, 2004); similarly, addictions literature and services subtly vilify rather than ‘empower’ users of illicit drugs, in spite of claims to the contrary.

3.6 Structural and interpersonal violence: class, race and colonialism

Substance-using men’s experience of trauma, through structural or interpersonal violence, has been obfuscated in addictions literature that has focused largely on women’s experience of trauma (Najavits et al., 2009). Yet these fathers’ experiences of colonization (Ball, 2009); exposure to forms of abuse in childhood (Libby, Orton, Beals, Buchwald & Manson, 2008); and exposure to community (gang-related) violence associated with illicit substance use are significant and warrant attention (Najavits et al., 2009). Other community forms of violence associated with drug dealing, crimes committed to obtain money for illicit
drugs, and police interventions may also constitute forms of violence to which male drug users are routinely exposed.

Consideration of factors that contribute to *family* violence among substance users does not imply a negation or minimization of violence against women; indeed it is only through a more complex analysis of family violence that progress towards increased safety for mothers can be achieved. A thorough analysis of family violence must consider intersecting structural factors that contribute to ‘private’ violence, and how this violence affects all members of the family.

Similar to addictions services, current models of treatment that seek to address interpersonal violence may be ineffective and based on sexist ideology (Featherstone, Rivet & Scourfield, 2007; Orme, Dominelli & Mullender, 2009; Milner, 2004); both streams of theory, policy and practice rely on gendered assumptions and divisions. Continued, unexamined acceptance of these models contributes to the risk of further interpersonal violence; continued problematic substance use; and constricted possibilities for fathers, mothers and children.

The relationship between interpersonal violence and consumption of illicit and licit substances (alcohol) is discussed at length in the literature (Humphreys et al., 2005), yet a causal relationship between substance use and interpersonal violence has yet to be established. A clear bias exists in the literature: as Humphreys et al. (2005) indicate in their review of the voluminous literature on the subject, “the sheer weight of research evidence in this area is initially daunting, particularly in relation to male perpetrators of violence and
substance use” (p. 1304). Yet the ‘evidence’ may be based on flawed assumptions (Humphreys et al., 2005; Milner, 2004).

For instance, one study of pregnant substance-using mothers’ and children’s exposure to violence measured exposure to community violence in addition to their exposure to interpersonal violence, and found “reports of lifetime violence in the community were also high” (Velez et al., 2006, p. 34). Velez et al. (2006) gloss over this form of violence, focusing only on violence perpetrated by mothers’ current sexual partner. This focus leads to recommendations that the “process of recovery for each pregnant substance-abusing woman experiencing violence must incorporate treatment for IPV issues both for herself and for her children” (Velez et al., 2006, p. 36). This recommendation is problematic for a few reasons.

Firstly, it does not address the authors’ findings of mothers’ exposure to and involvement in community violence: 40% of this sample of mostly young, Black, inner city single mothers reported “having been involved in fights in the street,” and “28% reported that their children had been exposed to frightening things in their neighbourhood (e.g. fights, knifings, shootings, and kidnappings); half of these exposures were categorized as shootings” (Velez et al., 2006, p. 34). Despite findings of a substantive degree of environmental violence, Velez et al. (2006) limit their comments to the effects of community violence on children, born and “unborn” (p. 36). A discussion with mothers of their involvement in street fights might have revealed dimensions of violence previously obscured. By retaining a focus on individual behaviours of mothers’ sexual partners, Velez et al. (2006) prohibit possibilities for recommendations on a structural level. This is particularly
significant considering that “only 6% of the women reported fearing their current partner” and only one third of the women “perceived a need for counseling” (Velez et al., 2006, p. 34).

Secondly, although Velez et al. (2006) indicate, based on their evidence, the likelihood of violent behaviour stemming from both partners, they make assumptions about mothers and partners. Velez et al. (2006) presume to interpret women’s perceptions of interpersonal violence, insinuating that the women in their study are not correctly construing their own experience: “the women involved in these episodes may not perceive these situations as an abusive event perpetrated by their partner” (p. 35). This assumption is made to support the argument that women will likely, through the course of “treatment,” begin to disclose to therapists “the reality of their everyday lives” which, according to Velez et al. (2006), means assigning blame to their partner, and assuming a victim identity (Velez et al., 2006, p. 35).

Velez et al. (2006) appear to presume to know the ‘truth’ of these women’s experiences; expecting women’s perceptions of their own lives to become transformed, through the normative institution of treatment, to a ‘truth’ constructed by the researchers. This is tantamount to excluding women’s views. As McHugh, Livingston and Ford (2005) explain “Our constructions and operational definitions of the phenomenon under study can also introduce limitations and distortions in women’s understandings of their own experience” (p. 325). McHugh et al. (2005) offer a postmodern perspective of gender and violence, emphasizing the “connection between the constructs we use, the methods we employ, and the pattern of violence we are most likely to find” (p. 333).
The ways knowledge is constructed in the addictions literature, as it pertains to both substance-using mothers and fathers, replicates oppressive structural conditions, constructing women as victims and as defective; mothers are depicted as in need of treatment to accomplish a regulating shift in their perception of their own experience. Perhaps women initiated some of the altercations described in Velez et al.’s (2006) study; perhaps these fights erupted due to the stress of poverty, racism and other forms of structural violence. Ignoring these potentially pivotal factors imputes mothers as victims and partners as perpetrators.

Thirdly, while Velez et al. (2006) appear to situate the entirety of a complex problem within the male partner, no recommendations were made that address the male partner’s needs or behaviours; the only data collected about male partner was obtained from mothers, and these were limited to information about abuse. We do not know if these partners were fathering the ‘unborn’ or existing children of this mother. We do not know their histories, views, challenges, or obstacles; nor are we informed of potential strengths that might exist in their relationships with mothers and children, and how class, race and the dominant patriarchal ideology intersect to affect their experience. Eliciting such information would go towards the development of services that may contribute in a more substantive and meaningful way to reduction of violence against women.

Other, similarly pathologizing studies focus on women/mothers, attempting to formulate and confirm dimensions of mothers’ psychiatric diagnoses, describing substance-using women in abusive relationships as having “greater psychiatric comorbidity,” (Tuten, Jones, Tran & Svikis, 2004, p. 1033). To their credit Tuten et al. (2004) do recommend
“couples or partner treatment” because “increased maternal social support mitigates the health consequences of violence exposure during pregnancy” (p. 1033). Fathers’ potential to provide this support is too seldom acknowledged in the body of literature pertaining to families and addictions.

The addictions and family discourse appears to re-produce the damage it purports to alleviate. The violent behaviours and nature ascribed to substance-using fathers, and, to a lesser extent, substance-using mothers, viewed in an environmental and structural context, may represent a human, normal response to racism, colonization and other forms of oppression. Rhodes (2009) summarizes these dynamics specifically in respect to users of illicit drugs:

The internalisation of social suffering reproduces a cycle of risk production in which those marginalised can become complicit, including unconsciously, in their ongoing structural subordination (Kleinman, Das, & Lock, 1997). In this way, symbolic and structural violence is reproduced through everyday interactions between drug users—for example, as shame (Rhodes et al., 2007), stigma (Simmonds & Coomber, 2009), and gendered violence (Maher, 1997), as much as through interactions between drug users and health systems (Bourgois, 2000; Radcliffe & Stevens, 2008) (p. 196). (Rhodes, 2009)
Thus, maladaptively reacting to the oppression extant in the dominant ideologies of hegemonic masculinity and neoliberal forms of capitalism, drug users may turn on each other. Instead of reifying this separation through a divisive discourse and programming, addictions research and treatment require a thorough re-structuring.

This divisive trend is reminiscent of Sartre’s (1963) words in the preface to Fanon’s (1963) *Wretched of the Earth*; referring to the moment when the colonized initiate resistance, Sartre remarks: “Tribal conflicts diminish and tend to disappear: firstly, because they jeopardize the revolution, and more precisely because they had no other purpose but to *shift the violence onto false enemies*” (italics mine) (p. iv). Fathers oppressed by race and class are constructed, in both addictions research and treatment, as the ‘false enemy.’ Consequentially, intended or not, partners are separated, with lone mothers commonly assuming responsibility for children, while fathers are excluded from their families and from services, their needs and behaviours unaddressed. Through this process, the capacity of these families to identify and assert their rights in respect to poverty, racism and colonization are diminished.

Researchers are also ethically remiss in omitting a structural analysis in studies that recruit convenience samples of mainly Black, single, inner-city, low-income mothers who are involved in relationships where interpersonal violence and problematic substance use exist (e.g. Tuten et al., 2004; Martin, Beaumont & Kupper, 2003; Velez et al., 2006). Although research participants are recruited from the “colonized’s sector, or at least the ‘native’ quarters, the shanty town, the Medina, the reservation…” (Fanon, 1963, p. 4), the research analyses rarely take into account the highly salient structural factors of race and class.
Sifting through the family addictions literature reveals only a couple of sources that at least hint at a structural analysis, specifically relating to gender, men and the dominant patriarchal ideology that underscores relationships between interpersonal violence and problematic substance use. Humphreys et al. (2005) accord some recognition of the complexity of relationships between substance-using partners, recommending individual assessment. Helpfully, Humphreys et al. (2005) also make the connection between internalized hegemonic masculinity (“patriarchal attitudes”), substance use and violence, emphasizing that “drug or alcohol use needs to be set alongside beliefs and attitudes about violence and abuse” (p. 1310). Although somewhat weak, this view infers the possibility that a more complex structural analysis is required.

Milner (2004) suggests that men vilified in this discourse are oppressed: “radical feminism has largely had the effect of influencing professional working hypotheses which demonize men who are already excluded” (p. 95). This is critical in analysing an addictions discourse that is equally complicit in problematizing mothers and fathers struggling with problematic substance use. With the emergence and reification of a ‘gendered’ discourse in addictions theory, research, policy and programs, we may be witnessing a kind of colonization in which families are fragmented and substance users are shamed.

Johnson (1995) makes an important contribution to this discussion in his description of “two major streams of sociological work on couple violence in families, one that is generally referred to as the family violence perspective, and the other of which may be called the feminist perspective” (p. 283). These two fairly distinct waves of research on domestic violence emanate from quite different perspectives, with family violence
researchers focusing on family conflict in an overall sense, and feminists focused specifically on male violence against women partners. Johnson (1995) points to differences in researcher method and sampling, which have led to “analyzing different phenomena” in interpersonal violence (p. 284). Johnson (1995) uses the term “patriarchal terrorism” to describe the violence rooted in “patriarchal ideas of male ownership of their female partners” (p. 284).

Importantly, Johnson (1995) distinguishes between “common couple violence” and “patriarchal terrorism” (p. 286). This distinction is critical because the totalizing claims made about men and violence, as described above, are frequently and inappropriately applied to situations characterized by a less severe and entrenched, and more mutual violence that may be frequently encountered in substance-using couples. The repercussions of ignoring this distinction are significant in terms of formulating responses to mothers and fathers struggling with poverty, deviant status, problematic substance use and interpersonal violence.

In terms of the contemporary Canadian reality of interpersonal violence, Ball & Daly (2012) report that:

While domestic violence is found in a small minority of (but still too many) Canadian families, in 2004 an estimated 7% of women (653,000 women) and 6% of men (546,000) over 14 years old reported some form of spousal violence in the context of a current or previous marital or common-law relationship in the previous five years (Statistics Canada, 2005). Other studies have similarly suggested a relative equivalence between Canadian men and women in their propensity to perpetrate
violence in family contexts (Dutton & Nicholls, 2005; Grandin, Lupri, & Brinkerhoff, 1998). (p. 4)

This evidence contests gender stereotypes relating to violence and sex/gender, debunking myths that converge to exclude men and fathers from spaces traditionally dominated by women.

Structural analyses would lead to models of care that mediate, rather than perpetuate, oppressive conditions. The models currently in place are problematic on a number of dimensions, seeming to emerge from oppressive theory and research. Milner (2004) recommends “listening to the preferred solutions of the victims – which have not been shown to be removal from the home” (p.88).

3.7 Fathers in the fathering literature

Clearly, generalizations about such a diverse group as “fathers” warrant caveats; differences exist across race, class, and degree of conscription to hegemonic masculinity (Collier & Sheldon, 2008; Connell, 2005; Featherstone, Rivett & Scourfield, 2007). However, research is illustrative of some of the challenges faced by fathers in participating in parenting and in seeking help. As discussed by Featherstone et al. (2007), men are less likely to seek help than women; this “clearly needs to be understood in the context of the social construction of the ‘stronger sex’” (p. 136).

Shame and stigma discourage men from seeking help for mental health issues; this is attributed to the strong association between rationality and hegemonic masculinity (Featherstone et al., 2007). Similarly, shame and stigma present a barrier for mothers
seeking help for substance abuse problems, for reasons related to normative ideals of motherhood (Poole & Greaves, 2002; Weaver, 2007a). Normative gender ideals thus function as barriers to both parents.

Father participants in Featherstone’s (2009) qualitative study reported that “services were considered to reflect outmoded notions of fatherhood that constructed fathers as either absent or disinterested” (p. 161). Fathers also spoke of “controlling aspects of the state,” such as police and child support officials; these agents of the state would figure prominently in the lives of substance-using fathers. Fathers reported “struggling against the odds to be involved, listened to and taken seriously” (Featherstone, 2009, p. 162). Father exclusion from parenting services appears to be well-established; this exclusion is apparent across class and race.

Discussions of domestic violence also permeate the fathering literature; these are sites of complex and contested debates. Central notions in this discussion are issues of power; the role of alcohol and drug use; class and cultural differences; the role of poverty, dislocation and colonization; and hegemonic masculinity (Collier & Sheldon, 2008; hooks; 2004; Featherstone, 2009; Featherstone et al., 2007; Hamby, 2005). Making the link between poverty, colonization and domestic violence, Hamby (2005) comments that “Contact with Westerners has had many negative consequences, including increased domestic violence rates, probably due in part to profound losses in the traditional status and roles of both men and women” (p. 179).

Conflicting theory as to the sources of, and recommended interventions for, domestic violence, plague the literature; one recommendation has been to join government
agendas in facilitating father involvement and addressing domestic violence (Featherstone, 2009, p. 170). As Featherstone (2009) remarks, this approach has the advantage of “challenging the split constructions of ‘father’ and perpetrator underpinning policies” (p. 170). Integration of these goals could accomplish a significant leap forward in this tension-ridden situation, resulting in refinement of theory and practice in both areas.

Locating the source of domestic violence in the “intersecting power relations of gender and class,” Websdale and Johnson (2005) argue that investments must be made in changing the structural conditions that promote domestic violence, noting that solutions based in criminal justice “ignore or downplay the social generation of crime” (Websdale & Johnson, 2005, p. 412). Websdale and Johnson (2005) focus on facilitating women’s economic independence and emancipation from abusive relationships; a more comprehensive response could include addressing these structural conditions with men in an educative process. Such interventions could focus on deconstruction of fathers’ assumptions relating to hegemonic masculinity, feelings of powerlessness and facilitating fathers’ emotional literacy.

Engaging substance-using fathers in maternity services for substance-using mothers may be accomplished by appealing to their paternal instincts:

A way in is to appeal to men as fathers. Naming such men as fathers opens up a number of possibilities. In a situation of resource constraints, resources may be more easily available if it is argued that it will have some spin-off for children. Appealing to men as fathers may help key into fathers’ own desires in relation to a more nurturing fatherhood model.” (Featherstone, 2009, p. 171)
In their mixed methods study, Raikes, Summer et al. (2005) found that father engagement in Early Head Start programs increased when programs actively involved fathers. Father involvement was facilitated through training father involvement coordinators, implementing an agency-wide mandate of father engagement and providing a “wide array of program efforts to include fathers” (p. 36). Father exclusion exists across social services relating to children; the reluctance of child welfare social workers to engage fathers is well-documented (Strega et al., 2009; Strega et al., 2012), as is father avoidance by healthcare practitioners (Daniel & Taylor, 2001).

Men struggle to claim space in the traditional woman’s realm of pregnancy and childbirth (Collier & Sheldon, 2008; Daniel & Taylor, 2001; Doucet, 2006). Maternal gatekeeping is central to the possibilities of men engaging in the antenatal period (Collier & Sheldon, 2008; Doucet, 2006; Raikes, Summers & Roggman, 2005). Collier & Sheldon (2008) summarize efforts to involve fathers in maternity services in the general population: “antenatal services for fathers tend to be thinly spread and reactive, with an emphasis on the father’s role as supporter, his needs overlooked” (p. 60). Yet pregnancy and childbirth may form a key opportunity to engage substance-using fathers in addictions health services. By creating a space for this marginalized group of fathers within the antenatal, natal and postnatal period, health services could ‘capitalize’ on their paternal interest, paving the way for continued investment in supportive, connected relationships.
3.8 Summary

As demonstrated, the representations of substance-using fathers that do exist in the family and addictions literature reflect a negative bias; this bias exists in other social science discourses. Fathering literature is beginning to initiate a shift in our perceptions of fathers. Yet thus far, very little research has been conducted with substance-using fathers. As a result, the few services that do exist for these fathers are misguided and ineffective. Further, the propensity of this group to engage in interpersonal violence may be overestimated; alarmingly, those fathers who do perpetrate violence are under-served, by ineffective models. Not meeting fathers’ needs results in increased risk for fathers, mothers and children. Further qualitative research with substance-using fathers will be critical and informative in revealing fathers’ experiences and needs; the structural forms of violence that contribute to interpersonal violence; and ways to safely, effectively engage substance-using fathers and families.

While fathers are conspicuously absent from addictions research (McMahon & Rounsaville, 2002a, 2002b; Barker & Hunt, 2004), mothers form a popular subject in addictions research. This literature too frequently reflects reified, atavistic notions of family and appears to be divided among alcohol research, theorized from a medical point of view, and drug research, based on a criminological perspective (Barker & Hunt, 2004). Positioning the family as both the cause and solution to the problem, the “theoretical depiction of ‘family’ is identical, invisible and ignored” (Barker & Hunt, 2004). As a result, policy aimed at prevention or treatment of problematic substance within a family context has been ill-
informed, lacking a critical analysis focused on exploration of “power relations within families or, as importantly into the coercive or oppressive potential of the state” (Barker & Hunt, 2004). Few marriages exist between progressive family theory and problematic alcohol and drug use, with Indigenous postcolonial literature forming the exception.

As discussed above, the gendered division that has developed in addictions discourse has onerous implications for mothers: the “‘reification of femininity’ risks glorifying the often oppressive conditions under which care is done” (Hankivsky, 2004, p. 14). Far from freeing mothers, ascribing ‘carer’ identities to women alone may restrict rather than facilitate their emancipation. Meanwhile, father’s potential as carers is thwarted, excluding opportunities for connection (Collier & Sheldon, 2008; Featherstone, 2009).

3.9 Summary of the literature review/research context

In summary, a critical analysis of addictions theory pertaining to women/mothers and men/fathers reveals numerous problems in conceptualization and actualization. The fathering, gender and critical masculinity literature is beginning to promote a shift in how we view men and fathers. These bodies of literature, unlike most addictions theory, incorporate a structural and critical analysis; this re-positions problematic notions of sex and gender as authoritative, towards revealing structural conditions and the hegemonic masculinity that supports capitalism, colonization and problematic use of illicit substances. Further, considerations of race and class, pivotal factors in both problematic substance use and identity construction, are emerging in postcolonial literature, useful in deconstructing assumptions about sources of violence in the context of problematic illicit drug use.
Based on outdated, faulty assumptions and problematic theory, addictions services have evolved into an industry that frames the individual as responsible. Services in Canada and elsewhere have developed in ways that separate -- literally and figuratively – mothers and fathers. Fir Square Combined Care Unit, the maternal harm reduction unit that forms the site of the current study, forms an exception to the bulk of addictions services, in that it reflects a structural analysis and a health promotion/harm reduction approach. Yet this critical harm reduction service, that responds effectively and non-judgmentally to pregnant users of illicit drugs, currently lacks the capacity to engage male partners. The aim of this study is to find out how mothers and fathers are affected by this gap in services. To date, there are no known qualitative studies conducted with fathers using illicit drugs; this study also aims to address this significant gap in the literature.
4 Research methodology

This study was reviewed and approved by the University of British Columbia Behavioural Research Ethics Board (BREB); the University of British Columbia’s Children’s and Women’s Health Centre of BC Research Ethics Board (UBC C&W REB) and the Vancouver Coastal Health Research Institute, in 2010. Separate applications were required for each site. The latter two Ethics Boards represent the sites from which participants were recruited. Revisions were requested by the UBC BREB and provided in December 2010; the study was then approved. The study was conducted through the University of British Columbia, as part of a doctoral degree. Each participant signed informed consents outlining potential risks and benefits, confidentiality, study procedures and the purpose of the study.

This study addresses a critical gap in the literature by investigating the experiences of marginalized men/fathers using illicit drugs that are excluded from services for their pregnant drug-using partners. Further, the study brings forward voices of mothers receiving services, to find out how father exclusion affected them, a noteworthy contribution for program developers, researchers and service providers focused on woman-centred care and research. I used a qualitative method of inquiry to find out how former patients of Fir Square Combined Care unit and their partners were affected by father exclusion from services; to generate theory, ‘grounded’ in their experiences; and to advance the development of more valuable services for expectant parents struggling with problematic drug use.

My pilot study revealed a paucity of data pertaining to fathers, rendering a quantitative method impossible to employ (Weaver, 2009). I chose to use grounded theory,
as opposed to other qualitative methods, such as phenomenology or biography, because my intent was pragmatic: I intended to generate theory, based on the experiences of service users, to inform the development of addictions services for expectant parents struggling with problematic drug use. Specifically, I chose to use Charmaz’s (2000, 2006) constructivist version of grounded theory.

Grounded theory is not a prescriptive, rigid method but offers “flexible, heuristic strategies” for the collection and analysis of data (Charmaz, 2000, p. 510). Charmaz (2000) discusses the positivist underpinnings that characterize particular strands of qualitative research: “Strauss and Corbin’s (1990, 1998) stance assumes an objective external reality” (Charmaz, 2000, p. 510). Alternatively, constructivist grounded theory is transparent in naming the researcher as an active participant in the production of theory, overturning positivistic notions of ‘nonpartisan’ research. This method is reflexive, acknowledging the researcher’s active participation throughout the study, including data collection, analysis, and theory development.

Charmaz (2006) describes constructivist grounded theory as “more than looking at how individuals view their situations...it also acknowledges that the resulting theory is an interpretation” (p. 130). In other words, both the meanings ascribed by participants to their experience, and the researcher’s interpretation of that experience, are socially constructed; the method is interpretive rather than fixed and static. Charmaz’ (2000, 2006) development of constructivist grounded theory galvanizes a significant shift in this method, away from positivism and towards postmodernism. Of import also is that “this constructionist view
acknowledges that outcomes result from social interactions, negotiations and power” (Charmaz, 1990, p. 1161).

Traditional positivist theory entails a causal equation in which certain events produce certain responses. In constructivist grounded theory, researchers “create theoretical categories from the data and then analyze relationships between key categories” (Charmaz, 1990, p. 1162). Although objectivist grounded theory “resides in the positivist tradition and thus attends to data as real in and of themselves” (Charmaz, 2006, p. 131), constructivist grounded theory “sees both data and analysis as created from shared experiences and relationships with participants and other sources of data” (Charmaz, 2006, p. 130). The constructivist approach makes transparent the presence of the researcher and her interpretation: “it does not and cannot stand outside” of the researcher’s view (Charmaz, 2006, p. 130).

Theory is developed from mapping the relationships between participants’ combined ‘key’ experiences, and the contexts in which they transpire. In this case, contexts include the specific places, times and ways that exclusion took place, subtle or overt, and how participants responded; the researcher deconstructs and illuminates power relations, linking “facts and values” (Charmaz, 2006, p. 131).

Based on my observations that the design of these maternal harm reduction services, and other addictions services, have yet to integrate and reflect an intersectional analysis,16

16 Intersectional analysis considers multiple sources of oppression simultaneously, such as race, gender and class, as opposed to considering a singular form of oppression (e.g. gender only); this also allows insight and analysis of how these multiple forms of oppression interact.
and persevere in foregrounding gender at the cost of race and class, I integrated an additional method of analysis (Cuadraz & Uttal, 1999) that would highlight how race and class manifested in parents’ experiences. My purpose was to investigate the mechanisms that formed an intrinsic, exclusionary aspect of these addictions health services, to find out how this structure affected participants, and how participants responded.

I wanted to find out “how individual experiences and biography are embedded in the social structure and history while simultaneously accounting for each of these multiple social structures” (Cuadraz & Uttal, 1999, p. 158). Integrating this additional sensitizing analytic method enhanced awareness of participants’ social location and how it influenced their response to services; this focus was central to the line-by-line analysis. The ‘how’ of exclusion emerged as a complex phenomenon in participants’ experiences and in relationships between institutions.

Cuadraz and Uttal (1999) explain that intersectional analysis is best accomplished by “examining the primary features of institutional arrangements and how individuals respond to their structural location” (Cuadraz & Uttal, 1999, p. 173). Cuadraz and Uttal’s (1999) proposed method for incorporating an intersectional analysis evolves in stages: rather than imposing sampling frameworks or quantitative methods to ‘identify’ race, class and gender through participant representation, Cuadraz and Uttal (1999) describe a process of 1) allowing issues to emerge and then 2) asking “how the categories, views and issues that emerge...are possibly shaped by each respondent’s social location” (italics mine) (p. 173).

Emerging themes, or “issues” are aspects of experience that are common across the data or are identified as discrepant, or atypical. The clusters of data that combine to form a
theme suggest a code of significant density; these codes become the foundation to theoretical constructs. The social location of these study participants shared a common theme of poverty and marginalization. Illicit drug use, also common to participants, invokes additional burdens of stigma and marginalization. Ethnicity is another axis of social location; over half of the study participants identified as Aboriginal; only five of the twenty identified as White.

Cuadraz and Uttal (1999) describe how Cuadraz initially analyzed data with a view to “treating each account as an individual account” (p. 171) and then “examined the structural level” (p. 172). In this way, the researcher can investigate: a) meanings participants ascribe to their experiences; b) strategies participants use to resist or take up forms of oppression; and c) how and when those forms of oppression interact with participants and with each other (Cuadraz & Uttal, 1999). I wanted to use a research method that would reveal shifting layers of intersecting oppressions: how did race and class affect service delivery, in the views of participants? Did gender, race or class issues arise in participants’ experiences of services? Did fathers feel they were left out only due to gender, or did they experience racism and classism as part of their exclusion? Did mothers identify gender, race or class as causal, or a factor, in father exclusion? To enhance collection of data relevant to race, class and gender, questions specific to these dimensions were initially included in the Interview Protocol:

3. In your view, how did other factors affect your experience of services, if at all?

• In your view, how did your ethnic background, or race, affect your experience of services, if at all?
• In your view, how did your economic situation affect your experience of services, if at all?

• In your view how did your gender affect your experience of services, if at all?

• Do you think any of these factors play(ed) a part in your drug use?

• Can you tell me more about that? Can you give examples?

(Interview protocol, Version 2)

These questions were omitted in the second set of interviews because, in the first set, they markedly disrupted the interview flow. Participants appeared confused and uncomfortable with direct questions relating to race and class, and how these affected their experience. Discussions of race, class and gender were not a familiar discourse for these participants. Yet as Cuadraz and Uttal (1999) suggest, it is not necessary to use purposeful sampling, or to ask specific questions to excavate these dimensions; intersectional analysis can reveal structural issues.

Sensitivity to whether and how participants’ race and class might be a factor in shaping their experiences was foregrounded in my analyses. For example, one Aboriginal father spoke about wanting to drink or use drugs to cope with emotional pain resulting from separation; he said he resisted the urge to use these coping strategies to avoid a) going back to jail and b) being prohibited from seeing his child. This story reveals numerous forms of oppression related to class and race: Aboriginals are over-represented in Canada’s prison population (Ball, 2012; Office of the Correctional Investigator, 2012) and in child protection services (Bennett & Sadrehashemi, 2008; Strega et al., 2009, 2012); problematic alcohol and
illicit drug use are higher among Aboriginal peoples as a result of colonization and the loss of culturally unique strategies of ‘coping’ (Ball, 2009, 2012); poverty is also a common denominator for Aboriginal people and for users of illicit drugs (Ball, 2012; Lawrence, 2003). Shame and stigma are intertwined with poverty, race and illicit drug use; these multiple layers of oppression can be disentangled and identified through deconstructing experiences of participants.

Criteria for assessing rigour include: “fit, work, relevance and modifiability” (Charmaz, 2000, p. 511, citing Glaser, 1978, 1992). Summarily, the theory must: a) provide a “useful ordering of the data that explains the studied phenomena” (i.e., offer a conceptual framework based on the data); b) “offer analytic explanations of actual problems and basic processes in the research setting;” c) account for variation and d) be open to refinement as new data or conditions emerge (Charmaz, 2000, p. 11). The present study meets these criteria: I developed a conceptual framework of the mothers’ data and the fathers’ data, and the relationship between these data sets; the processes and problems inherent in this setting are deconstructed and analyzed in detail; variation in respondents’ experiences are explored and explained; the present analysis was continually developed and modified throughout data collection, analysis and construction of theory.

4.1 Sampling

Ten pairs of parents were recruited: ten mothers and their partners, ten fathers (see criteria details below). A purposeful sampling method was used; participants were selected to facilitate in-depth descriptions of their experience (Coyne, 1997; Maxwell, 1996;
Polkinghorne, 2005). This method facilitates inclusion of “participants who suited our purpose of solving the mystery” (Stern & Kerry, 2009, p. 69). In qualitative research, sample selection is guided by the intent of the study (Altheide, 1987; Coyne, 1997; Polkinghorne, 2005). In this study, the intent was to generate theory to inform harm reduction health services for couples using illicit drugs, specifically those who become pregnant.

Service providers from Fir Square and from Sheway referred patients/clients who they felt had experiences that contributed most fully to the data sought. I met with staff from both sites on at least two occasions to describe the experiences and participants sought. These were former patients of Fir Square who had male partners that were in a relationship with mothers during the neonatal and postnatal period, who could best provide data in response to the research question: ‘How are mothers and fathers affected by fathers’ exclusion from addictions maternity services?’ To avoid coercion, service providers referred patients/clients to the research recruitment poster, posted on their respective sites; patients/clients then contacted the researcher directly.

The initial criteria for mothers were that they were former patients of Fir Square; had at least one child at least three months old; had a history of problematic illicit substance use; and were partnered with a father with a current or recent history of problematic illicit drug use at the time of their involvement with Fir Square.

Criteria for fathers were based on those identified by Strega et al. (2009): “birth/biological fathers, stepfathers, and men providing emotional, financial, or social support to a child or children” (p. 73). These criteria were modified to include additional factors relevant to the study, including: biological fathers of at least one child, and/or were
stepfathers; and/or were men providing or willing to provide emotional, financial or social support to the child recently born (i.e., the child with which the mother was pregnant while receiving services at Fir Square); a current or recent (within the last 12 months) self-reported history of problematic illicit drug use; and a current partnership with a patient of Fir Square. Initially, mothers in the study recruited father participants; this was later amended, as explained below. A preliminary analysis of the first six interviews allowed me to refine the criteria for the subsequent fourteen respondents.

4.2 Data collection instruments

Data collection instruments included: 1) the interview protocol for individual interviews with mothers; 2) the interview protocol for individual interviews with fathers; and 3) the interview protocol for the focus group with parents. Individual interviews questions sought to gauge life areas: emotional and mental health; relationships; drug use; and finances, before, during and after involvement with Fir Square. I also asked parents what services they received and how services affected them in these life areas.

The focus group interview protocol was developed from my first analysis of the data from individual interviews. I represented findings in two posters, one from mothers’ data, and one from fathers’ data (see Appendices F and G). I presented these to the group, asking whether the findings reflected what they had said, and for comments. They unanimously confirmed these analyses, indicating theoretical saturation had been achieved (Corbin & Strauss, 2000). I also asked participants specific questions arising from the analysis (see Appendix J), which sought further details of themes that emerged from the data.
4.3 Data collection method

I used two methods of data collection: individual interviews with participants, and a focus group. Individual interviews are key in qualitative research, because allow the researcher to attend to nuances of participants’ experiences. These can include tone of voice; hesitation; emotional expression (e.g. crying); and body cues (e.g. one participant began applying makeup during the interview). The researcher’s ‘read’ of these nuanced forms of expression enhance understanding. I conducted interviews individually, to allow participants freedom to speak without their partner present; in all but one case, this was accomplished. 17

I conducted and recorded all of the interviews and the focus group with parents using a voice recorder. The interviews were all approximately one hour long, yielding a total of around 20 hours of interviews. I also made written notes during the interviews, and completed a face sheet, including demographic information, at the start of each individual interview. On the face sheet I collected information about who the interview was with, when and where it was conducted and for how long, and any “special circumstances or contextual issues” that might have “impacted on the data” (Grbich, 2007, p. 25). I transcribed the first six interviews; the remaining fourteen were transcribed by a professional transcription service.

17 One set of parents could only meet with me at their home; both of them were present, as were the children. Although each parent went into another room for at least part of the interviews, there were times, in both interviews, when the other parent was present. Both parents were also involved in caring for the children throughout both interviews.
I interviewed four parents (two mothers and their partners) in May, and two (one mother and her partner) in June of 2011. I analyzed the first six interviews throughout the transcription process; I also analyzed these data by hand with the transcribed texts, using a block coding method to gain a crude understanding of the emergent themes. I compared these data to each other, and to memos and notes from the interviews.

During this period, I applied to the UBC Board of Ethics to increase the stipend from $10.00 to $25.00, as I felt that the interviews were long and sometimes difficult for participants; $10.00 seemed insufficient. I managed to locate prior participants and provide them the balance of the stipend. Other changes in the Ethics amendment were that a) fathers could contact the researcher directly (though still must be partnered with a former Fir Square patient) and b) the couple’s infant could be less than three months old.

I contacted service providers at both sites regarding these changes and the initial data analysis findings. I was then able to conduct the remaining fourteen interviews in October and November of 2011. The initial analysis of the twenty individual interviews, using Atlas Ti, was completed in February 2012, and the focus group with twelve participants was conducted in March 2012. Of the twenty participants invited, twelve attended the group, six fathers and six mothers.

Some of the interviews were conducted at the office spaces of Vancouver Area Network of Drug Users (VANDU); some at Sheway; and some at parents’ homes. Participants chose the site of the interview. The focus group was held at Sheway. For each interview, and for the focus group, I assessed the participants’ capacity for informed consent. They were informed of confidentiality protocols, and, additionally, for the focus
group, the limits of confidentiality. In several cases, participants wanted their real names used; however I chose to use pseudonyms, to ensure participants would not experience difficulties in the future through identification.

4.4 Data analysis method

All of the analyses were conducted using qualitative analysis software (Atlas Ti). My transcribing afforded an additional analysis of the first six interviews. Initially, I used an open coding method of data analysis to review for repeated themes (Coffey & Atkinson, 1996; Cresswell, 2009). I separated mothers’ and fathers’ interviews for analysis. The ten mothers’ interviews were included in one hermeneutic unit (or project file, containing all quotes, codes, comments and memos) and the fathers’ in another.

I used in vivo codes, that is, code names drawn from the participants’ words, and developed a coding matrix for each project file. The coding matrix is used to define codes. In the initial coding, I searched for repetitive words and aspects of experience, and grouped these together under one code. I created new codes for any dimension of experience that did not fit into existing defined codes. Towards the end of the analysis, I merged some codes together, as they fit well into larger codes and did not stand alone. Some of the in vivo codes were re-named to better capture the code definition.

For each data set, or project file, I used Atlas Ti to produce a ‘network’ view; this visual method facilitates conceptualization of relations between codes (see Appendices C and D). This allowed me to begin to visually determine the relationships between codes, grouping codes together as multiple aspects of a particular dimension. For instance, in the
second, line-by-line analysis, the dimension ‘relationships,’ for the set of father interviews, subsumed codes including 1) relationship with mothers; 2) relationships with children; 3) fathers on pregnancy and 4) birth as motivation to change.

I developed questions for the focus group based on my analysis of the interview data. I had the focus group transcribed and analyzed these data in a separate project file using Atlas Ti. The focus group analysis confirmed findings from the two analyses of the individual interviews, indicating theoretical saturation.

Following the focus group analysis, I chose to re-analyse the data obtained from the twenty hour-long individual interviews using a line-by-line method. My intention was to scrutinize the data again to capture anything that may have been missed in the initial open coding analysis. This detailed analysis revealed nuances previously undetected, and allowed comparison of the two analyses. The second, line-by-line coding yielded critical new codes, such as, in mothers’ analysis, poverty and resistance.

Memos were written throughout the analyses, part of the constant comparative method integral to grounded theory (Charmaz, 2000). In these memos I linked emerging codes to my own experience, to the sensitizing concepts described above, and to the theoretical framework with which I approached the study. Memos were also helpful in constructing conceptual analyses (Charmaz, 2003), and were sorted by participant interview, to determine what themes were prominent with different participants. I sorted memos for all father and for all mothers separately for review, to ascertain new themes or to elucidate existing themes. As a sensitizing tool, memos served to highlight relationships between
themes in the data and larger concepts, e.g. forms of resistance within institutional constraints.

Other means of constant comparison I used included: comparing data with codes/categories; comparing data against each other (e.g. comparing focus group data with interview data; comparing mothers’ data with fathers’ data; comparing data from participants with different cultural backgrounds; comparing the first data analysis with the second, line by line analysis); and comparing data with my own experience as a former drug user, as a mother, as the former social worker on this harm reduction unit (Charmaz, 2003; Grbich, 2007).

Applying the intersectional analysis described by Cuadraz and Uttal (1999), I reviewed the codes for each participant to find out how their individual experiences, their ‘biographies’ were shaped by their personal and social history. I could relate numerous biographical accounts to historical events, e.g. violence in childhood to colonialism/poverty in Canada. Other biographical accounts were linked to hegemonic masculinity: e.g. oppression of emotional expression in childhood for boys and aggressive behaviour. This analytic method led to increased conceptual clarity; for instance, a labyrinth of commonalities between mothers and fathers that shared the same race and class.

Member checks of individual interviews were done collectively, through presentation of these findings, in lay language, to participants in the parents’ focus group, as explained above. Peer review of the all of the data was conducted with my advisor; with colleagues having knowledge of the subject; and with members of my doctoral committee.
5 Results: Fathers

In this chapter I recount fathers’ experiences and the themes reflected in the fathers’ data. Six fathers identified as Aboriginal, three identified as White and one identified as Black. They were all Canadian, living on the West Coast. Eight of the ten were on social assistance. They ranged in age from 28 to 44 and had been with their current partners from 2-14 years. The range of years of illicit drug use, for this group of fathers, was 8-30 years. Eight of the fathers had biological children placed in kinship care; only three of the fathers had children living with them/were actively parenting. (See Appendix B)

5.1 Identity and Location: “Where I grew up”

5.1.1 “Bikers and hookers”

This code emerged from all references fathers made to the physical and/or emotional environment in which they grew up. Some fathers described environments characterized by neglect, alcoholism and addiction, and violence. Two of the Aboriginal participants were brothers (Richard and Andrew), and described very similar histories. Other Aboriginal fathers’ stories also reflected significant and severe violence and abandonment: “he would get mad, he would bash your head on the side of the door. I’d have goose bumps and all that, black eyes, fat lips...he was never around when we needed him (Michael).” Violence included intense traumas in addition to daily chaotic acts of violence: “I watched him kill himself in front of me when I was 8 or 9...I had a very violent home (Justin).” This familial milieu of violence experienced by fathers early in life has been
disappeared by both child welfare and addictions services in their response to drug-using fathers; while mothers’ experiences of trauma have, within the last 10-15 years, been recognized, fathers’ experiences remain invisible, with notable exceptions (e.g. Ball, 2009; Ball & Daly, 2012; Najavits, 2009; Libby et al., 2008).

Fathers described not wanting their children to witness and experience these conditions, including “drinking in front of them and spending all the money on booze (Michael).” They also described a lack of fathering as a deficit in their own knowledge and ability to parent: “to have somebody explain that to me a little bit younger in my life would have been great” (Clark). Ball’s (2009) work is illustrative of the ways that colonialism has shaped life for Aboriginal fathers; within the context of Canada’s residential schools, and other forms of cultural genocide, fathers have been bereft of parenting knowledge and experiences. These intersections of class, race and gender are pivotal in framing fathers’ experiences and behaviours; lacking the monetary and other forms of power that hegemonic masculinity confers on men in the abstract sense, First Nations fathers find themselves transfixed between gender expectations and the reality of scarce emotional and financial resources. A similar situation exists for Black fathers in the U.S. (Hill & Sprague, 1999).

One of the Aboriginal fathers described how his mom had been in a coma for 9 weeks after having been hit by a car. He described a house full of drug use and drinking, with “bikers and hookers (Joseph).” He and his sister were both introduced to crack cocaine and IV drug use in the home with and by their father: “there was no boundaries (Joseph).” Joseph reports having a 7-gram a day habit of cocaine use at 13 years old. He reported experiencing 27 different foster homes in 3 and ½ years, having attempted suicide four
times, as a youth in state care. While this may seem extreme, it is actually somewhat typical of these fathers’ experiences.

5.1.2 Fathers’ natural supports

Two of the participants, Aboriginal brothers, grew up in the Downtown Eastside of Vancouver, BC, identified as a neighbourhood characterized by poverty (Culhane, 2003). They were fathers of infants born nine days apart at Fir Square. One of the brothers reported being the “third generation of [his] family living at the Regent\textsuperscript{18} (Andrew).” His brother confirmed this. The brothers were raised in an atmosphere of poverty, abuse, neglect and alcoholism. One of them, Andrew, supported himself with traditional Native carving, an art he learned from his grandfather. Yet family members could not or would not provide financial or emotional support to these brothers.

Some fathers reported loss of family support due to illicit drug use, despite having been raised with alcohol and drugs. Some described friends as family, with the caveat that these friends were not a substantive resource: “none of them could help...[but] they let me vent (Omar).” Fathers said it “boiled down to, just like it does for everybody, I had to do it myself (Omar).” Omar was not the only father to reference individualism as a guiding premise; yet fathers spoke of how debilitating this was for them (see, for example, Wayne’s comments in ‘Fathers’ self-reflection’). Ball and Daly (2012) discuss fathers’ “apparent tendency toward individualism compared to women’s more collectivist or communal tendencies (Kaufman, 1993)” (p. 13) (italics mine), yet the fathers in this study contested this

\textsuperscript{18} The Regent Hotel is in Vancouver’s Downtown Eastside
assertion. They clearly valued relationships above almost anything else, and reference strong emotions about being excluded from family and community. This ‘apparent’ tendency may also stem from neoliberal Western ideals that place men, within a hegemonic framework, squarely in the seat of individualism.

Aboriginal participants reported numerous extended family members, some of whom they had not even met (Michael). Some had families spread throughout the province, and described a pattern of both urban and reserve living. Aboriginal fathers also described significant losses by death; one young father (age 32 at time of interview) spoke of having lost a cousin; his mother; and his younger brother before he was 30 years old.

These experiences speak to the impact of colonialism and histories of trauma carried by fathers. Alexander’s (2008) theory, which links problematic drug use to dislocation, resonates throughout these histories. Within these life contexts, gender pales as an intersectional axis; race and class are foregrounded as contextual issues. Poverty, loss, homelessness, distance, community and cultural breakdown: the cumulative impact of these forms of ‘dislocation’ constitutes a structurally imposed trauma.

5.1.3 Fathers’ values

Fathers’ articulations of values can be interpreted as a response to their social location; fathers contested perceived assumptions that they were depraved, or unfit. Richard described maintaining sobriety throughout his partner’s pregnancy: “I had to keep a clear head on my shoulders for me to cope with [her] and her mind.” He placed the needs of his child and partner first following the couple’s separation. His words reflected empathy; “I
thought about that (couples fighting over a child, without regard for the child’s needs) and I thought well I still want to be with Amy, just give her her space, right, and if it doesn’t work out then still, at least I still get to see my son, and we’re friends.”

Richard also reflected values relating to integrity in relation to self, and self-esteem, suggesting an internal, rather than external, locus of control: “it doesn’t matter what people think of me, it matters what I think about myself and I want to be a good father for my son.’ The statement also appears to express resistance to popular stereotypes of drug-using fathers, and an awareness of how he, as a poor, Aboriginal father, might be viewed by society.

Two of the fathers (Omar and Clark) expressed a view that their exclusion from services was not personal: “nurses are there primarily for the baby, secondarily for the mother, and being a man and being a father is about leadership to a point, and holding that family together (Clark).” While this quote suggests normative, gender-specific values relating to fathers’ role of ‘leadership,’ it also speaks to a collective ethic.

Clark internalized hegemonic masculinity (Connell, 2005); he explained his understanding of men’s role as leader: “The mother and the child, as a leader you put the people... they’re not less than you, but the people who are relying on you, you put them first.” Clark also discussed his views of responsibility: “All I can control or want to or know how to control is me and my behaviour and my actions, and that’s ultimately what I am responsible for. I’m not responsible for anybody else's actions or attitudes or behaviours, whether they're towards me as being a father or not.” Clark reported that his father is now
abstinent and involved in a twelve-step program; interestingly, this value embodies a

twelve-step notion of ‘powerlessness.’

Fathers in the study did not think that being under the influence of drugs in a
children’s hospital was acceptable:

So if somebody's using and they're coming to the hospital high and that's... and it's
noticeable, and you're acting like an idiot, then you don't need to be there... If you're
not respecting that, then you don't have a place there, because in my opinion, it's
something very sacred. It's something very beautiful, and it's something to be
cherished and loved and that doesn't need to be a part of it at all. (Clark).

Darren also described not immediately attending at the hospital following the birth as he did
not want to be present on the unit until he was ‘clean’ for a couple of days, and presentable.

This is interesting because this is a harm reduction unit; mothers’ chronic
intermittent use of illicit drugs is accepted and expected. For fathers, access to licit drugs,
such as the methadone mothers may receive on the unit, was more difficult, and expensive,
as fathers had to pay a dispensing fee to get methadone in the community. Mothers were
welcome at Fir Square whether under the influence of illicit drugs or not; not the case for
fathers.

These comments also demonstrate fathers’ internalization of the phenomenon to
which Foucault (1980) refers; the production of a ‘healthy population.’ The ‘surveillance’ of
health services, child welfare and other state apparatuses is aimed at those using illicit
substances. These two fathers, and others in the study, delineate a marker dividing illicit
drug use and birth/pregnancy; to them, these activities are morally incompatible. In this
way, fathers illustrated Fanon’s (1963) depiction of the ways that capitalist society works to foster a “mood of submission and inhibition” (p. 4). Were these fathers White, privileged and using licit drugs, would their observations be the same?

Darren’s values in respect to family and parenting fell within the scope of the world he occupied: the street, using illicit drugs, and drug dealing. He expressed an obligation to make every effort to provide for both mother and child to ensure his partner did not have to ‘work the street’ (i.e., prostitute). These values evince normative concepts of masculinity, specifically the ‘breadwinner’ phenomenon that Connell (2005) exposes as a “recent creation...produced in Britain around the middle of the nineteenth century” (p. 28). As fathers that fall into Connell’s ‘marginalized’ group, these study participants are far from being able to ‘provide,’ creating distance between their reality and expectations.

When Darren’s partner was pregnant, and left Fir Square to come back to the street to find him, he would return her to the hospital. He prioritized her health during pregnancy. Darren described their economic relationship as a mutually supportive one in which they shared everything ‘50/50;’ except that he would not accept a share of the food provided for her at the hospital, because she was pregnant.

Joseph and his partner have four children, 3 of whom are permanently adopted, following state removal, and the youngest is with his partner. Joseph spoke about what life “is about” for him:

It's not all about being rich and being... It's about being safe and being together and enjoying each other's company, and... you know, watching your kids grow up, or
watching him ride his first bike, or... It's the little things in life that are far more important today than anything. (Joseph)

Contesting values associated with hegemonic masculinity, Joseph valued relationships over success or money, collectivism over individualism. Yet at the time of the interview, Joseph did not have contact with his wife; she was in women-only housing, with the baby, and Joseph had again relapsed. Sadly, Joseph’s values were not reflected in his actual situation; he has not been able to parent any of his children. Part of this may be due to father exclusion from services.

Contrary to addictions theory that developed in response to a need to highlight women’s treatment issues as gender-specific and unique (e.g. Covington, 1998; Finkelstein, 1994), fathers in this study identify relationships and connections as priority. Although cognitive approaches have been recommended for men to address emotional illiteracy, I concur with Featherstone et al. (2007) that these may not be effective across class and race. Klee’s (2002) study with drug-using mothers reveals the importance of working with women’s natural supports, including male partners. Klee (2002) found that the “lack of a partner was significantly associated with the most damaging behaviour of all, that of continuing injecting” (p. 96).

Andrew valued carving as a traditional Native art form, and spoke about having learned this art form from his grandfather. He prided himself on being financially independent through his carving, describing himself as a “full time artist.” He said the hospital staff finally got to know him and recognize that he was making an “honest living” and was not a drug dealer; in fact he reported selling carvings to service providers.
Andrew’s positioning the sale of illicit drugs as a ‘dishonest’ way of making a living invites a re-framing; the only difference between the sale of illicit and licit drugs is legal status of the drugs. Heroin is a narcotic available in many legal forms; the sale of such drugs as hydro morphine and oxycodone is legal and those pharmaceutical companies, physicians and pharmacists involved in their sale are viewed as making an ‘honest’ living. In fact, sales of pharmaceutical are increasing rapidly: “In 2002, there were 9500 prescription drugs on the market compared with 300 in 1965” (Boyd, 2004). Andrew has developed a strategy of locating himself as a ‘moral’ person in the context of drug prohibition, through the sale of carvings.

Andrew supplemented the scant social assistance funds allotted to his partner and to himself through his carving. He was able to buy her the foods she needed during her pregnancy. Once the baby was born, Andrew said, he shifted his financial priority from his partner to his daughter, so she could have the “nice, new clothes” he never had as a child. This reference to the poverty of his early life reveals another strategy Andrew adopts to inch closer to the masculine ideal entrenched in neoliberal values: “All their projects are shaped by the fact of class deprivation” (Connell, 2005, p. 114).

5.1.4 Fathers’ self-reflection

Fathers reflected throughout the interviews on their strengths and their shortcomings with a remarkable honesty. Omar talked about being ‘top of his class,’ and in the next breath described his past behaviour as “selfish:” “at that time...I want[ed] to be a child, I’m just going to do whatever the hell I want and fuck anybody that is affected by it.”
He admitted to not “being sane most of the time” and to a history of aggressive and violent behaviour. Omar frames his history of violent, aggressive behaviour as resulting from a lack of emotional literacy: he described “putting walls up and having to “shut down any emotion [he] had.” Featherstone et al. (2007) frame this emotional dynamic as a capitalist survival skill for men in noting that “if man is to succeed in hegemonic gender terms, he not only needs to develop a limited emotional range but also a distance from the emotions of others” (p. 136).

Darren demonstrated insight into the needs met by using and dealing drugs: “it’s a big power trip, right? It’s a way of being in control of yourself...even though you’re in no control whatsoever, you seem like you’re in control.” Perhaps his sense of powerlessness as an Aboriginal man, without access to other economic resources, led him to find a sense of personal power elsewhere. As Connell (2005) explains, in reference to men’s development of ‘protest’ masculinity, “they have constructed gender from a starting point in poverty, and with little access to cultural or economic resources” (Connell, 2005, p. 115). Lacking resources with which to fulfill ideals of hegemonic masculinity, marginalized fathers such as Darren attempt to achieve these ideals through unconventional, proscribed means, such as selling illicit drugs. In this activity Darren feels “in control” and finds “power.”

Fathers actively contested gender myths, detailing the work of masking emotional pain and chaos:

We try to stay strong because we're the strong ones... portray we're the strong. But mentally, we're not. You'll see on the outside, physically, yeah, we're strong. We
show no emotions, but mentally, we're going crazy inside. I was going crazy inside.

(William)

This young Black father displayed remarkable insight into the relational needs of men; he also described the challenges for men in asking for help: “We’d rather suffer, be on our deathbed before we can say “Can you guys help us?”” (William). Internalized gender norms work to perpetuate problematic drug use by prohibiting fathers from asking for help. Wayne recommended fathers’ groups on the ward: fathers in a similar situation, helping each other.

As Hare-Mustin (1998) discusses, the individualistic focus of most psychotherapy indicates, peer support might be more useful for fathers to shift into developing relational capacities.

Justin provides further evidence of the importance of emotional connections for fathers. He described being “frozen” and “distant” prior to entering into a relationship with his partner. He attributed his shift out of a “gang mentality” to his relationship with his partner, describing her as the ‘best thing that has ever happened’ to him: “I think [she] taught me how to be loving. I was always probably loving, I just didn't know about it. I didn’t trust to show that side.” This quote exemplifies Connell’s (2005) observation that “men’s relational interests in the welfare of women and girls can displace the same men’s gender-specific interests in supremacy” (p. 242). Entering into a relationship where trust was established displaced the ‘gang mentality,’ a form of hegemonic masculinity.

5.1.5 Fathers’ drug use

The history of illicit drug use for these fathers was fairly extensive. The links between trauma and problematic drug use (Najavits, Weiss & Shaw, 1997), and the context of fathers’
early exposure to violence and other trauma, point to fathers’ heavy use of illicit drugs as a coping mechanism. In this study, fathers were motivated by the possibility of relationship and connection to stop using when their partners became pregnant.

Some fathers also reported efforts to support or encourage their partner to stop using through the pregnancy; in some cases they reflected strong values in this regard, similar to other fathers in this situation (Klee, 2002). Klee’s (2002) study describes the significant role male partners play in mothers’ lives, pre- and post-natally: “An agreement to modify drug use with a supportive partner is perhaps the most effective form of influence and a partner’s continued use the most damaging” (p. 97). Fathers also spoke of relapsing to alcohol and/or drug use when faced with exclusion from their relationship; from services; and/or from their child.

Darren voiced concern that if his partner went to a residential addiction treatment centre in northern British Columbia, with the baby, he would be left behind, feeling excluded and alone. He reported being “well known” in the Downtown Eastside, an area characterized by a high level of open, active, illicit drug use, and anticipated difficulty in resisting established patterns:

Because I'm kind of worried that if [my partner] goes to her treatment centre, which is in [a small city in northern British Columbia, over 800 kilometres from Vancouver], she goes with the baby and stuff, then I'm just going to be kind of back in the same thing, right, I'm pretty well known outside. It's not hard for me to go and just kind of hook myself up with whatever I need to do, and I'm really thinking of ways to avoid that whole… that whole getting drawn back in, right? (Darren)
The impact of exclusion is multi-dimensional; fathers used drugs to cope with lack of services; and with feelings resulting from exclusion from mothers’ services.

For Joseph, it took significant effort to develop non-harmful coping skills when faced with a barrage of overwhelming feelings of loss, shame and low self-worth, yet he cites the well-being of his partner and baby as motivation: “I have to work on those so I don’t take it out on her, so I don’t jeopardize where she's at, so I don't cause more harm than I do. Because ultimately I’m really happy for her and the baby, and that's the bottom line” (Joseph).

Joseph illustrated how problematic drug use was a response to emotional pain and low self worth: “It [his past] still affects me, and I'm not allowing it to today to the point where I have to go hurt myself or self-judge myself or tell myself how I deserve to be down on Hastings sucking on a crack pipe because I'm worthless.” While I concur with Featherstone et al.’s (2007) theory that emotional illiteracy is foundational to some of men’s difficulties in relationships, more is required than teaching men about “feelings and language” (p. 69). Given Joseph’s traumatic history of multiple (27) foster placements in 3 ½ years, and four suicide attempts prior to the age of nineteen, addressing emotional illiteracy falls short. Najavits et al.’s (2009) Seeking Safety model offers a more comprehensive program aimed at addressing trauma and post-traumatic stress. All of the father participants referred to histories of trauma; certainly men involved in illicit drug use encounter numerous traumatic incidents related to drug prohibition, such as police brutality; gang-related violence; prison.
5.1.6 Poverty/class

When mothers became pregnant, they were living, with their partners, in poverty and homelessness. The depth of this poverty permeated their situation: “We have no money. We're in the same boat. We're together. We're both homeless” (William). The total monthly income assistance rate for single, ‘employable’ persons in British Columbia is $610.00.\(^\text{19}\) If couples live together, the total they receive (if classified ‘employable’) is $877.22. This constitutes another example of the state’s division of families, discussed above; given these figures, couples’ strategy to present as ‘singles’ and maintain separate addresses is a pragmatic form of resistance.

For most of these fathers, poverty was generational; as the two Aboriginal brothers in the study reported, their parents had lived in the city’s poorest neighbourhoods, in ‘ghetto’ hotels, before them; impoverishment continues. Once their partners were at Fir Square, poverty interrupted fathers’ relationships with them; they could not stay overnight prior to the baby’s birth, and could not afford to come and go, without some effort and risk: “I’d jump on the Skytrain\(^\text{20}\), if the guards caught me I’d just explain my situation...give me a ticket, I don’t care, it’s more important to me than the ticket” (Richard). Pregnant mothers using drugs, upon admission to Fir Square, acquire a place to sleep; food; counselling; and referrals for housing; fathers do not. In the case of most of these ten fathers, their

\(^{19}\) [http://www.eia.gov.bc.ca/mhr/ia.htm](http://www.eia.gov.bc.ca/mhr/ia.htm)

\(^{20}\) Part of British Columbia’s transit line; currently $2.75 for a 90 minute fare
situations worsened; not only were none of their needs met within the context of Fir Square, they also lost the comfort of proximity to a loving partner.

Mothers’ exits from conditions of poverty, homelessness, lack of food and medical care, were facilitated by their pregnancies: “it’s easier for her to get housing because she has a child, it was all set up for her before she got out of the hospital” (Richard). But for fathers it was difficult to facilitate this exit: “for $375.00 that welfare was giving me [the shelter portion of the $610], there was no way in hell I was going to find a place that was big enough for three people” (Omar). Fathers could not compete with what the ‘system’ could offer single mothers; another example of what Featherstone et al. (2007) refers to as the ‘masculine deficit,’ described as:

[T]he idea that men in a socially marginal position...cannot fulfil the masculine dominance they have grown up to expect, because of the structural limitations imposed by their marginal social status, and this deficit will often lead to some kind of damaging behaviour – perhaps violence or other offending” (p. 25).

Omar’s history of aggressive behaviour makes sense within the context of a ‘masculine deficit’ model. Omar is a White man who describes a childhood in which he wasn’t ‘allowed’ to be a child, suggesting unreasonably high parental expectations, and the makings of emotional illiteracy. Unable to accomplish expectations of hegemonic masculinity, Omar’s frustration and anxiety became overwhelming, leading to problematic drug use.

Fathers’ lack of resources impeded prospects of parenting, on multiple levels. Scarce resources presented an obstacle to parenting that Omar addressed alone, through persistent efforts. Omar professed not knowing where to start: “I mean if there would have
been a worker I could have, somebody I could have talked to that would have helped me...I mean you forget those kind of skills, like housing searching and stuff. I don't know where to look. (Omar)

One Aboriginal father investigated possibilities of entering family treatment with his partner and baby; poverty was again an obstacle: “We've thought of that, the one on the island, but it's kind of messed up. It's like you've got to have 150 bucks every week to get your food, and if you run out of food, then you're kicked out” (Michael). One couple lived apart for financial reasons: “We'd rather not be a couple in the eyes of the Ministry or anything like that. We'd just rather have our own separate lives, our own separate finances, and just kind of help each other out” (Darren). This father approached financial assistance workers to try to get money for bus fare to the hospital, and a little food money, and was challenged by the worker:

And they were like, "Well, you guys aren't a couple but you're having a baby," and they were trying to lead us into these kind of conversations where I'm admitting that we're together and then they're going to try and... right? But... in their eyes, we're... I had to straighten them out in saying we're not together, it's just what happened and I'm going to be there for my child, so... You know, it's just... We had to deal with it that way, right? (Darren)

British Columbia’s social assistance rates divide families, as discussed above, resulting in aborted relationships or in partners maintaining deception about the relationship.
Another class issue emerging for residents of the Downtown Eastside was gentrification. One father explained his personal experience of this in relation to his housing:

And you know what? It's just got bought by some Chinese billionaire rich guy, and they're renovating every single place in that whole...they're going to raise our rent. I've heard they're going to give us a thousand bucks each to move out. They've already put in... They fired the manager, put in cameras. The whole front entrance is gone. They're making a high-end restaurant in the basement of it. It's all changed. They want to make it into a nice place for students, or... and stuff, right? (Darren)

This father will be displaced as a result of increasing gentrification of the DTES (Roberston, 2007; Bungay et al., 2010) and will again be forced to search for affordable accommodation. Without a credit rating, employment skills or education, his options are limited, curtailing his access to active fatherhood.

Robertson (2007), in her study with marginalized women living in the DTES, comments about the forces that shape their lives in negotiating spaces of ‘home:’

Colonialism and neo-liberal policies circumscribe spaces and delineate populations through the assertion of fiercely exclusionary and largely hegemonic ideologies. Meagre (and decreasing) social assistance rates force women into contested spaces like the DTES, where they negotiate gendered and racialized terrains and where they face the many-sided trials of taming space. (p.545)

While her study was with HIV positive women, the fathers in this study, living in the Downtown Eastside, face similar processes of negotiation; Darren described his challenges in
negotiating “gendered and racialized terrains” in the Downtown Eastside: for instance, his reluctance to remain downtown, without his family, given the difficulty he would have resisting taking up trafficking and using drugs, to manage his pain and to supplement his meager income. Class and gender shapes Darren’s experience also: as an Aboriginal man, living in this area, racial profiling has doubtlessly placed Darren ‘at risk’ for police involvement and violence.

5.2 Fathers’ relationships: “I experienced all that”

As a marginalized and excluded group, fathers show us that their early relationships were fractured and difficult; their relationships with children were fragile, hard-won or non-existent; their relationships with partners were life changing, and the most important part of their lives. Their relationship with self appears salient in their lives. Fathers also spoke of losses they incurred in relationships, and how they struggled to manage emotional pain.

Poverty, class and the configuration of addictions services combined to impact fathers’ relationships with mothers and children. The use of illicit drugs forms part of the complexity of divisive elements that fracture relationships between fathers, mothers and children. Fathers’ relationships with partners, the pregnancy and birth, and with children emerged in five categories: 1) “She opened my eyes” 2) “I had to switch everything;” and 3) “A turning point in a man’s life;” 4) “I got to hold his hand” and 5) “I got to hold his hand.” These five sub-themes revealed the importance to fathers of relationships with family, and ways they were affected by segregation from partners and children.
5.2.1 “She opened my eyes:” Fathers’ relationships with mothers

Fathers described the positive effects of their relationships with partners, and the struggles that ensued, most of which were related to poverty and illicit drug use. Fathers endeavored to support and protect mothers, and to effect personal changes to accommodate and respect these relationships. In cases where mothers ended the relationship, fathers were deeply affected. In other cases, the relationship transitioned into co-parenting and/or friendship. When partner relationships ended, fathers’ relationships to their children were also negatively affected. Fathers reported encouraging mothers to attend harm reduction and health services, even if this meant their own exclusion.

All of the fathers expressed the positive impact of their relationships with partners: “she’s the one that told me keep a clear head on my shoulders...opened my eyes to have faith (Richard).” As observed by others, relationships with partners and children emerged in this study as tremendously valued by fathers (Chodorow, 1978; Doucet, 2006; Featherstone et al., 2007; Klee, 2002). Fathers’ actions demonstrated a deep commitment to their relationships with partners.

Lacking guidance about relationships and access to services with their partners, fathers were left to their own devices: “Sure I had a violent past life but I’m getting over it now, just learning how to be more patient and kind, just from reading psychology books and parenting books and stuff like that (Richard).” Ball (2009) and others have documented fathers’ lack of learned relational skills (Ball, 2009; Ball & Daly, 2012; Doucet, 2006; Featherstone et al, 2007). This gap in knowledge is intrinsic to the reified gender framework that hampers development for both sexes. Norms of masculinity prohibit the relational
capacities of men; these norms form part of the backbone of Western capitalism in which individualism prevails (Connell, 2005). Racism and classism also shore up this framework for Aboriginal fathers, as colonialism and concomitant poverty have left Aboriginal fathers in a relational vacuum (Ball, 2009).

In spite of Richard’s efforts, once his partner had the baby, and was engaged in services, things began to change. His partner began to drift away, initiating a separation: “it drove her away from me, like after she had the kid she told me she didn’t want to be together anymore, she didn’t know what she wanted, it was a big life change for her” (Richard).

As Simmons and McMahon (2012) report in their recent qualitative study with 25 drug-using couples, one partner entering treatment without the other can affect the partner “left behind” in a “dramatic way, positively or negatively” (p. 247). Richard demonstrated resilience and commitment in his response to the separation. Although he initially “fell back to drinking” he was able to give his partner “her space” and continue access to his son as long as he stayed sober. After his brief relapse, Richard realized if he did not ‘sober up,’ he would lose his relationship with his son, so re-committed to abstinence.

Richard’s loss is positioned within the context of his exclusion from services and his partner’s inclusion. With services aimed solely at mothers, fathers’ opportunities to shift their lives away from problematic drug use, towards family and child care, are curtailed: “Fathers need to be engaged with meaningfully; few will engage themselves in classes that appear to be aimed at women” (Daniel & Taylor, 2001, p. 142). This leaves fathers “in the dust” (Ann).
Another father described his partner as his “best friend” and as someone he would “do anything for” (Michael). The strength and intimacy of these relationships supports other findings of qualitative studies with partnered illicit drug users (Rhodes & Quirk, 1998; Simmons & McMahon, 2012; Simmons & Singer, 2006). This couple describes a system of mutual support, with a lengthy (8 year) history of helping each other. This unconditional mutual aid manifested in all of the study participants’ relationships with their partners. The details of what this mutual aid looks like differed, but dynamics were similar: “Half of anything we had, we’d just give it to each other, right? Regardless of whether it was $100 or $50, it didn't matter. It was just... Half of anything we had, even right down to our food, and that’s just the way we are” (Darren). Rhodes and Quirk (1998) report a similar system of mutual aid between drug users. This form of economic interdependence is useful and respectful; it contests Bourgois, Lettierie & Quesada’s (1997) naming of the culture of the “homeless dope fiend” as a “social universe of mutual betrayal and auto-destruction” (p. 161). Or perhaps these relationships strengthened as a result of the context of illicit drug use and street life.

In the beginning of their relationship, Darren reports, he “never showed her the respect...I wouldn’t give anybody money to wake up in the morning to get high because, well, I can take care of my own self. Nobody takes care of me, right?” (Darren). Darren’s assertion that ‘nobody takes care’ of him, viewed in the context of poverty, neoliberalism, illicit drug use, colonialism and dislocation, facilitates a deeper understanding of how these relationships develop. Context is requisite in pre-empting a pathologizing view of Darren and his relationship; an individualistic, survival-based orientation makes sense in this
Justin describes a similar dynamic in this relationship: “Distant, really distant. We had to be distant for the stuff we had to do in our addiction. We fought lots - every day at that time.” This relationship also shifted over time: “we’re really close to each other and we tend to lean on one another. I’m more trusting than her, I think. So it’s hard for her to be without me in a place where she doesn’t know anybody. I keep her safe, basically. I’m part of her security.”(Justin) Forging trust is a challenge in the context of illicit drug use and structural inequities, yet once accomplished it is deep and vital to both persons.

Service providers frequently construct this form of trust and mutual aid as ‘co-dependency,’ a tendency rooted in the proliferation of resources, services and the self-help literature aimed at constructing relationship dynamics as pathological (Gemin, 1997; Simmons & Singer, 2006). As Gemin (1997) discusses, the discourse of co-dependency is marked by “themes of division, exclusion, and separation...separated from any outside, relational context” (p. 258). Further, researchers have not, with the exception of a very few studies, utilized couples as a “unit of analysis,” making claims of co-dependency among drug-using couples unfounded (Simmons & Singer, 2006).

Aspects of the co-dependency discourse, e.g. ‘boundary-setting’ in personal relationships, produce a form of interpersonal spatial exclusion, discouraging mutual aid and imputing a diseased identity to subjects. This discourse augments a neoliberal climate focused on individualism, rather than collectivism. As these relationships illustrate, collectivism is more conducive to relationship and individual well-being.

Once mothers are involved in harm reduction services, influenced by a therapeutic
discourse, separation begins, at times resulting in mothers excluding fathers from contact with children. Yet these fathers persisted in demonstrating unconditional support: “I'm kind of choked, but as long as my daughter and [partner] are okay, that’s all I care about. I just want them to be okay” (Michael). Maternal gatekeeping is an intrinsic structural component of these services; it is part of Sheway’s policy, because their clients are women. In terms of women-only housing, fathers are restricted to visiting hours and mothers are responsible for the behaviour of their guests.

5.2.2 “I had to switch everything:” Fathers’ on pregnancy

Fathers were protective of mothers during their pregnancy: “It was stressful. I was mental because she's never... I mean, I'd go see where she's gone and looking all over the place for her, you know?” (William). Most of the fathers focussed on achieving and maintaining abstinence from illicit drugs once they found out about the pregnancy; one father reduced his drug use from $500 to $20 per day. Fathers made efforts towards success in retaining custody of children: “then she got pregnant, then, a lot of work it’s been to smarten up. I had to switch everything” (Richard). ‘Switching everything’ meant not using alcohol or illicit drugs, and learning healthier communication styles, by reading “psychology” and “parenting” books (cited above).

Fathers also persuaded mothers to become abstinent and use health services, even if these excluded fathers. At times fathers portrayed a judgmental stance: “What got her the

21 Crabtree housing, funded by the YWCA is a housing resource for women and children who are Sheway and/or Fir Square clients. It is located on the Sheway site, in Vancouver’s Downtown Eastside.
most was when I told her you know what? You're not harming yourself, you're harming the kid more than you're harming yourself, you got so many weeks to choose to abort the kid or else you gotta quit cranking, can’t bring a kid into this world, like the way you are” (Richard). Klee (2002) found that “many partners were keen to help to limit the woman’s drug consumption, but some women were strongly independent” (p. 97). Mothers’ resistance to fathers’ efforts did not arise in this study; rather their focus was struggling with the choice between services and fathers.

5.2.3 “A turning point in a man’s life:” Birth as motivation to change

Like mothers, fathers experienced pregnancy as a powerful opportunity to change: “Yeah, it's a turning point in a man's life, for sure. Having a baby made me really want to change, like really have that chance to have a fresh start with another fresh beginning, right?” (Joseph). The event of the birth was moving: “And then as soon as she laid down on a bed, she was like, "She's coming!" So I put my hand there and baby's head fell into my hand... it's like I delivered my daughter...just so beautiful (Michael).

Joseph had been in a support recovery house for 7 months, and ‘slipped’ just prior to the birth. He was honest about his brief using slip with his partner and at his recovery house. Although he was able to remain at the recovery house, he was prohibited from attending the birth: “I told the social worker - and this is after seven months of being clean - and she red flagged me at Sheway...or at Fir Square, from the hospital. I wasn't even allowed to attend” (Joseph). Joseph was intensely disappointed about exclusion from his son’s birth, particularly given his efforts and honesty in revealing a ‘slip.’
Omar was prompted to examine his behaviours in light of his new role as father, and committed to making changes for his son:

And then I looked at myself again and I was like, "What else is in there that's not good? What do you not want to see in your son? Anger, violence, drugs, abuse of people, like just taking people for granted, taking advantage of people, stealing, lying." All that stuff was all stuff one thing at a time I looked at and went, "This is not acceptable. This has got to go." (Omar)

It may be that “not all fathers experience the birth or adoption of their child as a seminal moment when they don the mantle of fatherhood,” (Ball & Daly, 2012, p. 5), yet for the fathers in this study, birth was pivotal. Their inclusion or exclusion from antenatal, natal and postnatal events and services is a powerful factor that impacts potential for recovery from problematic drug use.

5.2.4 “I got to hold his hand:” Fathers’ relationships with children

Fathers expressed joy in respect to relationships with children and anguish when maternal gatekeeping and structural obstacles, which led to coping through problematic drug use, disrupt these relationships. One father found himself parenting alone when his partner left the home. He was left with few resources, and recounted his challenges:

I thought I could do it. I was doing a good job too but then it just got hard. I broke down and I basically ended up calling the Ministry [child protection services] on myself and saying, "Listen, I can’t handle this. I need someone to come get my son. That was the hardest thing for me to do. (William)
William reported impediments to parenting in the form of poverty and lack of services. He said drug testing was provided by state child welfare social workers, which helped him abstain from drug use. William related a love of parenting:

> I was there for his first footsteps, took him to his park first time. So I've seen all the experience of tasting dirt, throwing rocks, standing in dirt, playing with sand through his fingers, just like, "Wow, what's this?" All the different expressions he's making of the tasting of dirt, sand, just... He's stepping on uneven ground, like grass and he's just like [sounds like shuffling] on his feet, eh? And he wants to touch everything, everything. Everything he has to feel. So yeah, for the first time I experienced all that. I got to hold his hand and walk to the park. (William)

Despite obstacles fathers have maintained relationship with children: “he’s so happy to see me, every 3 days, if I don’t see him, him and I get moody, he gets moody with her and I get moody without him right” (Richard).

Fathers who lose relationships with children, through health and social services policy, experience deep wounding; yet demonstrate a singular determination restore relationships with children: as Omar declared: “I love my son. I mean I love him with all my heart. The day he was born, that's all I cared about anymore.”

5.2.5 “Services separated us”

Fathers were clear that the tone, nature and delivery of services caused a physical, emotional and difficult separation between fathers and mothers, and between fathers and children:
Interviewer: So what happened? How did those services and everything that happened, how did that impact your relationship?

Omar: Oh, it separated us. I mean she was left with the choice between me and the baby, is pretty much what it worked down to. I mean it hit me really hard because I'm thinking, you know, here it is, a family that has a chance with two people that are really trying hard, and they're doing everything in their power to separate us. I didn't get it. It all became about getting her services and getting me out of the picture. I mean there was volition behind it, but that was the plan. That was the plan right from the beginning. I mean that’s clear as day. (Omar)

Mothers’ total assumption of infant care affects both fathers and mothers. For mothers, this effect manifested in subtle and destructive ways: “Exclusive maternal child-rearing arrangements may well leave mothers, fathers and children vulnerable to fantasies that split mothers into ‘all good’ or ‘all bad;’ ‘all powerful’ or ‘diminished/devalued’” (Krane, Davies, Carlton & Mulcahy, 2010, p. 153). The ways that services promote single motherhood may result in the continuation of the “idealized and demonized” image of mothers (Krane et al., 2010, p. 153), particularly when mothers are poor, stigmatized, and subject to the structural conditions of a multitude of services. In the case of these mothers, the emancipatory nature of support services may be a double-edged sword, as they find themselves, further down the road, bereft not only of important, supportive relationships, but of services that have come to an end. A shared parenting model, that fosters, rather than curtails, relationships, would diminish this archetype.

For fathers, the negative impact of services was immediate and distressing: “and
another friend of mine, he's like, 'yeah, man, I don't know what it is, but when the girls move into there, it's like the staff turn them against us,’ and that's what I noticed” (Michael).

Michael described the impact of the divisive therapeutic discourse that impacted their relationship in negative ways: “It hurt. It made me want to go drinking, but I didn’t want to because I was thinking of my daughter, because I don’t want to end up in jail and do the rest of my time there.” In this statement, multiple systems of oppression are evident.

Structural inequities in the correctional system and health services interacted to define and restrict Michael’s options; yet he responded with unwavering commitment to family, as Ball (2009) describes: “Their accounts suggested that they were determined to become effective fathers and to stay involved with their children in spite of the relative lack of social or economic support and in the face of legislation, policies and social and health services that favor mothers” (p. 45).

If he had been offered the same services, Michael said, “We’d be a lot happier. I'd have the same life she does, but I don’t. They didn’t offer me nothing.”

Fathers knew services for mothers required their exclusion:

So only this amount's offered when you're with me, but if we're not together, then there's so much more available to you. What does that say to the father? That says a whole shitload to the father. And as a father, part of me just wants to say, "Okay, well, then go. If it's better for you to not be with me, then go," which doesn't make any fucking sense. (Clark)

Fathers understood mothers’ decisions to accept the terms of services involvement: “She put the needs of her and the baby first, ahead of the relationship. I don't think there was
much of an alternative at that point. And that's not her fault, and that's not my fault.”

Whose fault was it? An array of intertwined structural forces combine to separate families, prohibiting father involvement. In their study with poor young fathers of colour, Wilkinson, Magora, Garcia and Khurana (2009) found that fathers’ actions were “constrained by multiple forces and [were] generally inconsistent with the ideals they describe” (p. 964). The “cumulative disadvantage” identified by Wilkinson et al. (2009) consists of structural inequities that limit choices for both fathers and mothers.

Fathers felt left out: “I felt really left out when they told me, "Oh, [your wife] is going over to this place in [northern B.C.]" without even telling me or saying what's my involvement, right?” (Darren). To protect himself, Darren maintained an emotional distance: “And I wasn't upset with her, but I was upset that this baby's going to be out of my life just like that, and it made me feel really bad. I didn't want to get too attached” (Darren).

Fathers made efforts to anticipate and prevent family separation, but these plans were not supported:

Actually, when I was in prison, I applied to go to family treatment, and I was already accepted and I did all the legwork, and I had faxed an application to Sheway, but they talked her out of it. Yeah, I was going to go to family treatment. Yeah, I did all the legwork. I spent two months in there doing it - going to my six sessions and going to my counselling and staying sober, doing trauma therapy and... yeah, it's a lot of work, actually. I remember her mentioning, "Well, my social worker doesn't think that it's the best idea, and they don't want me to go there." And then I lost hope after that. It’s absolutely devastating. It rips your heart out. (Joseph)
Fathers compromised their dignity to maintain proximity to partners when partners were pregnant and fathers were not allowed to stay overnight; poverty was an obstacle to transportation to and from services, and to safe housing. One father reported sleeping outside on the hospital grounds:

I slept, I actually slept outside the hospital a couple of times. [It made me feel] depressed, it made me upset, yeah. But it was okay, I slept outside her window, in the grass. It was just like camping for me anyway. I woke up to a raccoon sleeping beside me one morning, a raccoon like cuddled up to me (laughs). (Andrew)

This story is illustrative of the impact of mothers-only services on fathers. The perseverance of this young Aboriginal father attests to his resistance to “forms of historical loss, the embodied complexity of addiction, and local and biomedical logics of chronicity” (Garcia, 2008, p. 720). Garcia’s (2008) work centres around how ‘addiction’ is made chronic by an array of health, criminal justice and culture; the assemblage of these institutions evoke repetitive and at times obscure instances of deprivation, loss and melancholy. Fathers in this study depict efforts to transcend these forces that collude to produce despair.

### 5.3 Dimensions of father exclusion: Food, space and family

#### 5.3.1 Exclusion

Data pertaining to father exclusion from these maternity harm reduction services fell along numerous dimensions. Some of these were prominent enough to form significant categories that were considered as separate themes (i.e., Food; Space; Child welfare).
Analysis of the major code *Exclusion* afforded insight into the subtler ways that exclusion was practiced, acted out. Some of these aspects of institutionalized exclusion fall below the radar in the sense that they were ‘invisible’ to the naked eye; focussed deconstruction of words, actions or the absence of actions revealed the intricacies of exclusionary practice.

Other forms of exclusion, such as fathers not being allowed to sleep overnight in the antenatal period, were more prominent and encoded. Prominent forms of exclusion also include ‘mothers-only’ groups on the ward; food and physical health services; assessment and referral by social work services; and individual counselling. Because this is a maternity hospital, father exclusion is implicit; yet there is a potential for father inclusion. The intention of woman-centred practice, the philosophical basis of the unit, is to respond to women’s needs; yet in many cases women want their partners included. It is recognized that service providers are already over-extended; may not have gender sensitivity in respect to fathers; and are not expected by the employer to provide services to fathers; these are obstacles that may be overcome.

The major code ‘Exclusion’ that emerged from the two analyses (‘block’ coding succeeded by ‘line by line’ coding) was analysed in a separate Atlas Ti project file due to its density (i.e., the number of quotations it contained) and its numerous dimensions. The four sub-categories contained within this larger code were: 1. “Kind of like I’m ignored”/No supports; 2. “That’s not yours, don’t touch it:” Exclusion/food; 3. “They kicked me out:” Exclusion/space; and 4. “Where’s the mom:” Exclusion: child welfare. I interrogated sub-themes to illustrate more specifically elements and impacts of father exclusion.
5.3.2 “Kind of like I’m ignored:” No support

Fathers spoke of exclusion on many levels and in many forms; they noticed passive exclusion: “the staff, they don’t pay any attention to you” (William). Fathers describe the experience as “kind of like I'm ignored” (Sean). All of the father participants reported experiencing this form of exclusion: “They would just... If you were there, they wouldn't really acknowledge that you were there, right?” (Darren). This invisibility is pronounced for fathers: “she could get this, she could get that. I'm just, like, wow, guys, what about me? You know what? I mean, I'm, like, a ghost? I'm here too” (father, focus group). The ‘ghost’ metaphor arose twice in this study, from two fathers; it is also prominent in other studies with fathers (Strega et al., 2009). The invisibility of marginalized fathers in child welfare and antenatal, natal and postnatal addictions services widens the gap for fathers between their own performance of fathering and ideals of hegemonic masculinity, which pose men as highly visible and dominant. This paradox may heighten the feelings of self-loathing marginalized fathers may experience, as they consistently try, and fail to achieve, the contrived goals of hegemonic masculinity.

Fathers’ efforts, including the effort required to be physically present on the ward, to support their partners and care for infants, were significant but invisible. Their obstacles were also significant: these included lack of resources to meet basic needs, such as food, and transportation to the unit. Fathers also grappled with independently managing their own physical and mental health issues, including achieving and maintaining abstinence from illicit drug use. While these goals were imperative and difficult to attain, their invisible efforts
remained unacknowledged and obscured by mother-centric services. As one father queried “they don’t think about us… how about us?” (William).

When fathers did attempt to solicit even minimal assistance, they reported being refused. At Sheway, with his son, one father could not engage a staff to watch his son for a moment so he could use the bathroom: “I asked one of the ladies if they could watch him for two minutes while I go to the bathroom…and no one would even do that. They looked at me like ‘what?’” (Sean). This and other acts of exclusion resulted in fathers avoiding this service, even if they were either a) the sole caregiver, if mothers had relapsed or b) providing valuable support to mothers as a co-parent.

While some fathering literature intimates that father engagement may rest on developing unique programs for fathers, which “are not likely to be the same as those for mothers” (Ball & Daly, 2012, p. 13), the simple request for support this father made is far from gender-specific. It will be crucial to deconstruct normative gender myths in developing services and supports for fathers; these are so embedded in Western culture that their continued reification will be challenging for even the most sophisticated theorists to avoid.

Ball and Daly (2012) also caution against adopting a uniform approach to fathers, noting they are a diverse group. This warning also requires foregrounding on the research and theory agenda; as discussed above, even valuable contributors to feminist scholarship, such as Teghtsoonian (2003), can gloss over class and race differences in an effort to hoist the gender flag.

For single fathers, who had part time care of their children or were sole caregivers, only sporadic support was available in respect to food, housing, child care, counselling or
peer support: “It drove me crazy because everywhere I turned everybody just ended up closing the doors on me and I had to keep a clear head on my shoulders” (Richard). Richard struggled to maintain abstinence ‘on his own’ and was able to have his son with him part time; his son’s mother was in supportive women’s housing, but Richard remained in a hotel in the Downtown Eastside. This meant that he did not have a place to visit with his son: She’d let me have my kid for a day, [but] I had nowhere to take him. I was still living at the Portland (Downtown Eastside hotel) at the time, so I was just wandering the streets with my son. I’d go on bus rides, [there were] no programs. I tried to go to that program. At first they didn’t allow me to, but then after a while they were like ‘here he is again, the father...’ (Richard)

Richard describes the Portland, a hotel managed by the Portland Hotel Society, a non-profit partially funded by Vancouver Coastal Health: “drug dealers, drug addicts like chaos man 24/7 everybody running up and down the halls screaming yelling at each other, fighting, and the smell, there is the stench of drugs, the smell of death in that building.” Richard was not the only father participant who lacked housing suitable for children: “You can't have him staying here. I will not have my boy in that environment. Like I will not subject him to an environment that will detriment his future forever” (Omar). Fathers’ lack of basic resources, such as housing, impinged on their relationships with children and partners, creating emotional risk for relapse for them and a disconnect with mothers and children.

This example contests notions of fathers as disinterested; it also forms a key example of multiple intersecting oppressions. Richard, a young Aboriginal father, is impeded from fathering by the poverty that limits his options, as is Omar, a White father. The social
exclusion they described is recognized by Health Canada as a contributor to poor health outcomes; these forms of social exclusion have layered effects: social, physical, mental and emotional. Ironically, the environment they described exists within a resource funded and operated by a local health authority. As Raphael (2003) explains “neoliberal approaches...fundamentally conflict with strengthening the social determinants of health” (p. 37).

Services at Fir Square and Sheway were largely unavailable to men: fathers report being told that services were “only for clientele.” At Fir Square, “for the women there was counselling, first mothers’ programs or something like that I think it was, can’t remember what it was because they all went in this kind of room and they closed the door, no men allowed” (Richard). This literal closing of doors was a visible form of exclusion. Fathers report not being allowed into the counselling group; not knowing what groups were about; not being offered similar groups and/or peer support. Fathers wanted counselling support and infant care advice on a day-to-day basis; they wanted respect and acknowledgement:

How about showing us stuff like that without making us feel like we’re children ourselves, you know what I mean? How about encouraging us to, you know, get out there and hold the baby properly, or... you know what I mean? (Darren)

Fathers’ inclusion also means individual attention; their knowledge of baby care reduces mothers’ burden, resulting in better quality care for children (Daniel & Taylor, 2001; Doucet, 2006; Krane et al., 2010). Although some fathers were ‘allowed’ into the parenting class, day-to-day support and teachings for fathers were unavailable.
Fathers wanted wraparound services, such as those offered mothers, to respond to their significant needs:

And we could've used couple counselling. That would be nice, both going there, get counselled together as a couple for helping raising a kid together and stuff like that. I wish they offered that. Parenting is not...all that does is just teach you skills of parenting, infant massages, what to look for. I enjoyed it because I learned a lot of things about how to discipline, this and that. And you know how to watch for signs of this, signs of that for babies. But I wish they would have services like that [couples counselling] and helped the guys find a counsellor. You know, give them a hand. Because they think it's...they cater to the women so much and they don't think about us. How about us? (William)

Inclusive, rather than divisive, services are required to strengthen community connections and prevent amplified dislocation (see Alexander, 2008).

All father participants spoke of the lack of services for fathers, single or otherwise:

“There's absolutely nothing out there. Nowadays everything is geared around single mothers. They're geared around separating the family, making it a single mother, because then you have control” (Omar). How this paradigm burdens mothers is discussed below.

Exclusion produces a separation of partners and family units. Division of marginalized families, living in poverty, excluded by race, class and the stigma of illicit drug use, can have devastating consequences. Single mothers are not eligible for numerous services if together with fathers; the system creates a population of single mothers, in subsidized housing, under the surveillance of provincial social assistance and child welfare...
programs (see, for instance, Carroll & Little, 2001; Fraser & valentine, 2008; Foucault, 1980); perhaps this is what Omar meant when he stated (above) “then you’ve got control.” If mothers continue relationships with fathers, they must be concealed. Mothers’ needs for support and connection are, at least temporarily, assumed by the state, ensuring a level of ‘policing’ and isolating mothers.

Fathers with histories of abuse, exclusion and problematic illicit drug use may have learned and been victimized by aggressive, violent behaviours through police brutality and structural violence resulting from current drug policy (Bennett, Eby, Richardson & Tilley, 2008; Bungay et al., 2010). For drug-using women, histories of violence and trauma have been foundational in the development of support services and resources; men share these needs. Omar demonstrated insight and motivation to change aggressive behaviours he engaged in while under the influence of crystal methamphetamine:

“There was no temper control, there was nothing. I was like a 5-year-old kid in a like 28-year-old man's body. And I was really strong, really aggressive, really little man syndrome. I ended up being really violent, really quick to anger, really unsolid in a lot of areas, like really paranoid, and that would drive me crazy. (Omar)

Given the increased risk of family violence related to drug use (see Section 3.3), a lack of services for fathers is confounding. They fended for themselves, to find counselling, supported housing, food, and community. Like mothers, some fathers needed counselling support to help them learn how to reduce or stop illicit drug use. Their attempts to emerge from the downward spiral of active drug addiction were lonely and difficult: “I was at a
critical part of my life where I needed services to be aware of my addiction, to work on myself. Like, I didn't have that” (Justin).

Fathers resoundingly felt judged simply for being male; two fathers used the word “man-haters” to refer to service providers at both locations. They felt they were not given a chance; that service providers made assumptions about their past and present behaviour and personalities. They lacked opportunities to demonstrate and prove who they were and what they could offer as partners, men and human beings. They felt invisible and one-dimensional: “Like, I feel judged by some of them, right? And there's some that I think have men issues - workers, I mean, that have men issues and they think all men are abusive” (Justin).

Biases against men and male partners in woman-centred spaces and services have a substantive history (Ball & Daly, 2012; Featherstone, 2007). The impact of biases is injurious and pronounced: “You feel less than. You feel like you don't deserve a family. You feel maybe that they're better off without you. You feel... just really hurt and alone” (Joseph). The implications are evident on multiple levels, for both parents; poverty and lack of connection are magnified.

5.3.3 “That’s not yours, don’t touch it:” Exclusion/Food

Exclusion: food emerged as a conspicuous form of father marginalisation, resulting in 22 comments by fathers specifically about food. Mothers and fathers managed this exclusion in various ways: mostly mothers ordered double portions of food in the hospital and shared with partners: “So what she did was ordered doubles of everything. You're
allowed to do that two times you order. So that's what she did. She ordered double” (William). Yet this was contrary to hospital policy, and both mothers and fathers were scolded for eating mothers’ food: “Yeah, the food's for them. And if we get caught eating it, they get in trouble” (William).

As discussed elsewhere, sharing food, money and other resources is a practice of respect and honour among couples living in poverty on the street. Food exclusion therefore constructs an ethical dilemma for mothers and fathers. Fathers’ dignity was compromised: “Not even the leftovers. The stuff that she's throwing out, I wasn't even allowed to touch it. I was told, "No, that's not yours. Don't touch it." I'm like, "Well, she's going to throw it away." "Well, it's not yours. Don't touch it. It's for her" (Omar).

Fathers’ values made this a difficult challenge, compelling one father to consider risky means of obtaining money for his own food: “I didn't want to eat the pregnant girl's food. I wasn't comfortable with that. I didn't want to go outside to sell any drugs to make money, so I tried to get them to give me some money or a voucher so I could have my own food here” (Darren). Fathers’ sobriety could potentially be compromised by lack of resources to meet basic needs; yet fathers’ abstinence contributes to family well-being. That this emerged as a tangible and fairly prominent issue for families underscores the poverty in which they live; middle-class White fathers would not have to contend with this dilemma. These are poor fathers: “they eat and we starve...we can't afford to buy hospital food every day. I gotta eat somewhere, right?” (William).
5.3.4 “They kicked me out:” Exclusion/Space

Spatial exclusion is reflected in multiple ways, particularly, in contemporary North America, in respect to the homeless. These forms of exclusion result from “perceptions of fear and compromised safety in relation to problematic drug use, crime and homeless persons” (Weaver, in press). The spatial exclusion at issue here resulted from similar fears, expounded by Western media and integrated into addictions theory and services, as described above. For these fathers, in the antenatal period, visiting hours curtailed their access to the space in which their pregnant partners lived: “I stayed right until visiting hours and then they kicked me out” (William). Getting ‘kicked out’ suggests enforcement of rules in place to exclude fathers from the space. These rules relate to times of day (visiting hours); they indicate that there are times when fathers should not be with their partner (late evening and overnight). Fathers must find other spaces to occupy during the night, and these spaces will not include their pregnant partner, unless she leaves the unit to be with them.

If parents had a disagreement, in the pre- or post-natal period, mothers decide whether fathers can enter the space of the maternity unit: “and then if I come back, ”Well, she doesn’t want to see you,” so they won’t let you in, even when the baby was born” (William). Staff at Fir Square must enforce maternal gatekeeping, because the mother is

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their patient and they are charged with her care and safety. As evidenced in these findings, and in other studies, mothers can both facilitate and prohibit father involvement and contact with children (Whitehead & Bala, 2012). Fir Square lacks the capacity to assist parents with relationship difficulties, which might improve outcomes for both parents, and the child(ren). This gap in service results in instances of father exclusion at mothers’ behest. Because fathers are not ‘patients,’ their presence is mother-dependent.

Spatial rules dictate where fathers can sleep, even within mothers’ rooms. Once allowed to stay overnight, in the postnatal period, there is no co-sleeping: “I wasn’t allowed to have her and my son beside me, I always had to have my own cot on the side of the bed on the floor” (William). Fathers are to sleep on the floor, mothers in the bed, and the baby must be in a bassinette provided by the hospital. These are ‘safety’ rules, and are also a result of the hospital’s woman-focussed care; certainly women would not be sleeping on the floor. Couples with new infants who want to sleep together and “hold each other” are prevented from doing so: “And we were sleeping on the bed and they came in and woke us up and told me I had to sleep on the floor” (Omar).

Fathers felt uncomfortable in a woman-centred space: “I didn’t want to go outside [of the room], I just felt kind of really uncomfortable...[but] I’ve just got to go out there and forget about what other people are thinking and concentrate on what I’m doing and why I’m here” (Darren). At times fathers felt excluded from even common areas, retreating to mothers’ rooms, having little if any contact with other fathers: “They [fathers] just do their thing. Most hide in rooms. You don’t know unless they come out for a smoke” (Justin).
Mothers on the unit interact on a consistent basis, gaining peer support, but fathers are isolated. Father to father contact is not facilitated.

Fathers can also be forcefully removed from the unit:

The father’s trying to be there and be a father but they get kicked out or they get charged with trespassing right, cause the security guards there are like, I don’t know like they’re on the ball cause like as soon as Fir calls them then that’s it, boom, they were there, right away...as soon as the nurses call they’re right there right away in minutes and they’ll drag you out, and call the cops on you. (Richard)

Fathers’ anger may be attributed to repeated acts of exclusion. Marginalized fathers experience exclusion in multiple locations due to race and class; their marginalized status makes them even more suspect in mother-centric spaces where the gaze is predominantly one of “distrust, suspicion or neglect” (Featherstone et al., 2007, p. 90). While keeping safety foregrounded, increased sensitivity to the conflicting, complex array of challenges fathers face may mitigate tense situations and form an axis of prevention. For service providers, support is also required, to address their “fears, anxieties as well as hopes” (Featherstone et al., 2007).

As discussed, services for troubled fathers are lacking, in this and other domains. For aggressive/violent men, the standard fare of ‘anger management’ and the Duluth model are demonstrated as ineffective (Featherstone et al., 2007; Featherstone, 2009); the heterogeneity of even this specific group of fathers suggests the complexity of developing an effective response. Inroads in the effective development of supports are slow, but culturally sensitive and ground-breaking ideas are beginning to appear (e.g. Ball, 2009).
Featherstone et al. (2007) raise a crucial point in asking “how are safe spaces developed and fostered for those using such services to heal from and escape violent and abusive relationships with men?” (p. 93). Fir Square may be a refuge for some of their patients who find themselves escaping abuse; in these cases mothers’ position as maternal gatekeeper must be decisive. However none of the mothers in this study made such claims about fathers. The central issue appears less one of safety than of “challenging the centrality of the female role” in reproduction (Collier & Sheldon, 2008, p. 64). This paradigm engenders fathers’ assumption of the additional burden of “labouring for relevance” (Collier & Sheldon, 2008, p. 59, quoting Jordan, P., 1990).

5.3.5 “Where’s the mom?” Exclusion/Child welfare

Fathers encounter implicit exclusion in the child welfare system:

Like even when you go to court... You go to fight...Oh, excuse me. For court, first thing the judge said, "Where's the mom?" "Well, who cares about the mom? I'm here." [laughs] And then they say, "Well, isn't this... we're trying to get the kid back to Mom?" I go, "Well, why, when she's not here?" Everybody automatically thinks kids always go to the mom... automatic. (William).

Child welfare officials insisted that mothers leave partners behind, facilitating mothers’ move to family members’ home or women-only resources. Contact with fathers could jeopardize their having custody, leaving fathers ‘in the dust.’ “They went out to Creston and we talked for a little while, and I don’t know what happened, but all of a sudden it was done and I didn't see them for three and a half years” (Omar). Omar reports being present, willing
and able to be involved; he was excluded from the decision making process, and not notified of the outcome: “They said I don't have a file. Pretty much, I don't matter” (Omar).

Omar’s partner returned to Omar three years later with the baby, citing loneliness and lack of support. They reunited and are parenting together; he attends university and both work. Omar refrained from casting blame or personalize these decisions, despite their devastating impact on him:

If there is any reason... It's all checkmarks. It's not a hateful thing either. I don't think they're out to get nothing or me like that - I mean I've never thought that - but they don't at all account for people being not normal, whatever "normal" is. Like they have little checkmarks in boxes, and I fit into a couple of those boxes and that meant that I was no longer in the picture. (Omar)

As Strega et al. (2012) observe, “child welfare interventions are, and always have been, disproportionally aimed at families already marginalized by race and poverty” (p. 173). Omar’s observation that “it’s not a hateful thing” suggests an understanding of how deeply entrenched this bias is in child welfare services, policy and legislation.

Fathers were affected in consequential ways by this exclusion; similar to mothers in these situations, they may eventually give up and return to familiar, destructive means of coping: “they have to go to court for it, right, it’s a long hard process, that’s why fathers go back to using too because it’s a no-win situation right” (Richard). Some became suicidal: “I mean I tried to kill myself once, literally” (Omar).

Fathers reported receiving “no help whatsoever”(Omar) during the pregnancy or after the birth. Clark wanted help before the birth, to prepare himself mentally for being a
father: “instead of reinforcing me and my strengths and trying to build me as a person, the attitude was exactly opposite” (Clark). The limited and limiting child welfare discourse relating to fathers is phenomenal; constructed as dangerous or absent, these marginalized fathers found themselves encumbered by their past, present and perceived future, creating a no-win situation (Strega et al., 2012). These threads of father exclusion are well-documented and strangle hopes for marginalized fathers.

5.4 Routes to belonging: “They didn’t push me away”

5.4.1 Resistance/Subjection

Cuadraz and Uttal’s (1999) analytic method entails simultaneous analysis of the biographic and the structural; that is, investigating personal experiences of participants, and noticing how these intersected with forms and instances of oppression. In the line-by-line analysis of these data, the biographical and structural converged conspicuously in the code ‘resistance.’ The direct words, actions, omissions, or implications of oppressive hospital ‘codes’ or policies elicited responses ranging from ‘muffled’ to ‘prominent.’

As Wade (1997) writes in his seminal work, “whenever persons are badly treated, they resist” (p. 197). Wade’s (1997) work is of great import; his therapeutic model invites oppressed (including victims of sexual and physical abuse) peoples to identify the multitude of means they employed to resist abuse/oppression; in so doing, victims re-claim power. Other therapeutic approaches, focused on the effects of oppression, contributed to constructing and reifying victimhood. Anecdotally, I have witnessed this countless times with
patients/clients who self-describe with a variety of diagnoses, e.g. “I’m borderline, co-dependent and have PTSD.”

I concur with Wade (1997) that healthy acts of resistance have been either ignored or pathologized in the literature, with notable exceptions (e.g. Reynolds, 2010). Wade (1997) identified four qualities of spontaneous personal resistance: 1) opportunistic (i.e., not “prescribed”; 2) prudent (mindful to not incur greater harm to self); 3) determined (i.e., persistent) and 4) performed without expectation of success (p. 28). The resistance demonstrated by fathers in this study exhibits these qualities, particularly prudence, which I termed ‘muffled.’ Wade (1997) also notes that “open defiance” is the “least common” form of resistance (p. 30).

Fathers’ resistance to exclusionary structural conditions was for the most part strategically avoided; this is prudent. Fathers instead adopted a ‘low profile’ strategy to ensure that at least one parent could successfully claim custody. High tension is common among parents under child welfare surveillance; both fathers and mothers described “the anxiety, distrust and isolation that results from feeling constantly watched and judged” (Bennett & Sadrehashemi, 2008, p. 25). Despite these tensions, and enormously high stakes, at times fathers spoke up.

Richard and his brother both had partners on Fir Square at the same time. These Aboriginal brothers tried to offer each other mutual support in sharing infant care, but hospital policy forbade this. Richard resisted, linking criticism, exclusion and policy to the potential for relapse:
“You can’t tell me I can’t look after my niece, that’s my flesh and blood. You kind of people should encourage fathers to be fathers, I said, you guys don’t give us support...that belittles us, make us feel bad, when people feel bad they go back to old habits, like when you’re a big person and you’re trying to diet and people are calling you and belittling you and that, you eat and you eat, so that’s how it is with fathers when they’re trying to recover from alcohol and drugs. (Richard)

From my work with mothers with children in kinship care,23 I developed ‘practice strategies’ for child welfare workers, emanating from acts of resistance identified in the data.

Following this model, we can take Richard’s claim as educative of service providers. Resistance is instructive in informing us about services; these acts are tantamount to naming needs. Fathers doing so in a woman-centric space required courage and can be supported. Validating fathers when they contest oppressive conditions is an act of engagement.

William attempted to resist maternal gatekeeping:

"You gotta go...” "Well, I didn’t do nothing! She's freaking over me. I'm just sitting here." "Well, you gotta go." "Well, whatever." And then if I come back, "Well, she doesn't want to see you," so they won't let you in, even when the baby was born. And I got rights because that's my kid too. And they said, "Well, she doesn't want to see you." "Well, that's fine. I want to see my kid." "Well, you gotta come back. "Well, why you stopping me from seeing my own son. He's mine too." (William).

William’s resistance contests mother-centric biases in maternal services, in this case services further complicated by meeting needs of marginalized drug-using mothers. In this scenario, William’s partner, not William, was “freaking.” Yet mothers are supported to claim this space, not only for themselves but also for the couple’s infant. William’s resistance displays a pernicious (determined) quality and it is likely that he had no expectation of success. An effective strategy in meeting this resistance would be to validate William’s assertion of fatherhood of this child, and to commit to facilitating contact with his son.

This is not outside the box of possibility; there are ways to accommodate fathers in this space. Collier and Sheldon (2008) argue that a shift away from medicalization of childbirth would promote greater father involvement in the prenatal period and the birth; delivering babies at home, with a midwife, all but insures father inclusion. Doubtless Collier and Sheldon (2008) are referring to middle class families; those that populate Fir Square are mostly homeless when they arrive, and under the watchful gaze of child protective services. Still, there is potential here for alternate locations and reduced medicalization of these services, that are more amenable to father involvement.

Omar names the subtlety of exclusion, positioning this obfuscation as a structural impediment for him and as a form of protection for the institution. His resistance is more informed and incisive, ready to take up institutional arms (legal services) to defend his rights:

But like really, they didn't care what I had to say. I mean it was really simple, like really overtly clear that they didn't give a crap about me and they'd rather me just out of the picture and "Get on it with already, get on with your life, this is nothing to
do with you" kind of deal. They wouldn't say that because I would have had lawyers in there like that. [snaps fingers] If there would have been any overt like thing where I could actually prove something, half those people wouldn't have a job anymore.

(Omar)

Wade (1997) observes that sometimes, “the only possibility for the realization of resistance may be in the privacy afforded by the mind” (p. 3). These acts occur in extreme cases of violent victimization, and are pathologically constructed as ‘dissociative,’ far from pathological, they are oriented to survival. Omar’s case is less extreme, yet his mind is a safe place to realize other options for his own protection and sense of power.

Fathers thought strategically about their resistance; what weight would it carry? How might it backfire? Some fathers adopted strategies of doggedly inserting themselves into the process:

Well, for me, I just get myself involved anyway, right? I just... I just make sure that I'm in there anyway, right, whether they like it or not, or whether they ask me to be in there or not. (Darren)

Darren carried this resistance further by coaching his partner about her rights as a mother:

She has lots of rights that she isn't... she's not aware of, right? And just because the Ministry says to you, "Well, we encourage you to go do this," it doesn't mean that you have to do what they're saying to you, right? You know, they're saying things, and the words that they use are really tricky words, right? [My wife] is not really... She'll take what...Say that the ministry is sitting here with their lawyer and they're telling her, like they're talking to her really nice. They'll pretty much convince her
that this is the way... that's what she should do. [She] has a lot of rights that she
doesn't know about. (Darren)

For women who have struggled with systemic abuse, racism and poverty, resistance is
muffled in the company of government representatives with enormous power (Bennett &
Sadrehashemi, 2008). In this case, her partner acted as her advocate.

Resistance was risky for fathers: “and then when it comes to the Ministry [child
welfare], they decide whether you keep your kid or they're gonna find someone... If you
don't take part in things, they write all that stuff down, right?” (William). Fathers assessed
the situation and weighed implications of speaking up:

I was really upset about it and I couldn’t say anything about it cause I watched how
they are towards men, as soon as they raise their voice or they look at them the
wrong way, boom. I didn’t want to lose, like rights to my son, losing my son and
Amy so I just bit my tongue and let it be. (Richard)

Fathers’ prudent resistance exacted a daily emotional cost, overshadowed by concern for
the ‘bigger picture:’

I woke up every day and looked at their picture from mother-baby pictures and
thought, "Man, I’m not there. What am I doing? Why don't I just go out there?" but I
realized anything I do now is just going to make trouble. (Omar)

These fathers grappled with the disparity between ideals of hegemonic masculinity and the
deficits that curtailed their ability to meet these ideals. Their biographies speak to structural
oppressions: poverty, racism and sexism. Their strategies are prudent (see Wade, 1997),
seasoned and sophisticated.
My experience, when you're a guy with your pregnant girlfriend going to places like that, is usually you're pretty quiet. In places like this, I'm on really, really good behaviour. I'm really attentive to what people say and I'm really careful, so nobody has any reason to say anything about me. Because I know we're under watch here totally, right? (Darren)

Fathers’ resistance is complex, coordinated and necessarily shrewd. Skilfully, they assess dynamics and manage situations in which their abilities, motives or actions may be ‘suspect:’

Like yesterday, I was with the baby by myself, right? And she was kind of tripping out, but I waited until she calmed down. Then I went and got the nurse and asked her to come into the room and show me techniques of how to burp her and stuff like that while she wasn't all tripped out, right? *First I have to get the situation under control, then...*” (Darren) (italics mine)

‘Prudence’ was prominent in fathers’ resistance; partially, their efforts were aimed at reducing harm to the family. Fathers were also intimidated in women’s space. They hosted a mixture of respect, fear, and confusion: Justin felt resistance was not a right:

No, I didn't feel I had a right to. It's not my place to say anything there. That's probably another big thing that I didn't realize until now. I didn't feel that I was... I had a say in anything, right? (Justin)

Marginalized fathers habitually employ prudence in institutional settings, measuring carefully the cost of speaking up.
5.4.2 Inclusion

Fathers described occasions of inclusion: in one case, a father was allowed to stay with the mother, at the hospital, before the baby was born. He reports that:

[Staff] keep asking her, "Why you keep leaving?" Well, because she wanted me there. She hated being there by herself. So that's why. Yeah, now they can request. If they want their partner to stay, they can request that now. We still get treated like shit though. (William)

Hospital policy allows fathers to stay overnight in the antenatal period if mothers experience significant medical complications, and refuse to stay without fathers.

William also described instances of inclusion at Sheway: “[they] opened the door to me wide. The back part where women only can go grab food, just that one part... like, 'cause there's two sides. Yeah, every time I came there, I could go in that side”(William). In another part of the interview William described lacking the means to get to Sheway, making access a challenge. Overall, William was very appreciative of the service as a single father:

Keep going to Sheway and they will take care of you, no problem. If you're struggling finding housing, they'll get you in. They'll find a place for you. Oh yeah, that's one thing about Sheway loved. They'll take care of you. (William)

But he adds a caveat: “But, you know what I mean... it all depends on staffing too. There's some staff that see what goes on and see the struggle some dads have and they'll come talk to them” (William). Justin also mentioned differences in staff attitudes:

Depends on the different people. Some people, I felt that I was stereotyped a lot for being a male. And then there was other people that treated me really good because
they were like, "Whoa, you're a father who actually cares about your kid and you're doing something," right? (Justin)

Justin also reported feeling “lucky” in terms of how he was treated, noting this was consistent with experiences of other fathers: Well, yeah, they didn't push me away like I've seen them do the other guys. I was lucky” (Justin).

Other fathers described helpful staff at Fir Square, describing them as “all friendly, willing to talk to you, give you information if you need it and help you with the baby” (Sean). Sean reports having “enjoyed” being at Fir Square, describing it as “excellent” and “friendly.”

Richard noticed a shift in his treatment at Sheway: “Oh they’re more adaptable to me, they see how far I’ve gotten and they see me taking care of my son, and they see how my son is. He’s such a happy kid, he has such a happy way” (Richard).

Sheway staff also offered one father suggestions: “They said I should go to treatment and that, clean up if I want to be around my daughter, and [my partners] even said the same thing - she doesn't want me to be apart from her” (Michael). Clark felt supported at Fir Square, but noted the support came too late:

"Okay, well, you're going to be a father. What have you done? What are you doing to get ready to do this? And I was kind of... it was kind of like, well, that was the first time that somebody had kind of thought of me that way, because up until then with the services not being offered and whatnot, it was like, "Why bother?" (Clark)

Clark was not offered referrals to services, just asked what he was doing to get ready; a critical difference. Acknowledgment of pending fatherhood could be extended through father-specific services. Inclusion had a significant impact:
Interviewer: How does that feel when you get that experience of [inclusion]?

Justin: You feel like you belong there... *like you belong* more there, right?

Interviewer: And how does that make you feel?

Justin: Good. That makes you want to stay there, makes you want to learn more, opens your mind up more.

Service providers at Fir Square participated in a focus group for the pilot study that preceded this study (Weaver, 2009). They too expressed resistance to father exclusion, citing structural barriers to efforts to include fathers:

Confirming other research findings (Ball, 2009; Parikh, 2009; Taylor et al., 2004) one service provider stated that “a lot of these young men that have come are really interested in parenting ... it would take a whole other piece to do the work and to look at what you could do to help them go through a healing process as well.” (Weaver, 2009, p. 10)

Some acknowledged barriers for fathers, describing their own resistance to structural impediments to inclusion: “as one nurse explained, they do “try to engage the fathers...’cause there are some positive experiences and there are some partners that want to be clean with the mom and I think that it is a barrier for them here” (Weaver, 2009, p. 10).

### 5.4.3 Services wanted

Fathers wanted services “just for dads” (William). They wanted housing, not church shelters, or “just bouncing...hotels, right?” (William). Family inclusive services would “have
been part of a bigger picture of me being a father” (Clark). They wanted to be with mothers
during the pregnancy, in a “safe place” (William). They contested maternal gate-keeping.
Fathers’ groups were highly recommended, particularly for new fathers in terms of providing
knowledge: a “first time dad” group to “share experiences.” Fathers yearned to acquire
relational skills:

Especially if somebody asks, "How you feel?" "Okay, well, I don't know yet... happy,
confused, scared." There's a whole lot of emotions and you don't even know where
to start. Some men need to express. I needed that. I didn't have that. You know,
"How do I feel?" (William)

William described the loneliness of single parenting, citing fathers’ groups as a remedy:

Because you can relate to a group of men and it's like, "You know what? My girl left
me." And then at least have support that, "You know what? We're here for you, at
least." Especially if they're addicts and stuff. It's hard when you're in a straight
group  and they're trying to relate to you but they can't. (William)

Fathers requested wraparound supports, and services aimed at deconstructing oppressive,
normative gender roles:

I'm too proud to ask for help. Every man is. We'd rather suffer, be on our deathbed
before we say, "Can you guys help us? Can you help me? I'm dying now. And I'm like
that. I'll suffer a lot of pain before I finally grovel and say, "Okay, I need
help."(William).

Fathers sought acknowledgement and respect for their efforts: “I'm a ‘get things done’ kind
of person. So I was doing the majority of getting stuff done and just not getting treated very
well. I’d just like to ask, why am I any different than any of the mums here?” (Sean). They also requested assistance, in the antenatal period, in preparing, mentally, physically, financially and emotionally for fatherhood: “stuff like that needs to be offered to fathers months in advance” (Clark). Fathers spoke of the need for validation of their identity as fathers:

If I believe I can do it, I will do it. If that's what I think I am, that's who I am. But to have everybody around you say, ‘Well, no, sorry, that's not who you are. That's not what you are. Really, you're this, and you're never going to be this.’ Then what am I going to be?”(Clark)

Identity as ‘father’ is not so familiar to this marginalized group; theirs are not the faces reflected in media portrayals of fathers (Ball & Daly, 2012). Reinforcement of an ‘addict’ identity facilitates shame, prohibiting possibilities for expanding identity constructions that better reflect their potential as human beings and as fathers.

5.5 Summary: Fathers’ data

Fathers’ early years were beset by poverty, social exclusion and problematic drug and alcohol use. Despite these origins, fathers’ values emerged with a strikingly robust quality, forming an unsolicited and substantive theme. Fathers in this study contested tenets of ‘difference’ feminism that ‘other’ fathers in respect to relational needs and capacities (see Doucet, 2006, 2009a, 2009b).

For this marginalized group of fathers, relational needs formed the most prominent dimension of their experience. Fathers’ capacity and desire for relationship was perhaps
accentuated by stark and numerous forms of exclusion experienced in these and other services. Father participants cited fervent motivation to father, and despair at exclusion from these relationships. As Doucet (2009b) suggests, “rather than using a maternal lens...what is required are novel ways of listening to, and theorizing about, fathers’ approaches to parental responsibilities...” (p. 117). Fathers in this study recounted numerous, specific ways that class, ethnicity and gender interacted to produce their significant and multi-faceted exclusion. They also described the import of instances of inclusion.
6 Results: Mothers

Of the ten mothers, six identified as Aboriginal; two identified as Aboriginal and White; and two identified as White. All of the all mothers were on disability, temporary or permanent through provincial social assistance. They ranged in age from 25-37 years. All of the mothers had at least one child in kinship care; three had children in state care or permanently adopted through state care; two had current custody of children of current partner and were living with partner in their own home. The length of the current relationship with their partners ranged from 2-14 years. The length of problematic drug use ranged from five to twenty years. Of the ten mothers, five were living in supported housing for women with children; one had been living with her family of origin and had returned to live with her partner; two mothers were in their own home with their children and partner.

6.1 Identity and location: “A lot of bad stuff happened to me”

6.1.1. “See you later, have a good life”

Mothers, like fathers, recount past and current trauma, as children and as adults:

With my mom in the drug house and back and forth a lot, they took me away, gave me back, took me away, gave me back. I was a permanent ward of the court when I was 13, in foster care right until my nineteenth birthday. Then they put me in that shit-ass hotel and said, ‘Okay, see you later. Have a good life.’ (Ann)

Other mothers, who grew up in state care, reported that they “[didn’t] have any family.”

They described histories of extreme violence and instability:

My mom was murdered when I was 3½...I’ve been in care all my life... cause I
witnessed her being tortured, I was like a special needs, and hard to place, in different foster homes and moved around like lots. (Diane)

Mothers report self-medicating with illicit substances for most of their lives. Mothers who identified as Aboriginal may be “second generation survivors” of residential schools (Lisa). Non-White mothers using illicit drugs fall easily into a marginalized status, as “Policy-makers have historically capitalized on the ‘fit’ between drug use and non-normative racial-ethnic, class and gender formations to achieve their political aims” (Campbell, 2000, p. 9). The relationship between drug prohibition and race is entrenched, historic and well-documented (Boyd, 2004; Campbell, 2000).

Some mothers described long term effects of trauma: “I was hit in the head a couple times, so I lost a lot of my memories from before, and right now having a hard time remembering things in general” (Cathy). Poverty and drug laws contributed to mothers’ physical and mental health challenges (Boyd, 1999, 2004; Bungay et al., 2010; Campbell, 2000): “I was a drug addict for many years and had a lot of bad stuff happen to me. That doesn't just go away just because you get sober” (Cathy).

Ann has adopted an identity constructed by the illicit status of the drugs she used. The ‘bad things’ that happened to her as a user of illicit drugs constitute structural violence; had she used legal drugs, and had access to adequate resources, her exposure to illicit drug use-related violence would be nonexistent (see Bungay et al. 2010; Campbell, 2000). Substantial cuts in mental health services in British Columbia have also contributed to unmet needs for mothers (Bungay et al., 2010); this health services deficit parallels increasing deficits in social services in British Columbia (see Bennett & Sadrehashemi, 2008). Ann’s
narrative captures the expounded effects of single motherhood in a neoliberal context in which health and social needs are low priority:

But even trying to go to therapy being a single mom, once that therapy session's done, you've opened up all this crap. I don't have any time to digest that or close it off or whatever. I just have to put on the mommy face and go back to work...it’s not fair to our son...he didn't have a very happy home life either because Mommy can't deal with her sadness. (Ann)

Ann’s circumstances resulted not only from poverty, but also from father exclusion from services; had her partner been included, Ann would have additional support. Ann struggled with poverty and isolation as a single mother in a small town; the illusion of autonomy and agency for mothers who chose abstinence, unfettered by ‘dangerous’ male partners, is exposed as a mirage.

**6.1.2 “Waiting for me to screw up:” Mothers’ natural supports**

Mothers reported conflicted relationships with family members, who are commonly regarded by child welfare workers as a supportive placement for mothers with babies; at times placement with family members is the only permissible option for mothers to retain custody: “it was either that or I would have lost her” (Georgia). Yet histories of family conflict made these situations difficult for some mothers (see Weaver, 2011):

I have things that are not good that I need to work on and deal with, but I was the only person doing that. And so in the relationship [with grandparents], nothing changed. The only thing that changed was me and I could only do so much, and [my
grandparents] would just sit around waiting for me to screw up. (Ann)

Family support was limited and complex for this group of mothers. As Cathy explained “I grew up being the protector and the caregiver.” Some do not have family in Vancouver, so rely on partners for support (Erin). Coping successfully with histories of trauma requires a ‘whole community’ of support, particularly as relationships may have been damaged or severed by attitudes towards mothers’ illicit drug use. Mothers may also be scapegoated for family problems (Weaver, 2011). Sometimes mothers withdrew completely from family and friends, self-medicating alone: “absolutely no relationship with friends or family; it was just me and my pipe” (Mary).

6.1.3 Poverty

All of the mothers lived in poverty at the time of the interviews and were on social assistance. Most had “been on the street for years” (Amy). All of them had lived in bug-infested hotels downtown: “I was sleeping in a hammock because the bugs were so bad” (Amy). When Amy moved into a small, one-bedroom women’s housing unit, she said “it seemed like such a waste of space” (Amy). For her these were luxury accommodations, and it took her some time to feel comfortable: “After living, sharing for so long and tiny rooms and you know even sharing your tiny rooms with people, other people on the street and stuff right, so it was really nice, but I felt like it was decadent” (Amy).

Ann shared a similar experience: “I moved into the shabby shack of a room with no lock on the door, no lights, there was like a couple of old desks in the room and there was a giant hole in the window to the outside” (Ann).
Mothers’ poverty sends a red light to child welfare authorities. Poor mothers are “under surveillance” as a result of poverty (Boyd, 1999, 2004; Buchanan & Young, 2002; Swift & Callahan, 2009). Poverty may be misconstrued as neglect (Swift & Callahan, 2009), and prevented both mothers and fathers from accessing safe housing in which to parent. Father exclusion disappeared fathers as a placement options, and determined where mother and child live:

But I chose to go back to [a small, distant town] because that was the best chance I had at providing some kind of a good life for my son, because my grandparents had a nice place to live and they were willing to put me up, and I tried to find a place but I couldn't afford anything on my own either. (Ann)

Income assistance in British Columbia is inadequate (see ‘Services for mothers” below). As Diane calculated:

Yeah you don’t get very far with that disability or income assistance. Like [my partner] only gets 185 bucks a month or something, well now he gets another $50 so he gets like $225, that’s his support, and then he gets $375 on top of that for rent but I mean, so it’s like $750 bucks, his total cheque is, and like you can’t live off that, like I don’t know. (Diane)

Diane is on Persons With Disabilities (long term disability) social assistance, so receives a little more than this. She is grateful that her partner earns extra income as an artist. When asked if there was any reason she does not live with her partner, she explained: “For welfare, cause that would mean like we’d lose another 100 dollars if he was added to my file” (Diane). Thus the British Columbia’s Ministry of Social Development is complicit in
separating families.

Mothers commented about fathers not being able to visit Fir Square daily, during pregnancy, for financial reasons. Food for fathers was unavailable and transportation was an obstacle: “I think it's a couple bus rides over here and you can't always get a free bus ride every single day. So he wasn't able to come every day” (Cathy). Diane’s partner slept underneath a tree on hospital grounds when she was on the unit pregnant, because he could not afford bus fare to go back to his ‘SRO’ (single room occupancy hotel room) in the Downtown Eastside each day. Food was also an issue, as discussed above:

Because we don't have the money. I got my food and when baby was born, I couldn't breastfeed with her but I was trying to pump. But I had to share part of my food that I got with him and he felt bad. He was like, "No, that's your food." But we didn't have the money that we could just run downstairs and buy him food or bring it in or whatever because he'd want to be there as much as he could with our daughter.

(Erin)

These circumstances rob fathers of their dignity and create tensions that are difficult for mothers to witness and manage.

6.2 Motherhood

6.2.1 “I’m high risk:” Mothers on pregnancy

Ann internalized substantial guilt about drug use in pregnancy, despite evidence that these effects have been over-stated (Messinger et al., 2004): “I felt so bad about what I’d put this little guy through, and I didn’t even know” (Ann). Similar feelings are echoed by
Lisa: “I wanted to quit dope because I knew that there was a life growing inside of me and I knew it was wrong.” For the most part, mothers were very grateful for services available to them as pregnant, drug-using women: “And then I got in to Fir Square and I was so frickin’ grateful that I was there” (Mary).

Cathy found out she was pregnant at five months, at which time she accessed Sheway to begin a methadone program; Erin also went on methadone after learning of her pregnancy. Georgia was already on methadone when she became pregnant; she reports being unaware of her pregnancy prior to going into labour: “I don’t know. I think I just didn’t want it to be real. There was so much loss that happened with the last baby that I just didn’t … I’m not really sure.”

Georgia struggled with unresolved grief and guilt while pregnant, as a result of having lost children to state care. The disenfranchised nature of this grief impedes its resolution, potentially contributing to mothers’ increased self-medication with licit and illicit drugs; this substantive, hidden grief is rarely addressed in the addictions or other literature\(^24\). Georgia’s disenfranchised grief, fear and ambivalence may have contributed significantly to avoidance of the reality of her pregnancy, and therefore of services.

Diane used medical terminology in referring to both her self and her baby. She reports: “The baby’s high risk for complications especially withdrawal. If it’s a methadone baby, they definitely want to watch the baby, you know to make sure it has no withdrawals”

\(^24\) Recently, a group facilitation guide was developed by a team of researchers working with drug-using mothers in the Downtown Eastside, aimed at addressing this ‘unspeakable’ and profound grief (Salmon, Weaver, & Gloyn, 2011).
Pregnant mothers using drugs are subject to numerous identifiers drawn from a socially constructed medical discourse surrounding their drug use and pregnancy (Campbell, 2000). As Boyd points out, “there is no such thing as a methadone baby” (Boyd, S., March 29, 2013, personal communication).

Diane’s identity constructions raise additional concerns about rationales underlying drug-using mothers’ receipt of services and the lack thereof for fathers: “unlike ‘normal’ women, pregnant drug users’ bodies are viewed as lethal foetal containers” (Ettore, 2004, p. 331). Drug-using mothers’ bodies are viewed as ‘lethal’ vehicles for babies: if fathers’ bodies carried foetuses would they then be the focus of services? As Campbell (2000) documents, the “role of maternal behaviour in producing, transmitting, and reproducing addiction became an object of scrutiny by a range of academic, clinical, and therapeutic professions over the past 30 years” (p. 165). This scrutiny resulted in a proliferation of maternal addictions services; the real focus of services appears to be mothers as bodily containers, not mothers as persons.

Adopting this identity, as Diane has, casts mother and baby as objects, lacking in agency. Diane’s personification of herself as a “high risk mother” and her baby as a “methadone baby” constitutes an ‘othering’ of herself and her baby, part of the making of subject/patient. Drug-using mothers with successive pregnancies are repeatedly audience to medical terminology in reference to their bodies. Mothers appear to assume identities implicit in the terminology. Internalized, this discourse shapes mothers’ self-images as defective/dangerous (“high risk”) and as producing defective babies.
6.2.2 “Having that child saved my life:” Birth as motivation to change

Pregnancy and birth, and concomitant supports and services, precipitated pivotal changes for mothers:

I just did it [stopped using illicit drugs] using their programs and you know ‘cause I was pregnant I decided to...having that child saved my life in a lot of ways, and it totally opened so many doors for me to give me a chance at a real future” (Amy).

Others stopped using illicit drugs in the post-natal period: “I used right up until the day after our son was born, and then I quit completely (Ann). One mother with previous losses of children to state care was adamant that, this time, she was willing to do ‘whatever it took’ to keep the baby; she informed her partner: “There's no way that I'm leaving this hospital without my baby, and if that means without you, then so be it, because I don't think I'd be able to survive that again” (Georgia).

These narratives speak to how drug laws and policy have shaped mothers’ circumstances and beliefs (see Boyd, 2004). Amy’s “real future” is dependent upon not using illicit drugs; yet prescribed drugs, such as the methadone many women are prescribed, are not prohibitive of a “real future.” Narrowly designating specific substances illegal restricts mothers’ autonomy and compels a moral paradigm of possibilities: only by choosing to use prescribed substances can mothers’ potential as active citizens be realized. These designations (licit and illicit) have the power to revoke mothers’ parental rights; hence Georgia’s exhortation to her partner to join her in discontinuing illicit drug use. Georgia speaks to a history of colonization and ruptured relationships in saying that she would not survive another loss of her child to the state.
Eight of the ten mothers had children not in their care; two did not have previous children. Past child loss was conflicting for mothers, triggering either hopelessness or determination: “I wanted to at least give this child a chance” (Mary). Michelle exhorted herself to become abstinent from illicit drugs while pregnant: “‘come on, Michelle. Get your shit together. You know, you don't want to leave your child like that again,’ because I left my other two, right?” (Michelle). In her conceptualization of history, Michelle assumes complete responsibility for her use of illicit drugs and how it affected her relationships with children; the context of her loss, including poverty, racism, histories of abuse and neglect, possibly punitive and judgmental child welfare services, are absent from her framework. Yet these contextual factors shape mothers’ choices and lives (Bennett & Sadrehashemi, 2008; Callahan & Swift, 2009; Weaver, 2007b).

Mothers’ omissions of structural equities in conceptualizing their circumstances can be attributed in part to treatment models that lack a structural analysis; in most historical and contemporary health and social services, mothers are framed as responsible for exponentially increasing a deviant population through birthing ‘addicted’ babies. Thus the cycle of shame continues (see Salmon, Weaver & Gloyn, 2011). Absent from these discourses is acknowledgement of the multiple layers of intersecting oppressions based on race, class and gender, which shape mothers’ options and experiences, situating them squarely in a context of poverty and instability. A shift in this discourse may be on the horizon, as recent research confirms (e.g., Messinger et al., 2004) the significance of social determinants of health in postnatal outcomes.

Messinger et al.’s (2004) ground-breaking recent study generated significant findings
that contest contemporary and historical exaggeration of the effects of illicit drug use on the foetus: “Infant prenatal exposure to cocaine marked deficits in mental performance, and exposure to opiates marked deficits in psychomotor development. However, both sets of deficits were attributable to factors associated with illicit drug exposure rather than to exposure itself” (italics mine) (p. 1682). These ‘associated factors’ include “disruptions in maternal care, low SES, and low vocabulary scores” (Messinger et al., 2004, p. 1683). This means that poverty (low socio-economic status) and lack of education (low vocabulary) were more significant factors in infant ‘deficits’ than was cocaine or heroin use. Most services, and mothers, remain unaware of such findings, consciously or unconsciously perpetuating drug use and pregnancy as a moral issue (Salmon, 2004).

6.2.3 “A real handful:” Mothers about children

In this study, mothers’ talk about children was focused on children’s health concerns, particularly those at birth:

I didn’t even get to hold him right away because he had a hard time breathing and stuff. They had to pump the fluid out of his lungs and hook him up to all these IVs and things like that. And I got to hold him for a few minutes before they put him in the incubator and he was in the... in ICU for ten days and was fed through a tube in his nose. (Ann)

Erin, describing a similar situation, expressed how she felt about seeing her baby undergo postnatal medical services: “When he was born, he went through bad methadone withdrawal. He had the IV in his head. He was fed for the first 24 hours in that IV. It was sad.
It was so scary” (Erin). Erin’s fear may be compounded by perceived judgments about her as a mother; by moral discourses related to drug use and mothering. Hospital staff in B.C. Women’s Neonatal Intensive Care Unit may reflect more judgmental biases than staff at Fir Square.

Despite literature that contests negative effects of illicit drugs on the foetus (Messinger et al., 2004), mothers carry deeply internalized pathologic constructions of themselves as ‘bad mothers’ for any drug use in pregnancy (see Salmon, 2004). This may be due to the history of “conflicting research evidence on this issue” (Klee, 2002, p. 90) and the prominence of maternal risk discourses circulated by health providers and social workers. Mothers using illicit drugs fail in neoliberal exhortations to produce a ‘healthy population’ (Foucault, 1980, discussed above), and are viewed as “unnatural and deviant” (Lewis, 2002, p. 40).

While harm reduction service providers contest myths relating to pregnancy and illicit drug use, this mythology is substantive, universal and difficult to unseat. Further, other treatment service providers may also be complicit in reinforcing this ideology: “Treatment providers, too, can compound substance abusing women’s shame and guilt about their addiction, perhaps often unwittingly, by reinforcing society’s expectations about the image of the ideal mother (Finkelstein, Brown, & Laham, 1981)” (NAIARC, 2002, p. 7).

Perhaps attributable to supportive harm reduction service approaches, mothers reported being motivated, not discouraged, by effects of their illicit drug use on children:

He was seven at the time, and I was sitting with him, and he saw my track marks. And he asked what happened, right? “I thought your scar was on the other side.” Because
the last time I saw him, it was only the one side I was using in. By this time it was
everywhere. And I told him that, you know, "I'm sick." And I told him, you know, "I'm
going to do my best to get better now," and the day... the next day I went to go see a
doctor to get on methadone. (Georgia)

Once Georgia transitions to methadone, a licit drug, she is better able to achieve norms of
mothering, and active citizenship; harm reduction services support this transition.

Mothers struggled to parent alone, challenged by children’s health concerns and
behaviours: “he’s a real handful” (Ann). Ann, like other mothers in the study, reported
significant distress about ways that services divided her family, particularly how structural
issues affected her son:

We're doing pretty good right now on our own merit, right. But we could have used
the help in the first place, and so maybe this wouldn't have had to happen to our
child. I mean he's traumatized now. He's been in two different foster homes in the
past nine months, and he's with people that, they take good care of him, but they
don't love him. And it's sad, and the only thing stopping us from having our son back
is a place to live, but you think they would get on giving us housing, or helping us get
housing. That was the last thing they did for us. (Ann)

Lisa contested plans of the state aimed at permanent wardship: “Well, my son's in [baby’s
paternal aunt’s] home right now. He [social worker] wants to go for a CCO [Continuing Care
Order] or whatever until he's of age. I don't want that. I don't want that. We're still visiting
him every two weeks” (Lisa). In B.C., the failure of the state to support marginalized parents
is well-documented (Bennett & Sadrehasemi, 2008; Callahan & Swift, 2009; Weaver, 2007b).
Marginalized parents lacking strong advocacy are positioned as weak in the face of the state’s power.

6.3 Services for mothers: “Being a good mother”

6.3.1 “How to be polite with people”

Mothers held both negative and positive views of services; overall, they expressed a deep appreciation of services at both Fir Square and at Sheway. These services included: food; housing; counselling; parenting classes; methadone and other medical support; vitamins; safety; support to reduce or stop using illicit substances; mutual support from other mothers (peer support); security; recreation; alternate forms of therapy (art; music).

Mothers also identified urine drug screens as a support; two mothers reported that drug screens ‘held them accountable’ and formed an impetus to refrain from illicit drug use. A caveat in respect to urine drug screens, however, was choice: “having that door open to having random urines, it’s awesome; to have it mandatory is just bullshit” (Lisa). Other mothers chose to have constraints upon agency: “I had to do [services] because it was mandatory, which was good, you know. I needed that” (Ann). Choosing to have constraints upon agency is choosing to have no choice. As Fraser and valentine (2006) discuss, the assumption of responsibility and agency brings illicit drug users closer to approximating the neoliberal ideal; while this may have benefits in terms of de-stigmatizing and reducing isolation for illicit drug users, promoting their active citizenship, the cost of this orientation entails colluding in the disappearing of socio-historical dimensions of users’ lives.

Thus when mothers claim benefits from mandatory requirements, they give credence
to a neoliberal mechanism (urine drug testing); while this serves as a framework of ‘accountability’ for mothers, and results in mothers’ approval by the neoliberal state, positioning themselves as adherents suggests their ambivalence in respect to their own agency. Assuming responsibility for ‘inadequate’ agency disappears its context; yet are these mothers in a position to contest this framework without incurring substantial losses? Realistically, were mothers to garner and provide evidence of intersecting oppressions that led to their current circumstances, the benefits to them would be negligible. For this reason, their choice to move closer to a neoliberal idea yields at least short-term benefits, as suggested by Moore and Fraser (2006).

Mothers’ engagement in services that excluded fathers requires mothers to take up the discourse of individualization and single motherhood that forms an integral part of residential treatment services for women and children:

So when I went to treatment I decided to stop talking to his dad because it was just easier that way, so I could go to treatment and actually focus on me. And being with me and my baby for the first time, just us, and so I did my ten weeks at Peardonville and I really loved it. It was awesome. I totally found God and I was committed to my sobriety, committed to being a good mother. (Ann)

Ann recounts how bending to the structural forces that required father exclusion was “easier;” her “focus” on herself and the baby emerged in the context of a women-only treatment centre that promotes ideals of ‘God’ and ‘being a good mother.’ Treatment discourses traditionally encourages a focus on self, eschewing involvement in interpersonal relationships (Simmons & McMahon, 2012). Yet “[t]argeting relationships as agents of
change is likely to prove as useful for drug treatment and counseling interventions as it is for harm reduction interventions” (Rhodes & Quirk, 1998, p. 168). Rhodes and Quirk (1998) recommend that strategies be developed to address the “context of private lives,” rather than ignore these cathetic centres (Rhodes & Quirk, 1998, p. 168).

Treatment centres can also be complicit in perpetuating ideals of the ‘good mother’ (Boyd, 1999; Salmon, 2004). Hegemonic ideals of motherhood weigh heavily on women involved with illicit drug use, overwhelming them with shame and stigma (Weaver, 2007a). Yet adding fuel to fire by eschewing intimate relationships has not been fruitful. In the case of Ann, three years after leaving her partner, as directed by child welfare authorities, she found her situation intolerable. Isolated, alone, overwhelmed with responsibilities, and poor, she returned to her partner.

Mothers equate “stability to live in society” with abstinence from illicit drug use (Ann). Yet the wider context of their stability requires adequate means to meet basic needs; ensure optimum mental and physical health; and have access to community resources, i.e., social inclusion (Raphael, 2003). In mothers’ views, transitioning to abstinence, or the use of licit rather than illicit drugs (e.g. methadone, anti-depressants) was perceived as ‘life-saving’ (Michelle); certainly the licit status of drugs has significant benefits, obviating the need to commit crimes, engage in prostitution or incur further criminal justice system involvement.

Both Sheway and Fir Square serve to shore up escalating economic inequities resulting from over a decade of neoliberal governance in British Columbia, by providing access to necessities such as housing, food and baby items. Because B.C. has “one of the lowest levels of support for income assistance recipients in Canada” (Butterwick, 2010, p. 4),
lone mothers on social assistance are encountering increased barriers and social exclusion. Sheway in particular is critical in reducing the impact of the neoliberal agenda for pregnant, drug-using mothers, by providing access to services on a regular basis. Sheway’s location, in the heart of Vancouver’s Downtown Eastside, was also cited as a positive, because mothers did not have to leave their “little security blanket area” (Cathy).

Mothers also highly valued the ‘protection’ afforded by both Sheway and Fir Square. Mothers reported that staff “helped a lot” with child welfare “situations” (Georgia). As Georgia reports, “had it not been for the help that they gave us, [we would not] have our child today. And because we have our child is why we don’t use anymore.” Because Georgia had used illicit drugs while pregnant, Fir Square staff helped her to effectively navigate the system in order to retain custody. This was accomplished by supporting Georgia to contact family members for support. While some mothers experience difficulties with family members in terms of child custody and access (Weaver, 2011), in this case Georgia was supported.

Diane reported that because of her ‘history,’ i.e., previous losses of children to the state, child welfare authorities would not allow her any opportunity to parent this baby; her preceding children (born at other hospitals) were apprehended at birth. With this baby, born at Fir Square, Diane was able to room in and bond with her baby. The child is placed in a foster home, in custody of the state, but Diane and her partner continue to have supervised visits with her child.

Fir Square also advocated for mothers in interactions with other medical professionals. Georgia was required to undergo a psychiatric assessment:
I started telling [the psychiatrist] about the [project] and the people involved. Luckily one of the nurses came in and asked for evidence of what I was doing. I had a brochure, and she photocopied something. She came back to tell me that the lady said I was crazy. (Georgia)

Georgia was involved in an art project in the Downtown Eastside, with other marginalized women. When she described her project to the assessing psychiatrist, the psychiatrist assumed Georgia was delusional. Fir Square staff intervened to provide evidence of Georgia’s project, legitimizing her work. A psychiatric chart recording, in which a mother is assessed as ‘delusional,’ could result in removal of the child from mother’s custody and/or access. Fir Square staff contested this assessment on the mother’s hospital chart, a critical document frequently requested by child welfare workers to form part of a risk assessment.

Psychiatric discourse is powerful (Foucault, 1980) and can contribute significantly to discourses of risk in child welfare. Thira (n.d.) terms psychiatry, and other forms of medicalization of the responses of the colonized, as the “fourth wave of colonization.” Fir Square plays a vital role in advocacy for mothers.

For some mothers, Fir Square’s harm reduction policy created challenges in maintaining abstinence from illicit drug use: “Like, you could just smell crack and it fucking triggered me” (Lisa). Yet for other mothers, this policy was critical: “I kept using and going back to [the unit]. So eventually after I got a little bit stable…” (Michelle). Stabilizing, in this case, means, “not deteriorating in health.”

Illicit drug use is of course not allowed on the

25 New Oxford American Dictionary
unit, but women who are under the influence of illicit drugs are assessed and admitted. This mix of women who are abstinent from, and those still using, illicit drugs, appears to be inevitable.

Michelle goes on to describe additional benefits gained from Fir Square in that she learned: “how to come back to civilization and how to be polite with people.” Far from contesting social norms and their implications, Michelle welcomes the opportunity to achieve acceptable citizenship status. Within the context of the construction of certain substances as illicit, and the violence (structural and interpersonal) this spawns (Bungay et al., 2010), Michelle's comment makes sense; perhaps she perceives civilization as a safer place than street life.

Ann left Fir Square to do errands without notifying staff at Fir Square. Upon returning to the unit she found that staff had contacted child welfare authorities, because they thought she had “abandoned” her baby (Ann): “I didn’t know, because I didn’t read the package of stuff that they leave in the room, because I’ve just never been a big reader, and nobody verbally told me the rules” (Ann). This communication gap can be traced to understaffing, due to substantial cuts in health spending engineered at both provincial and federal levels. As Carroll and Little (2001) explain, Canada’s downloading of fiscal responsibility to the provinces “compelled some provinces with insufficient tax bases to reduce the size of their public sector by cutting back on social services” (p. 39). Understaffed health and social services increase ‘slippage’ which in this case had substantial cost to the patient; it is safe to assume that with adequate staffing levels, the information Ann needed would have been verbally communicated to her by one or more members of the interdisciplinary team.
One mother mentioned feeling “judged” by a couple of staff who “would write everything down...I had to watch every step because I felt I was judged and they might take my baby away at any moment” (Erin). Yet Fir Square staff do not have the power to remove children. In fact the unit is exemplary in advocating for its patients with child welfare authorities; their practise of advocacy and health care actively contest the mechanisms of child protection authorities. While Fir Square staff firmly and unequivocally abide by Child and Family Services Act legislation, their approach contests that of the Ministry.\(^{26}\) Patients’ confusion about these vastly different roles is concerning.

As a medical institution, Fir Square staff are required to chart patients’ health status and behaviours; for the most part patients are not immediately privy to this document. The majority of Fir Square patients carry histories of stigmatization, as a result of their race/ethnicity, class and use of illicit drugs. Their experiences with government institutions are not likely to be positive. Patients are therefore sensitive to methods of surveillance in this environment (hospital). While their staff take a supportive, non-judgmental and transparent approach with patients, they are still required to maintain safety and documentation.

The requirement for documentation, and the advocacy-focused role of staff could be more clearly explained to patients. Due to under-funding and insufficient staffing levels, however, this could be a ‘luxury’ service the unit cannot afford. Further, mothers at Fir Square are in vulnerable situations, medically and emotionally, requiring individual, gentle

\(^{26}\) Ministry of Children and Families, B.C.’s child protection authority
explanations, perhaps over a period of time.

### 6.2 Relationships with fathers: “Best friends”/”Tired of trying to help”

The length of mothers’ relationships with fathers ranged from 2 – 14 years. Two of the couples had been in a relationship together for fourteen years; one of these couples had five children together and the other had six; these four parents were Aboriginal. Mothers described varying trajectories in relationships with partners: some began as friendships; some had used together and entered recovery together; some had conflict, which resolved; some were separated.

The findings of the present study shift the prominent paradigm of intimate relationships between users of illicit drugs that has characterized the literature; Simmons and Singer (2006) and Cavacuiti (2004) observe that thus far, in the literature, insights into these relationships have been non-existent; constructed as co-dependent and/or enabling; focused on injecting practices and HIV transmission. Other lenses have positioned mothers as lacking in agency, victims of men’s efforts to seduce them into addiction (e.g. Finkelstein, 1994; Laudet, Magura, Furst, & Kumar, 1999).

These studies reveal significant omissions in analysis. Laudet et al. (1999), for instance, recruited a sample of 81 African American males, yet the study is void of any reference to race or class. Neither is racial profiling in drug law enforcement discussed, despite its significance for Black men using illicit drugs in the U.S. Neither are the pressures of hegemonic masculinity discussed. All of these are integral to illicit drug users and the nature of their intimate relationships. Simmons and Singer (2006) note the need for research
with users of illicit drugs who are not in treatment, and exploration of “how these dynamics are shaped by larger forces” (Focusing on couples as a unit of analysis section, para. 4).

Mothers in this study reported both difficulties and strengths of their intimate relationships; they recounted their own challenging behaviours and those of partners. They described challenges inherent in maintaining a relationship in the context of poverty and illicit drug use, being on the ‘street;’ these relationships were inscribed by current configurations of drug laws, economic inequities, and structural violence.

**6.2.1 “Best friends”**

Ann and her partner were friends prior to beginning a romantic, committed relationship. Initially, she said, her partner espoused values of “honour and loyalty,” then he became quite “controlling” and “suspicious;” Ann described this as “suffocating.” Ann also pointed out that she was very “submissive” at that time and that he had to “put up with a lot of crap” from her. Ann’s history in foster care; abandonment by the state once she reached the age of majority; and removal from biological family multiple times contribute to the dynamics of her intimate relationship. Her partner reported “not being allowed to be a kid” growing up, and being emotionally “shut down” (Omar). Thus, both brought significant challenges to the relationship, “the complex interpersonal dynamics enacted among couples” (Simmons & McMahon, 2012). Meagre welfare rates, substandard housing, and social exclusion further complicate these histories. Within this context, their survival as a couple denotes a tenacious commitment.

Cathy characterized her relationship with her partner as “rocky” during this last
pregnancy. She said this was due to her tendency to “blow up over anything.” Cathy felt that her partner was a significant support; “he's helped me access the services to their full, and go through with it all the way.” He also encouraged her to get a lawyer and to speak up for herself in interactions with child welfare authorities, encouraging her input into decisions about her treatment plan. Cathy acknowledged her “needs” for encouragement and advocacy; she self-describes as having “post-traumatic stress disorder” due to a history of trauma, and having been “hit on the head a couple times,” which affected her memory. Like other couples in this study, disabilities presented additional challenges. Yet relationship dynamics were not unusual: this couple “cared for each other similarly to the ways that non-drug-using couples care for their intimate partners” (Simmons & Singer, 2006, Background, Introduction, para.1).

Diane said she and her partner “never fought, it was really weird.” She expressed guilt that she had not informed him of her history with child welfare, which, she felt, resulted in losing custody of their baby. This was his first and only child, while Diane has had five previous children, all of whom were in kinship care. She also reported feeling fortunate to be with Andrew, because he earned additional income as an artist, providing her with better nutrition during her pregnancy. Like most couples in the study, Diane and her partner valued stability, fidelity, and honesty. Gender norms were evident in the financial responsibility her partner assumed, particularly during pregnancy. Other gender norms were unattainable for this couple, for instance those related to mothering.

When Erin became pregnant with her youngest child, she and her partner were homeless and using heroin in a small rural town; they returned to Vancouver together and
went on methadone. Erin didn’t “want to be away from him;” during her pregnancy, she chose to stay on the street rather than on Fir Square, so she could stay with her partner. She describes them as “best friends,” reporting that he has “always been a good support” for her. Erin said she had difficulty building trust, which, she said, might be why “it was so important for [her] to have Justin.”

Georgia said that she and her partner were using when they met, and had wanted to get their life “back together, on track” since then. Georgia reported that her partner used drugs on one occasion after their baby was born, resulting in her giving him an ultimatum, because “there wasn’t going to be anything stopping me from leaving with the baby.” At the time of the interview, they were both abstinent and had custody of all three of their children.

Mothers described mutual aid in relationships. Forms of support included advocacy, financial, emotional and parenting support. Mostly, couples shared everything “50/50” (Cathy). Some of the fathers continued to participate in children’s lives, and supported mothers in care of children: “The only thing he doesn’t help with is finances. But he helps with everything, he helps teach [our son], he plays with him, he watches him so I can go to school” (Amy). Despite his exclusion from her housing and services, he maintained contact and assisted in any way he could.

In spite of difficult circumstances, perhaps partly because of them, couples in this study were very close: ‘Yep, me and him...just clicked. I mean, he's always been a good support for me and always wanted the best” (Erin). Even though her partner was not the baby’s biological father, and they were no longer romantically involved, he attended the
birth and continues to act as the baby’s father. Sherry described her relationship with her partner as very caring:

When I feel like I can’t talk to anybody else, he's there. When I had my slip he almost cried because he doesn't want to see me back down there. He didn't like to be seeing me when I was using either. (Sherry)

These close, mutually supportive relationships were central to mothers’ survival in the context of histories of loss, chaos and poverty.

6.2.2 “Tired of trying to help”

A couple mothers in this study expressed concern about fathers “not doing anything,” not being “responsible,” and not thinking “about their future” (Amy). These sentiments were coupled with acknowledgment that fathers lacked “proper examples” in their childhood, and lacked support (Amy). One mother was critical of her partner’s past behaviour: “he was pretty still in his own all about himself kind of thing, selfish and really angry and jealous of things” (Ann). Yet Ann also acknowledged his strengths: “he is working really hard, and he’s a really good guy” (Ann). She felt, like all of the mothers in the study, that fathers’ efforts were disappeared by service providers: “People need to give the husbands and the fathers a lot more credit than they do” (Ann). Fathers’ positive transformations were accomplished independently: “he’s done it all by himself too” (Ann).

Lisa struggled with her relationship, reporting that her partner was unfaithful; during the pregnancy, she tried to end the relationship, so she could “straighten out.” Lisa was very upset about her partner’s infidelity, which she stated continued at Fir Square, and involved
other patients there. They engaged in couples counselling through an ‘outside’ therapist. Lisa reported feeling “scarred” from her experiences in relationships with men.

Mary had, at the time of the interview, ended her relationship with her partner. She described the relationship as “hell.” She reports constant fighting while living in a hostel together, where everyone “knew [their] business.” She resented his continued illicit drug use, citing this as the reason she ended the relationship. She identified this as a “trigger” for her, describing more intense cravings when she knew he was using. Partially, she said, this was because they had used together.

Using drugs together can affect the relationship; sometimes couples go their ‘own separate ways’ while using. This can be due to differences in drug of choice, and also to drug laws, which compel women to work in the sex trade, and men to do crime to support their habits. For Michelle and her partner, this pregnancy was “different;” Michelle said the couple were distant, separated and involved in other intimate relationships.

When Michelle went to Fir Square to stabilize medically and stop using, her partner visited but had to leave every night: “I knew he’d be back out doing crime, doing drugs.” Because her mother died of an overdose, his continued using intensely affected her. They both continued to live in the Downtown Eastside, Michelle in women’s housing with the baby, so have a relationship. Michelle felt this would change when she moved out of the area.

Michelle said, regarding her partner, “some weeks it’s ok, he gets those motivations, but then once he sees one person he uses with, it’s gone.” She said he talks about getting into programs, getting a job, going to school, but has not followed through. She said she
was “frustrated” because she “felt like nobody wanted to help him.” Michelle reported having faith in him, and his potential, stating that he has attended university and is “amazing.” Sometimes fathers’ continued use wreaks emotional havoc for mothers: “it’s too much to watch him go through that. He’s been stabbed three times and bear-maced and stuff” (Sherry).

Sherry curtailed her relationship with her baby’s father because he continued to use drugs and she was abstinent. This couple also “did [their] own thing” while using; “I was doing my own thing with my own people; he was doing his stuff” (Sherry). She said she was “tired of trying to help” someone who “doesn’t want help.” They had two boys together, and although not the biological father of this baby, he was at her birth and calls her his daughter. Sherry described him as a best friend, someone she can “talk to.” They remain best friends; Sherry reported that he had now begun asking for her help to get into treatment.

One of the mothers had virtually no hope or faith concerning her former partner, father of all of her babies; when asked if services might have made a difference for him, she said: “For the relationship that I was in - I can't speak for all men - probably not. I really don't think so” (Mary). Mary reported being “sad” about this and stated that she still wants him in her son’s life.

Some mothers exited relationships following their stay at Fir Square, but wanted fathers to remain involved with children. Most relationship breakdowns resulted from fathers’ continued problematic drug use, or lack of services. Mothers felt they had to sever contact with their partners to remain abstinent and retain custody of children. Mothers
expressed anxiety about fathers’ problematic illicit drug use, and sadness at the loss of partnerships; in some cases they hoped for future change. Other couples continued their relationship.

Of the ten couples, six were together at the time of the interview. Of these, three couples were abstinent and parenting or nearing the return of children; in two of these couples, fathers had prior treatment experience. Two couples stayed together and continued with problematic drug use, with their children in care of the state. One couple (with a 14 year history) was still at Fir Square at the time of the interview; mother was abstinent and planning to take the baby to residential treatment, and the father was seeking services.

Of the five separated couples, four of the mothers were abstinent, in women-only housing with babies, and one mother was homeless and using; all five fathers partnered with these mothers continued problematic illicit drug use. Viewed individually, 8/10 mothers remained abstinent; 4/10 fathers achieved abstinence.

The few studies that do exist with couples using illicit drugs describe challenges for couples using illicit drugs in respect to accessing treatment (Rhodes & Quirk, 1998; Simmons & McMahon, 2012; Simmons & Singer, 2006). The “most significant” structural barriers to treatment identified by drug-using couples “included having to care for, or not wanting to abandon, a significant other” to access treatment (Simmons & McMahon, p. 243). This formed a principal concern for mothers in this study.
6.3 Mothers on father exclusion: “Nobody’s going to help me raise this kid”

Forms of exclusion included: counselling groups at the harm reduction maternity ward; food, health care and counselling services from both Fir Square and Sheway; staying overnight at the ward prior to the baby’s birth; staying overnight in women’s housing; caring for children at mothers’ housing without mothers present; peer support services; attention and care from both the Fir Square and Sheway; free access to methadone.

Fathers also faced poverty-related structural exclusion in their inability to meet basic needs such as food and transportation, necessities to maintaining contact with infants and partners on Fir Square. Mothers remarked that even when fathers were technically ‘allowed’ they were not “welcomed,” an invisible exclusion noted by other researchers (see, for instance, Doucet, 2006, 2009a, 2009b). Fathers were ‘watched’ for behaviours that might indicate illicit drug or alcohol use; a double standard in a harm reduction unit which allowed mothers to come and go, using or not. Fathers were ‘barred’ from housing for women only27 if a history of interpersonal conflict existed; in one case, the mother had a criminal conviction for assault against the father, resulting in father’s exclusion from the building.

For the most part, fathers were excluded from ‘case planning’ meetings at Fir Square concerning their partner and child. Advocates often supported mothers; fathers were not present. Mothers were well aware of forms of father exclusion and how it impacted fathers

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27 Crabtree Housing
and children.

6.3.1 Pressure: Mothers’ burden

Emotional support

Father exclusion created an enormous burden for mothers, impacting mothers’ emotional and mental health. Mothers describe being “exhausted and focused on [baby] all the time” (Amy). They were continuously responsible for caring for the baby:

He wasn’t allowed to watch him [at my house]. If I wanted his father to watch him I had to find somewhere else, and the place he was living was no children allowed. I had to be with [baby] all the time” (Amy).

Mothers also felt the need to reassure fathers through the separation forced on them by services:

I want us to be a family. I'm going to do everything I can to come back as soon as I can, and it was a lot of pressure on me to try and convince him that, “Listen, I don't want us to be split up. I really don't, but we have to do this right now.” (Ann)

As Ann explains:

He totally got railroaded right out of the picture just like that. And everybody was all for it. But it didn't open any doors for him, and it just kind of left him in the dust, holding pictures of us waiting for us to come back” (Ann).

It became mothers’ burden to support partners, to explain that the separation was temporary, and that it stemmed from policy, not mothers’ wishes.

Essentially mothers were put in the position of initiating discussions with fathers
about how the family would cope with the enforced separation. Fathers’ experiences of rejection not only jeopardized mothers’ utilization of services, mothers also had to reassure fathers about their love for them; fathers’ worthiness; and the ability of the family to survive this emotionally challenging situation. For marginalized fathers, with histories of neglect and abandonment, this could not have been an easy task.

**Mothers’ stress and worry**

Mothers also relayed the pressure involved in being separated: “I'm always worrying about him. I'm always thinking about, "Is he okay?" It puts a lot of stress on me because I worry about him” (Cathy). Fears regarding fathers’ continued use, resulting from father exclusion was at times a ‘trigger’ for mothers: “It was absolutely stressful in the beginning. I would have cravings” (Mary). This dynamic may be typical of drug-using couples, when only one enters entering services (Simmons & McMahon, 2012). In addition to activating cravings, mothers worried about partners:

Because he's an IV drug user and I never was, ever, right? And that's how my birth mom passed away, so I'm really scared when I think about it. So that really... it put a lot of stress on me in the evenings. And sometimes he wouldn't come back for days and when he would, he'd be so strung out, so tired and I'd have to wash his clothes. So it's really a drag when the partners do have to leave at night. (Michelle)

Mothers were also concerned about how fathers would meet basic needs that mothers were getting met through ‘wraparound’ services: “A lot of stress and with the food thing, they'd have nutrition too and wouldn't have to worry about nutrition or their health or their stress
or what they're gonna do” (Erin). Erin’s trepidation attests to the ‘care and concern’
dynamic prominent in this and other studies (Rhodes & Quirk, 1998; Simmons & Singer,
2006; Singer & McMahon, 2012).

**Teaching fathers**

Mothers also conveyed both an obligation and a concern about relaying teachings to
fathers: “So how am I supposed to go out and teach him when it's supposed to stay in that
room, right?” (Lisa). Imparting experiential learning is a contradiction in terms, yet mothers
felt compelled to share. This obligation reduced mothers’ ability to be present in group
counselling, as they were ‘listening’ for partners. Their efforts were aimed at keeping
partners on the ‘same page,’ a daunting task.

Erin felt father inclusion would offer mothers immense relief:

Well, I wouldn't... sure as heck not be as stressed. I wouldn't feel like I'm the one that
has to take all the responsibility and [my partner] is just there after the baby's born. I
think it would be shared between us like it's going to be out here when we're not in
Fir. It'd sure take a lot of the stress out of things and we could learn, they could start
teaching us there with our problems and issues and stuff, how to deal with it rather
than just the ladies, and the men don't get that education. (Erin)

Erin’s partner had experience in treatment so was familiar with recovery, resources and
supports; however, Erin is contesting the way that father exclusion increases her parenting
responsibility, her burden of care, the “social isolation, and pressures and challenges
associated with the caregiver role that is traditionally ascribed to women in American
Mothers’ loss of support: “it kind of sets you up for failure”

Mothers relayed feelings of substantive loss: “it's like everything is kind of pushing him back onto the back burner. And it’s not fair, and it just affects me in that it feels like they're taking away part of my support system” (Cathy). A relationship 14 years in length is remarkable under historically difficult circumstances; its rupture occasions significant emotional cost. For most mothers, this was the price extracted to retain custody of infants.

Klee (2002) found in her study with drug-using mothers that “the psychological health of the women was strongly influenced by their partners’ support” (p. 169). For partners to be able to provide support, they must be supported. Father exclusion places both parents at risk for increased stress, poverty, structural oppressions and isolation, all of which can contribute to relapse.

Numerous obstacles beset mothers’ attempts at single motherhood:

So he's bouncing off the walls and I'm trying to do my schoolwork. I had seven college courses to do at once, which is ridiculous. But I had to keep a full-time caseload otherwise I wouldn't qualify for my student loan funding, and I wasn't on welfare or anything anymore. I didn't even have medical. I was like... I couldn't understand it. (Ann)

As single mothers with histories of neglect, foster care, and multiple moves as children, family and professional supports were insufficient; these eventually deteriorated, leaving mothers at risk of ‘cracking.’
Way too much pressure, way too much stress. And so they put me back on welfare and then I was left alone. I was totally left alone, and I was relying... like the service providers were my family. So I cracked. I started drinking and smoking weed. Like I’d been sober for two and a half years. I think it just kind of set us up for failure. They’re just feeding the beast. If they would help us to be a family instead... (Ann)

Part of the dynamic visible in Ann’s story of ‘relapse’ can be traced to Western hegemonic ideals of individualism and independence. This paradigm has a powerful influence in perpetuating numerous forms of addiction (Alexander, 2008); as connections and supports are severed, individual responsibility and isolation mount.

Family members who stepped up to help mothers retain custody were appreciated, but limited in what they could offer and how they approached the task of supporting mothers with small children: “my grandparents were supposed to be my support, like fill the role of [my partner], and they didn’t do that. They never gave me a break. We never took turns watching him” (Ann).

Mothers also expressed concern about services ending:

It kind of sets you up for failure...you do really good for a while, then they leave you alone. And eventually your stress piles up or some kind of crisis happens, you can’t deal with it, then you go back to the services. (Ann)

The crisis-driven child welfare system in B.C. has been soundly criticized for its lack of preventative supports (Bennett & Sadrehashemi, 2008) and significant father exclusion (Strega et al., 2012). Ann requested support from child welfare services as her supports withdrew and stress mounted; yet, without an “open file” she was not eligible for help.
Ironically, child welfare had mandated her separation from her main support, her partner.

She explained the differences father inclusion might have made:

But it would have been so much healthier and more proper for us to have been together in the beginning, and to have us both work through our stuff side by side so that when crisis happens still at least we would have each other, because I mean, there was common ground for why we got together. (Ann)

Instead of the trajectory Ann described, this couple were separated for 3 years following the birth of their son. Despite concerted efforts to parent alone, Ann eventually succumbed to the realization that her task was impossible and unnecessary; she eventually returned to her partner, and they now live together with their son.

**Mothers’ guilt**

Mothers felt guilty about receiving numerous services while partners received virtually nothing:

I had a nice place, food in my fridge, it was warm, it was light coloured, no bugs in it, and I had a washroom all to myself, and I had a kitchen and everything, and he didn’t have any of that, he just had a room with mice in it. (Amy)

Guilt intensified when mothers’ services were contingent upon status as ‘single mother,’ in the context of ongoing relationship with fathers:

There’s a program that will pay certain of those debts as long as you don’t owe the government money but they’ll pay bills, the thing is for the form, I had to fill out that I was a single mother, and he looked at that and he got so mad he ripped it up, and I
was like it’s just a little lie that I have to tell because it will help me to pay my bill
right and he was like “forget it you don’t need it.” (Amy)

Fathers’ bureaucratic displacement by mechanisms in place to assist mothers emotionally
impacted both parents. They were helpless in the face of numerous systems that made child
custody contingent upon mothers’ declaration of single parent status; two-parent families
were ineligible for services. Parents were forced to lie about and/or hide their relationship
to meet the family’s basic needs:

Because [housing] was for women only so it was under my name and it was for me
and my kids. And because I had a partner or something, I wouldn’t have been eligible,
so we had to do it like he was my friend or something like that. It was strange. (Erin).

Another dimension of mothers’ guilt is feeling ‘singled out:’ “I felt singled out and I try and
share or, you know, include him. And then we have people say, ‘Well, that's not really for
him.’ It's upsetting” (Erin). This positions mothers as privileged in contrast to fathers; at this
point structural inequities directly enter the relationship. Erin felt guilty:

Guilty. [laughs] Really guilty, because he has just as much right. I mean, he is the dad.

He's going to be in the children's life and he should have just as much as me and
baby. But they really encourage mothers and babies but not the whole family
setting. We really need that encouragement that, "Yes, you're going to do good as a
family. Yes, dads, they have their issues but it's okay for them to be..." instead of,

"Oh, he's like this so he's no good. You should stay away from him." (Erin)

The structural divide placed solidly between mothers and fathers by health and social
services reifies embedded gender categories that position mothers as caregivers (Krane &
Davies, 2000) and fathers as problematic (Strega et al., 2012). Outcomes of positioning mothers as lone and fathers as unworthy run counter to the professed aim of health and social services to promote family health.

Mothers feel simultaneously grateful and guilty. Their guilt compels efforts to somehow impart knowledge; share food; offer comfort to fathers. Yet this urge to assist and share is mitigated by fear of losing custody. Custody depends on mothers’ ability to protect children. If fathers continue to use, mothers must balance assistance with caution: “Okay, I'm on the fence of trying to keep it to strict rules with him, but also try to help him at the same time because I feel bad” (Michelle).

Mothers noticed and reacted to more subtle forms of father exclusion:

With baby, he'd go in and he'd be, "Baby's jittering a bit. Her rasps seem a little high," and they'd just ignore him or put him off and then they'd talk to me and he felt very left out. And I got kind of upset because, I mean, he's dad. He's very involved. He should be encouraged because he is involved like that. (Erin).

These situations can result not only in mothers’ guilt, but also in fathers’ leaving: “Once they know that they aren't included or whatever, they feel left out, so they're like, "Okay, well I'm outta here then," you know? It's really sad that way” (Erin). Effects of forms of exclusion are far-reaching; it was not uncommon for mothers to leave Fir Square to remain with fathers, forsaking safety, medications, and adequate food and support services.
Refusing services that exclude fathers

At times, mothers refused services to preclude abandoning partners:

I couldn’t leave [my partner] and go somewhere and... especially with the first pregnancy because he would’ve been out here on his own and we weren’t exactly stable until... So I didn’t want him to have to be by himself when I was all full, I had food and I was safe and warm and comfortable. I didn’t want that. (Erin)

Poverty shapes experiences of services; food, safety, housing and health services are limited resources for these couples. They cope with “persistent poverty, intermittent homelessness, chronic illness...and stigma attached to addiction, AIDS and prostitution” (Simmons & Singer, 2006, Caring for each other, last para.). Pregnancy, the result of their intimate relationship, introduces the possibility of access to sufficient resources: for mothers only.

Mothers’ own needs for support, intensified during pregnancy, formed part of the impetus to avoid services and be with partners. Sleeping alone every night did not meet mothers’ needs for closeness:

They made it a little bit hard, because they wouldn’t allow [my partner] to stay past ten o’clock, before I had the baby, that’s another reason why I didn’t stay the whole pregnancy, we were inseparable till then, and then for the first 48 hours or 72 hours you don’t, you’re not allowed to have contact with your partner either so that is to me, those are the only things I would change, is the access to the partner. (Diane)

Diane strongly supports Fir Square and Sheway, yet decided to remain in her hotel downtown near her partner for most of her pregnancy; she relied on him for financial and emotional support.
Exclusionary aspects of Fir Square and Sheway were problematic for couples: “I didn't access the services at all because I didn't want to go by myself. I didn't want to do all this, go through this pregnancy by myself. I didn't want to do all this by myself” (Cathy). At some point along the trajectory of pregnancy and recovery, each mother in the study resisted services that provided food, housing, counselling, referrals to treatment and medical care, because the price of services, to ‘do it alone,’ was too high. As Ann explains:

Like they offered me to go live at Fir Square or whatever, but he couldn't come with me. So it was like, "Wow, you can't just separate us." So yeah, like right from the beginning they were trying to split us up because they could offer me services but they couldn't offer him anything. (Ann)

Forms of exclusion were not always overt; sometimes fathers were ‘allowed,’ but spaces were not father-friendly, discouraging fathers: “he just didn't feel like he was welcome. So he didn't really want to go, and I didn't want to go without him. So I just wouldn't go” (Cathy). This is strikingly similar to Doucet’s (2009b) description of “stay-at-home” fathers who “face difficulties gaining full acceptance” in “playgroups” and other woman-centred child-care spaces (p. 110).

Cathy initially blamed her partner for feeling “uncomfortable” in these spaces, stating “it was too much of a distraction trying to make him feel comfortable, and I wasn’t getting what I needed out of whatever was happening.” Cathy explained the dynamics of blame more fully: “throwing a lot of the blame on him...wasn’t productive... and I'd blame him because I wouldn't go to these places, but in reality it wasn't his fault because there was nothing for him.” Exclusion caused tension that sabotaged mothers’ engagement in services.
In effect, services hindered, not helped, mothers’ relationships with partners, primary supports in their lives. Cathy deconstructed individualistic ideals embedded in contemporary approaches to recovery:

It just seems like everything just works either for me or just for him. Never.... Like even when they say in recovery, "You should do it by yourself and you shouldn't be in a relationship," but how can that be when we have children? It's a different story for us. And it's just like, well, I don't want to leave him in the dust. (Cathy)

This couple have six children and a 14-year long relationship. The ‘recovery’ rhetoric promoted by health and social services, aimed at drug users, is faulty in its foundation: “researchers have not adequately examined ways in which both men and women make sense of and experience these relationships” (Simmons & Singer, 2006, Focusing on couples as a unit of analysis, para. 1). In Alexander’s (2008) view, the co-dependency construct is useful mostly in providing “evidence that social relationships are a major part of the pay-off of addiction” (p. 166). These relationships offer an antidote to the hegemonic individualism characteristic of Western capitalism, which results in ‘dislocation,’ and perpetuate addictions (Alexander, 2008).

6.4 Mothers’ views: Impact of exclusion on family

“Didn’t open any doors for him:” Impact on fathers

Mostly, mothers felt that had fathers been included in services, they “would have reacted differently...wouldn’t have been a deadbeat” (Amy). But this was not the case:

He had to go home to his bed in this place that everybody’s doing speed all the time,
and staying up and doing who knows what else. Well I know what they’re doing, it’s just a crazy fuckin’ place. He had to go to bed all by himself, while I got to sleep with [baby] and you know he was so sad going home because [baby] is his first born; he was sad that every night he had to go home. (Amy)

Fathers’ anger, jealousy and hurt are legitimate; they are excluded from the paved route to a better life that mothers must take without them, to keep babies:

At first I was like you know maybe I shouldn’t be staying here...maybe we should get like a cheap place and at least we could both stay there, but I stayed anyways because it just seemed like the smartest thing to do, all my decisions that I made I made with him in mind first, with [baby] in mind first.” (Amy)

Father exclusion puts mothers and fathers on different paths: “I’m moving forward, he wants to move forward, but what options does he have?” (Cathy). The growth mothers experienced surrounded by a safe, secure, holistic safety net, left fathers “in the dust:”

I was finding my independence; I was finding who I was as a person for the first time. Like having that child saved my life in a lot of ways, and it totally opened so many doors for me to give me a chance at a real future. But it didn't open any doors for him, and it just kind of left him in the dust, holding pictures of us, waiting for us to come back. (Ann)

It is not surprising that fathers continued to self-medicate with illicit drugs: fathers were “just kind of on the sidelines, just watching” (Cathy). Mothers also noticed the impact of father exclusion in fathers’ relationships with children: “I just think that he's getting cheated out of the bonding area” (Cathy). Mothers view the impact of exclusion on fathers in terms
of the bigger picture; a profound impact:

I think if he was there the full time with me he wouldn’t have been using, and that would’ve, when we had our hair, they did a hair strand test on him, when that was done, he probably wouldn’t have, he, that would’ve been the only factor that would have made him be able to go home, the baby would’ve gone home with him. (Diane)

Diane feels that had her partner received services, he would have stayed abstinent, and their child could then have been placed with him. She said her history with child welfare prevented placement of the child with her; but this was her partner’s first child, so would have been given a chance to parent their daughter. Thus the opportunity for this young Aboriginal father, a traditional artist, to raise his daughter, and for her to be raised by a parent, was eroded by his exclusion from services available only to his partner.

Mothers’ views of father exclusion offer insight into how services separate families. The few studies that exist with drug-using couples illuminate the importance of relationships to each partner, excavating these dynamics (Rhodes & Quirk, 1998; Simmons & McMahon, 2012; Simmons & Singer 2006), yet these studies did not encounter or address the compounded complications, and meaning to participants, of a potential family unit that includes children.

“My son needed a father:” Impact on children

Impacts of exclusion on mothers and fathers ‘trickle down’ to children, with some specific, immediate effects on children. Mothers directed to parent alone remarked on effects of father exclusion:
My son needed a father. He would cling to men, like anybody. He would run up to strangers and go sit on men's laps and stuff like that. He really wanted a male figure in his life, and I didn't know what to do about that. (Ann)

Children’s separation from fathers began in pregnancy, when fathers’ proximity to mothers was limited. At birth and onward, the separation was distinct: “Since he's not given all the stuff like that, it kind of goes into their bonding time. He’s not able to bond as much as I am with her, and I don't think that's very fair either” (Cathy).

Cathy was critical and astute in her observations about father exclusion, linking it to economics: “Everywhere it seems like they're trying to save a dollar, save a dollar, save a dollar. So how are we going to save a dollar? Let's exclude the father. The baby doesn't need the father essentially, but yes, the babies do.” Cathy spoke about how investing in comparative services for fathers could support families: “But it's money well-spent though, because it keeps that family unit strong.”

The fact that mothers “didn’t stay the whole pregnancy” because their partners were “not allowed to stay past ten o’clock” may also result in physical effects. As Messinger et al.’s (2004) study findings inform us “disruptions in maternal care” and low socioeconomic status, factors “associated with” cocaine use, rather than cocaine use per se, were associated with infant deficits (p. 1683) (italics mine). Mothers’ safety, nutrition, and overall health may be compromised by staying ‘on the street’ with partners, rather than on a hospital unit with ‘wraparound’ services (Diane). Erin made the same decision, stating “they wanted me to go up to [the maternal harm reduction unit] to stay, but I didn't want to because [my partner] couldn't be there.” Erin had medical concerns throughout her
pregnancy, which may have put the baby at risk: “I had cholestasis and it made my liver counts go sky-high. And I guess as she went full term, there could have been a chance she would've been stillborn, so they wanted me to go up to [the hospital harm reduction unit]. And again, I was like, "No."

As described above, Diane’s partner may also have been able to assume custody of their baby: “he would've been able to go home with the baby, that’s the only thing yeah” (Diane). Long-term outcomes of the separation of families through father exclusion are documented in other studies: “failing to engage fathers in child welfare potentially deprives mothers and children of supports and resources, and potentially fails to protect mothers and children” (Strega et al., 2012, p. 184). Harm reduction services offered to drug using mothers in pregnancy have the potential to set the standard and incite a transformation of child welfare approaches, towards father inclusion. With both parents receiving wraparound services, and learning healthier ways of coping, child welfare authorities would be more visibly remiss in dismissing fathers as potential carers.

“Services separated us:” Impact on relationship

Three of the four mothers in the study not currently in a current romantic relationship with partners, due to partners’ continued problematic drug use, stated with some certainty that father inclusion could have prevented this separation: “I think too we might have actually stayed together because I think like the separation is like part of his change of attitude and mine were because we were separate” (Amy). The ways that services divided parents are foregrounded in mothers’ perceptions: “right from the
beginning they were trying to split us up because they could offer me services but they couldn't offer him anything” (Ann). Services for mothers were mandatory, according to one of the mothers, and none were offered to fathers, “totally driving [them] apart” (Ann).

Mothers were directed to exclude fathers from planning, and from their recovery: “there’s nothing in place for us as a family to do things, and everyone just keeps on saying ‘just concentrate on you’” (Cathy). Mothers felt services were aimed not at facilitating healthy relationships with partners but were “trying to push us apart” (mother, focus group). Separation through service delivery is not limited to these services; government social assistance policy contributes to the separation of families. As Diane reported “we’d lose another 100 dollars if he was added to my file” (Diane). One mother deconstructs the assumptions implicit in father exclusion:

And I understand it's a women-centred program, but I came with [my partner] and [my partner] and I are together and I think that they should have programs for couples, you know? Not every woman is alone by herself or has a safety concern with her partner. (Erin)

Recognizing that safety concerns form a rationale for father exclusion, Erin’s statement is important in pointing out that this is not always the case. When fathers’ behaviour presents as problematic, his need for services can be viewed as even more substantive.

Erin identified specifically how services divided the couple: “I felt like there was something for me and it would kind of put a barrier against me and [my partner], because he's like, "Oh, you've got this to go to. I don't," you know?” (Erin). Michelle felt that father inclusion would have strengthened their relationship, partly because “he would know how
[she is] doing” (Michelle).

Father exclusion from addictions services, during mothers’ pregnancy, and in the postnatal period, sets the stage for a longer-term division of the family. Of the ten couples interviewed for this study, half were not together at the time of the interviews; one couple had reunited after a 3-½ year separation. The other four couples remained apart, with mothers in women only housing and fathers continuing illicit drug use. Of the five couples still together, two were abstinent, living together and parenting their children. Of these two couples, both fathers had completed previous addictions treatment, positioning them as less in need of services.

“You look like an idiot:” Child welfare

Child welfare practice also excludes fathers (Strega et al., 2012). Mothers in this study had been children in care, and were mothers of children in care. For first-time mothers abstinent at the time of delivery, and through most of their pregnancy, child welfare was not involved; only one of the mothers in this study fit this criteria.

Ann was a first-time mother who grew up in foster care. Her child welfare social workers insisted she live with her grandparents, without her partner. Her story is typical of clients at the mercy of a crisis-driven system. Consistent with the Hughes (2006) report, criticizing B.C.’s Ministry for Children and Family Development, child welfare authorities were not responsive to her requests for assistance, but were reactive to reports they received from the community: “When you go in to see a social worker for help when you don't have an open file and stuff like that, they look at you like you're an idiot. Like, ‘what
are you doing here?”(Ann). Ann reported that allegations made to child welfare authorities, suggesting she had mental health issues, were investigated but proven unfounded.

Three of the mothers reported that child welfare authorities forbade them to have contact with the baby’s father until and unless he had clean drug screens (for illicit drugs). While mothers agreed, they were frustrated that services weren’t offered to fathers, to facilitate fathers’ ‘clean drug screens.’ Other mothers were required to live with relatives, with the baby, for a period of time, to demonstrate abstinence and ability to parent. None of these situations included fathers. Mostly, mothers were unwilling to be assertive about fathers’ exclusion, fearful authorities would remove and place babies in foster care if they advocated for fathers’ involvement.

6.5 Routes to belonging: “Put the welcome dad sign up”

Resistance/subjection

Mothers were reluctant to rock the boat with such high stakes; one mother and her partner described resistance to father exclusion, but not until their son was 3 years old:

We've gone back and insisted, saying, "Listen, he is part of our life. You're not going to separate this man from our family because it's just not going to happen. You did that once, and it's not going to happen again, and we're fighting and insisting on having him as an equal person in this relationship.”(Ann)

At last report, these parents were abstinent and parenting together; yet for three years they were separated; the father was not offered any services by maternal harm reduction services or child welfare authorities. Ann received services, but they ended and she found
herself unable to cope as a single parent. As a result, their son was placed in foster care.

One mother was confused about what services were available to fathers, and was afraid to ask: “I don't know how to bring that up to them” (Cathy). She said she did not know what her “rights or options” were, because she did not yet have a lawyer (Cathy). Mothers’ resistance is also reflected in examples discussed above, such as refusal of services without partner inclusion.

Erin found it uncomfortable to be the centre of ‘services attention’ and described this as a “stressor” (Erin). Erin and her partner coped with these tensions by congregating with other parents on the “smoking patio” to “vent” (Erin):

They have that smoking patio and us mothers and [my partner] and whatever dads are there, we just go out and vent. And we vented to each other so that helped a lot.

With this pregnancy, we had a good group and we vented. (Erin)

When asked whether she addressed her discomfort with staff, she said: “No, no. Like I say, I'm not a very trusting person and I wouldn't want it to affect anything. You just grit your teeth and you go through it and you leave” (Erin). Erin’s barriers to resistance included trust; being shy, and fear of having their child removed. Erin was not alone in her distrust; Georgia would not leave her baby in the nursery at all, to be cared for by staff:

There was nobody that didn't have blood relation to him that was with him. I mean, when I left, [my partner] was with him, and when we had court, my parents were with him, so we just... he was never left alone. We're just scared, I guess. Paranoid.

(Georgia)

Overall, mothers were cautious and protective; resistance was avoided, perceived as too
risky. Mothers’ silence suggests we need to listen to what mothers are not saying.

**Inclusion**

These are ‘discrepant’ data, capturing instances where mothers perceived father inclusion. Mothers appreciated that fathers could stay with them once the baby was born, in spite of a lack of access for fathers to food, counselling, and other services: “after we had the baby it’s a lot different. He can spend the night with me here and it's just helped me in my stabilizing period because I have his help, and I know he's safe and I know he's okay” (Cathy). Father inclusion can be pivotal in stabilizing mothers.

Fathers were allowed to attend parenting groups at Fir Square and Sheway although did not, for the most part, feel comfortable doing so. Fathers also attended doctor’s appointments with mothers: “he always went there with me; that was his choice and he was allowed to be there with me” (Amy). This couple was offered counselling at a women’s only resource; this was an exception, as couples counselling was not part of the service’s mandate: “that was way beyond her job description right and she just offered to do the couples counselling. She really wanted to help us” (Amy). Amy felt service providers appreciated her partner: “everywhere that we have gone, every services that we have had, the staff have always complimented him on how involved he is” (Amy). Yet her partner did not perceive himself as included.

One mother thought partners were treated equally to mothers after the baby was born, on the harm reduction unit:

The spouses, after the baby's born they're treated the exact same, they have access
to everything the woman has, they can go to any of the groups, they have access to talking to the nurses, going into the nursery, anything” (Diane).

Yet fathers do not receive food, medical care, alcohol and drug counselling, assessment, referrals or advocacy services. Georgia had a similar experience: “They offered him everything that they offered me. They were really good with us.” (Georgia). Georgia and her partner only arrived at Fir Square following the birth. One mother said that her partner was able to stop using for longer periods of time when he was able to stay with her on the unit, because he was involved in helping with the baby.

Michelle also said that staff at the Sheway, “try to include the partners with doctors' visits and stuff like that.” She said women were allowed to “bring guests to have lunch, which includes your partner” (Michelle). One mother was transferred to a unit for mothers with very high-risk pregnancies (Evergreen); in this unit, fathers are allowed to stay overnight prior to the birth. This policy suggests potential for changing the current policy at Fir Square.

Variations in fathers’ experiences of inclusion at both Fir Square and Sheway are inexplicable; these could be attributed to differences in approach, attitude or personality on the part of either staff members or of fathers. Fathers’ perceptions of inclusion may also differ somewhat, based on their sensitivity to exclusion. My own perspective suggests that race, class and behaviours of fathers, in combination with staff attitudes and biases, formed the basis for variations in father exclusion.
Services wanted

Mothers wanted services that would facilitate a healthy relationship: “problem solving with each other, and good communication skills” (Ann). Mothers also wanted social work services, specifically “a housing worker;” “referrals to parenting groups;” help with housing and financial assistance; and “skills to work together and hang in there as a team” (Ann).

Mothers wanted fathers to be able to “access all the things that were given, like parenting groups and doctors and whatever, and to deal with his issues,” in addition to a “meal program where he can get some food too on the side, because it would encourage him to be here because he wouldn’t be hungry all the time” (Cathy). Because mothers want to stay with partners, they want “anything that would help [them] in [their] recovery together” (Cathy). They requested supported, supervised housing, for mothers, fathers and babies, together. Part of the reason for involving fathers is mother engagement and retention in services: “it would actually encourage the mothers to actually to go through with it and stick with it if the father could be there with them” (Cathy). They want “programs for couples,” a “couples’ group.”(Erin). Mothers requested family treatment at all stages, from detoxing to maintaining abstinence, along with help meeting basic needs such as food, housing and life skills, including parenting.

One mother recommended peer support for fathers, and extra staff on weekends at Fir Square. They want services to “help rebuild families instead of pulling them apart” (Mary). Mothers understand the implications of services for fathers:

Well yeah, because then, obviously, he's going to have to go somewhere else or find
other ways to get money. And obviously, he could go back to his old ways to get money and just to survive, right? Like stealing to eat and shit like that, so it's... yeah. Something like that from the beginning; I think that would really help. But we have our own separate space. We can work on ourselves but still have the support and I think that would really work. And then eventually get support to go out on our own and live as normal people do; whatever that's like. [laughs] (Mary)

Mothers wanted “the opportunity for men to live there before the baby's born, because that might ultimately change that person's life” (Michelle). They want “more services for fathers...I would like to see them help with dads too, if they're struggling with recovery, not just thinking about us. Help them get into a recovery home or programs” (Sherry).

Mothers, too, were angry about being forced to choose between partner and child: “I wanted to keep my daughter in my life. So what I did was, is I just did what they wanted me to do. I jumped through their hoops, and I did what they wanted me to do.” Mothers and fathers felt service providers needed some training, and resources needed re-alignment: “I think the service providers need kind of a consciousness raising around how to welcome men. Like, put that ‘Welcome Dad’ sign up there” (mother, focus group).

6.6 Summary: Mothers’ data

Mothers’ data unfolded ‘stories’ that began with mothers’ experiences in their family of origin: ‘A lot of bad stuff happened to me.’ Mothers’ stories of family depict traumatic beginnings and distant, unsupportive family relationships that hindered mothers’ growth and potential. Poverty also constricted mothers’ potential.
As mothers became pregnant, their identities shifted into a ‘risk’ category, as drug users carrying foetuses. Entry into a category of ‘risk’ brought mothers into a system of addictions services, aimed at meeting numerous needs, for housing; counselling; nutrition; licit drugs; parenting. This package also entailed child welfare involvement, and in almost every case, the risk of losing partners. Mothers viewed pregnancy and concomitant support systems as a turning point, away from illicit drug use, towards ‘normalcy,’ safety and security, achieved by, in most cases, sacrificing partner relationships.

Mothers’ relationships with fathers form a dichotomy, between ‘best friends’ and discouragement with fathers’ continued illicit drug use. The impact of father exclusion on mothers can be summarized as onerous: ‘Pressure’ on mothers includes a variety of ways mothers attempted to provide services to fathers. As mothers struggled to achieve ideals of autonomy and self-sacrifice, separated from fathers, the cost rendered for their partial ‘active citizenship,’ for some mothers, became weighty and intolerable. Mothers’ appeals for father inclusion mirrored those of fathers, as did their descriptions of services needed for fathers.
7. Summary of findings: Dynamics of father exclusion

An essentialist, ‘difference’ feminism underpins addictions services for women, concealing class and race, constructing fathers as dangerous and mothers as able and encouraged to attain ‘good mother’ identities alone. Omitting class and race is highly problematic, particularly for the mothers and fathers in this study, who shared biographies of limited resources, abuse, neglect, poverty and problematic substance use. Class and race are critical to understanding the vulnerability of both fathers and mothers in their interactions with health and social institutions.

Following mothers’ involvement in services, for most couples, paths diverged. The institution responded only to mothers’ needs for food; space; shelter; transportation; safety and counselling support. Fathers went without. This separation by gender introduced an additional class difference: suddenly mothers were, relatively, ‘haves’ compared to fathers.

Fathers in this study placed primary importance on relationships, contesting individualism as a masculine trait. Fathers experienced despair at separation from partners. Effects of oppression and structural violence were compounded by exclusion. Post-exclusion, they fell into depression, suicidal ideation and behaviours; prison; and/or and continued problematic drug use. Those fathers who remained with mothers, abstinent, drawing on shared resources, and parenting, had completed treatment prior to mothers’ pregnancy, so perhaps did not require services. These were the two fathers not ‘left in the dust.’

Further, within the context of treatment services, mothers assumed a ‘false autonomy,’ influenced by subtle yet powerful discourses of individualism. Letting go of
relationships with fathers, entering the category of ‘single mom,’ mothers experienced hope at the possibility of exiting a marginalized status, and achieving active citizenship status; this prospect may have been made more attractive by the intense stigma occasioned by mothers’ illicit drug use. Mothers’ hopes were dampened, however, initially in the face of pressure to support or let go of fathers, and finally as services eventually disappeared.

The trajectory begins with the ‘difference’ feminism theory underpinning services, which disappears class and race; this leads to further institutional structural inequities in the provision of harm reduction maternity services, and the production of stress and isolation for both mothers and fathers; ultimately fathers are ‘left in the dust’ and mothers are alone. These mothers and fathers contested gender binaries, suggesting that essentialist feminism is a false dichotomy that requires deconstruction.

‘Difference’ feminism

The ‘difference’ feminist lens (Doucet, 2006) that appears to underpin addictions services developed over the last decade or more in Canada, exaggerates and reifies constructed gender differences, constricting possibilities for both parents (see Doucet, 2009a; Fausto-Sterling, 1985). Mothers are separated from family and community; their focus on developing autonomy/independence supports neoliberal values of individualism, conferring on marginalized mothers a false sense of agency.

In reality, mothers’ agency is continuously undermined by an ‘expert’ model of intervention prominent in treatment services and in child welfare. The mechanisms of this model include surveillance, foregrounding of maternal responsibility, and inculcation into
‘recovery’ and co-dependence theories, while excluding relationships, family, biography, social context and the role of structural violence. Problems are individualized, constructed as pathology.

Hegemonic masculinity in the context of neoliberalism creates ruptures for marginalized men, who are in a deficit position in their ability to meet these standards. There were no incidents of violence recounted in the data; yet fathers felt they were viewed as dangerous. They were well aware of ‘security’ at Fir Square. Limited understandings of interpersonal violence are embedded in the discourse of addictions services for mothers; this discourse continues to function as a rationale for father exclusion. Sadly, effective responses to interpersonal violence have yet to be developed; those that do exist are located in ‘hotbeds’ of structural violence, such as prisons. Structural violence continues to be excluded from discussions of violence in theory and services for marginalized drug-using fathers and mothers.

These essentialist attributions of gender demonize, and caricaturize, fathers and mothers using illicit drugs. Their heterogeneity is left unpacked. The importance of relationships to fathers, and their capacity for relating, is disappeared. Mothers’ agency is attenuated. Further, the ways that class interferes with mothers’ and fathers’ ability to ‘achieve’ these stereotypes is concealed under the blanket of ‘gender’ differences.

**Structural inequities**

Fathers’ and mothers’ stories wind through structural inequities, from their beginnings. Emerging from substantive histories of poverty, racism, social exclusion and
stigmatization, the offer of services opened a door to an option for social inclusion for mothers, once they became pregnant, and most took the opportunity. Social inclusion means the ability to participate in society, facilitated by having basic needs met. The institutional favouring of mothers and the exclusion of fathers resulting in an additional structural inequity in which class and gender intertwined.

For fathers, conditions of poverty, racism and social exclusion not only continued following mothers’ involvement with maternal harm reduction services. Fathers were assumed to have access to their own food, housing and transportation. For the father participants in this study, such was not the case. In fact, structural inequities were exacerbated, as fathers’ lack of fit with White middle-class norms of the institution formed an integral part in casting them as unworthy partners/fathers.

Formative, pivotal axes of race and class are dismissed in the context of gendered services. Currently, structural inequities in this system increase mothers’ burden, and facilitate fathers’ isolation and harmful means of coping, through continued self-medication. These findings support those of the few qualitative studies with drug-using couples that do exist (Rhodes & Quirk, 1998; Simmons & Singer, 2006; Simmons & McMahon, 2012).

**Orchestrating mothers’ collusion: ‘left him in the dust’**

Mothers found themselves in a predicament: their pregnancies were life-changing, services opened doors for them, to housing, security, stability and personal growth. Yet engagement in services resulted in forced or ‘natural’ separations from partners not privy to these opportunities. Mothers who entered residential treatment services may have been
subject to further father exclusion, through a discourse that promotes ‘independence/’individualism and disavows mothers’ important relationships.

Mothers were caught in a dichotomy: ‘Pressure’ from working at father inclusion, and at being a ‘good mother,’ contrasted with ‘moving forward’ towards active citizenship. Mothers were influenced by service provider discourse relating to relationships and ‘co-dependency.’ They learned to ‘focus on themselves,’ to collude in father exclusion. Initially resistant, mothers eventually succumbed to structural ideology, moving forward alone, leaving fathers “in the dust.”

Fathers’ stories reflected a deep love for and commitment to family; followed by a wall of exclusion and loss. Fathers depicted subtle and overt exclusion, and what inclusion would look like. In ‘Routes to belonging,’ fathers instructed us to nourish their relational capabilities and teach them what they need to know: about loving and fathering. Their statements confirm their significant potential as fathers, partners and friends: our refusal to facilitate these routes takes fathers to streets and prisons, sites of intense structural violence. Their stories told us how fathers were affected by exclusion: that most fathers in this study returned to the ‘dust;’ the street, and problematic drug use (and/or prison), speaks for itself.

**Destabilizing gender**

The findings of this study disrupt the gender binaries prominent in addictions literature, services and elsewhere, illustrating how these oppress mothers and fathers engaged in these addictions services. The strongest thread in fathers’ data pertains to
relationships; fathers described their relationships with mothers and children as pivotal, contesting their positioning in the addictions literature as distant and dangerous.

Mothers in the study were constrained, by the high stakes of losing custody of their babies, from resisting their positioning as able and willing to take on single motherhood. Mothers in the study told us about the enormous burden created by expectations that they ‘do it all,’ that they achieve idealized images of motherhood, alone, and unsupported. Learning to ‘be polite with people’ wears thin for single mothers who find themselves alone and overwhelmed with, for example, going to school, parenting, ‘doing recovery,’ and working. These findings contest the tenets of ‘difference’ feminism, illustrating that myths of gender ‘differences’ can be located in hegemonic structural ideals.
8. Conclusion

In the first part of this chapter I describe the strengths and limitations of the study, including an explanation of my decisions relating to method and analysis. I then discuss the implications of the study, and summarize how addictions services and cultural constraints of gender, class and race combined to produce unexpected findings in fathers’ and mothers’ data. In the final part of the chapter I review literature, making recommendations that could support actualizing this theory in services redesign.

8.1 Strengths and limitations of the study

The conceptual framework I developed from these data encompasses four dimensions: a) ‘difference’ feminism and its unintended consequences; b) structural inequities; c) how mothers’ collusion in father exclusion is orchestrated through health/addictions discourses aimed at separating couples; and d) disrupting gender binaries. This analysis meets the requirements of Glaser’s four criteria for rigour: fit; work; relevance and flexibility (Charmaz, 2000) (see p. 87, this paper). I have established in detail how these four dimensions emerged from the data, and explain the “studied phenomenon” (Charmaz, 2000, p. 511), in this case father exclusion in the context of maternal harm reduction services. The theoretical analysis offers an explanation of what happened for these mothers and fathers as a result of father exclusion: they were separated by services; their divergent paths and difficulties are described and explained. Throughout the analytic process, initial
codes emerged, further interviews were conducted, data was analysed and re-analysed, and codes were modified; the analytic process was lengthy, thorough and ‘flexible.’

The findings of this qualitative study with a sample of ten mothers and ten fathers, former patients of Fir Square, appear to be representative of the population of marginalized families who have populated Fir Square. As the former social worker on Fir Square, I can say with some confidence that this set of twenty parents was analogous to those I worked with. I observed father exclusion and its immediate effects in numerous situations. Demographics of this set of parents were also comparable to those I worked with: for instance, all twenty parents interviewed were on social assistance; only one was educated beyond high school; parents used primarily illicit, rather than licit, drugs; those with children had children in care of the state; 80% of the mothers identified as full or part Aboriginal; 60% of the fathers identified as Aboriginal.

As a quantitative method was not used for this study, inference to the general population based on statistical significance is not an appropriate assertion; yet it is fair to say that views of these twenty participants reflect the perspectives of many other former patients of Fir Square, particularly since these findings are confirmatory of those of the pilot study. The possibility does exist, however, that there are views, behaviours and circumstances of former patients of Fir Square that were not represented here. Nevertheless, the findings do provide a substantive basis for initiating inclusive actions in addictions services for partners of drug-using mothers.

Following Charmaz’s (2006) constructivist epistemology, the knowledge drawn from these data is co-constructed by participants and the writer/researcher. The depth of my
experience as ‘insider’ is significant in this study. As a former illicit drug user, a former child welfare worker, a mother, and the former social worker at Fir Square, my sensitivity to the nuances of participants’ experiences was heightened. Constructivist grounded theory disavows claims of objectivity in any research endeavour; with this in mind, coupled with the magnitude of my insider location, I strove to attend to those instances where I may have reached beyond the data or neglected to address discrepant data.

Although the pilot study employed both quantitative and qualitative methods, because insufficient data pertaining to fathers exist on hospital charts, I chose to forego a quantitative method. In conducting the pilot study, I found almost no information was collected about fathers of the babies born at Fir Square; BC Women’s standard hospital forms, used on the postpartum units, do not collect information about fathers; the Vancouver Coastal Health Authority community health forms used by Sheway collect only a minimal amount. This is concerning because, as Daniel & Taylor (2001) point out: “Genetic information may be important for health reasons, but the lack of information about origins can have other effects...for some children this gap is keenly felt, perhaps particularly for children of mixed-race heritage” (p. 185).

Research with non-drug using mothers, and their partners’ experience with maternity services did not form part of this study; a comparison to experiences of middle-class, non-drug-using fathers may be useful. Father exclusion may not be limited to marginalized, drug-using fathers; yet class is a significantly germane factor in the impact of this exclusion on fathers.

As this is the first known study conducted with drug-using fathers, it could not build
on previous studies, with the important exception of the pilot study for this study. The findings from this study are consistent with those of the pilot study (see Weaver, 2009).

8.2 Implications of the study

This study was unique in that it focussed on marginalized drug-using fathers, excavating their views of addictions services for pregnant partners; such a study is, to my knowledge, unprecedented. As Doucet (2006) points out, “studies on shared-caregiving couples or primary caregiving fathers have continued to focus mainly on the narratives of middle class white fathers and families” (p. 31). Qualitative studies with drug-using fathers are very few, and none elicit fathers’ views of these or similar services. Very few studies of couples using illicit drugs exist (Simmons & McMahon, 2012). The study findings make a significant contribution to the literature and theory that inform addictions services in North America, for pregnant mothers and their partners.

The study is also unique in that the voices of mothers contest the current ‘status quo’ in terms of the ways that services for women are designed and delivered. The mothers in this study clearly state that they would like partners to be included. These data contest assumptions that have guided the design and delivery of current ‘woman-centred’ services for users of illicit drugs.

Further, these findings contribute to destabilizing gender norms embedded in patriarchal culture in North America and elsewhere. Contesting these archetypes, fathers in the study placed perhaps even greater value on relationships than did mothers. These findings may be partially attributed to the philosophy, approach and guiding theory of
addictions services; as I have shown, relationships with male partners were subtly or overtly discouraged, resulting in fathers’ despair. Mothers, conversely, appeared to prioritize their own development, at the repeated behest of service providers.

8.3 Inclusivity framework

I have condensed the thematic analysis of these data to form an analytic framework to apply to service design, development and delivery. I identified three overarching dimensions, encompassing: 1) deconstructing gendered assumptions; 2) intersectional analysis: program design and delivery; and 3) integrating partners.

1. Deconstructing gendered assumptions

This entails examining current policy and services with the intent of identifying and deconstructing program elements based on normative gendered assumptions. Program reviews will identify a) who is excluded from the program(s); b) what values inform the program(s); c) how and where are values actualized in all program areas; and c) what gendered assumptions inform policy and practice. Policy and services should intentionally cultivate and integrate space for ‘non-normative’ gender traits/behaviours.

For instance, fathers in this study indicated that their relational capacities were limited, and identified a longing for connection. They expressed a desire to engage in caring, and demonstrating caring behaviours with partners and children. Conversely, mothers in the study expressed resistance about
shouldering the ‘burden of care.’ These findings stem from gendered assumptions about fathers and about mothers that informed these and other harm reduction and other addictions services. Staff will require education and training to be able to deliver gender-neutral services. They will also need support and a culture of safety to share biases and challenges in working with a de-gendered approach.

2. **Intersectional analysis: program design and delivery**

The point of intersection of class, race and gender must inform service design and delivery. Class and race may need to be consciously foregrounded in reviewing programs with deeply gendered theoretical underpinnings. The intersectional ‘light’ must be shone on all program elements. How does the program incorporate awareness of structural inequities produced by class and race? Who is excluded, subtly or overtly, and how might this be related to class? What assumptions guide program design and delivery, which are produced by unconscious assumptions about race and class? How are intersections of class, race and gender routinely interrogated in program design, and in practice? How are service consumers’ problems framed – do race, class and gender, and related structural inequities, form part of assessment, treatment and discharge planning? What are staff biases and assumptions in these areas, and is there a safe space for them to talk about them?
3. Integrating partners

Excluding significant others from services aimed at healing and recovering from problematic substance use is counter-productive (Klee, 2002; Simmons & McMahon, 2012). Mothers and fathers in this study identified their relationship as vital. Program content and service provider approach can be evaluated and shifted towards inclusivity of significant others. This can begin in the referral and intake procedures, in collecting demographic data about family members (e.g. use of genograms). These documents, and other program policies, will also be scrutinized with an intersectional analysis: how have the intersections of class, race and gender shaped the life of these families? What historical damage has caused ruptures in relationships? How can we best respond to fractures in this family? How can we ask questions to help family elucidate the impact of structural forces? How can damages be repaired?

8.4 Implications for practice: Applying promising practices

Participants’ experiences point to the necessity of addressing structural conditions and biases in research, theory and practice. This presents a challenge for service providers who may be, for the most part, unwitting participants in father exclusion; “it is crucial that a process of engaging with women workers’ fears, anxieties as well as hopes is undertaken” (Featherstone et al., 2007, p. 93). Services are driven by theory and how it informs program development; for the most part, this is out of reach for service providers; “As Agar notes,
‘saying that poverty is a risk factor for drug use does not help much. What is the clinician to do, tell the person to stop being poor?’ (Rhodes, 2009, p. 197).

**Cultivating resistance**

Yet there are possibilities for transformation of services. Theory and models of practice have emerged that meet this challenge. Reynolds (2010), for instance, in her work with survivors of torture, has developed a “supervision of solidarity” paradigm that directly and consistently links the personal with the political. Reynolds (2010) avoids a therapeutic “positioning which could invite practices of judging, diagnosing, educating, explaining, encouraging, applauding...” (p. 3). Reynolds (2010) emphasizes “looking for the person’s own account of their sites of resistance, their resistance knowledges (Wade, 1996) and the meanings these acts of resistance hold for the person” (p. 11). This approach “decentres” the helper, and facilitates highlighting people’s acts of resistance to oppression in whatever form and location these acts of resistance took place. For substance-using parents, routinely exposed to numerous forms of structural violence, highlighting their acts of resistance to this violence shifts the focus away from personal shame and towards social change.

Working with marginalized fathers and mothers in this way may contribute to shame reduction and thus to reduced substance use and conflict; as they identify times and ways that they have actively resisted oppression, they would be better able to recognize and name forms of self-advocacy they have already practiced. Unlike other models, this approach links adaptive substance use to structural violence, facilitating the capacity of users to name and more effectively respond to forms of oppression in their everyday lives.
Addressing violence in context

Taylor et al. (2004) explain how Western conceptualizations of domestic violence emerge from “the dominant culture that emphasises intimate relationships occurring between adult partners in a relationship and isolates these from family and community relationships” (p. 72). Important to note is that Western constructions of domestic violence have excluded the views of Indigenous women (Taylor et al., 2004). Taylor et al., (2004) espouse a holistic approach to interpersonal violence that is sourced from, and sustainable by, the community and its strengths. This framework enhances social integration, effectively reducing maladaptive substance use and interpersonal violence.

Hearn and Pringle (2000) argue the necessity of a “fundamental reconstitution of patriarchal relations and dominant forms of men’s subjectivity” (p. 375) in changing men’s relations to children, and, I would argue, to mothers and others. Hearn and Pringle’s (2000) work, however, is set within a European framework: the subjects are the colonizer rather than the colonized. In North America, “Indigenous children are over-represented in the child welfare system, while Indigenous fathers “remain on the margins of mainstream society” (Ball, 2009, p. 44). The framework that Ball (2009) developed provides a roadmap that offers “numerous points of entry for effective positive change” with and for Indigenous, marginalized, substance-using fathers (p. 44). This framework includes collaborative interventions in the life areas of Indigenous men, along with public, political interventions (i.e., changes in policy and legislation).

Like Ball’s (2009) framework, the models proposed by Reynolds (2010) and Taylor et al. (2004) constitute initiatives that begin to bind the personal and political, situating the
problem within the community and larger social structure rather than in the individual. I propose building on and connecting these models to address hegemonic masculinity, and its concomitant manifestations of problematic substance use and violence. Reynold’s (2010) therapeutic model, based on work with torture survivors, is well-suited to forming the basis of an ethics and discourse of resistance in practice, and in addictions research and theory. As revealed, the current theoretical frameworks that govern addictions research and practice perpetuate gender binaries that problematize men rather than hegemonic masculinity. Application of a structural lens exposes false dichotomies, illuminates obscured sources of oppression, and suggests possibilities for positive change at multiple levels.

Structural violence, integral to globalization and capitalist society, produces alienation, also referred to as “dislocation” (Alexander, 2007). In contemporary North American society, substance-using fathers may experience a uniquely acute sense of dislocation, or lack of social integration, particularly those oppressed by race and class.

**Reproductive processes: Integrating fathers**

Another aspect of fathers’ dislocation may lie in fathers’ experiences with and (lack of) involvement in reproduction. Carter (2009), in her qualitative study with eighteen postpartum women, sought to extend Mary O’Brian’s (1981) theory that for women, connections with their children are affirmed through childbirth, while fathers “attempt to affirm their own integration in the human species through artificial claims to the products of women’s reproductive labor, such as the legal appropriation of children”(p. 121).
This theory further proposes that “reproduction lies at the root of male domination over women” (Carter, 2009, p. 122). Although patriarchal medical structures have claimed and now dominate the process of reproduction, Carter’s (2009) study confirmed “men report feeling detached from the childbearing process...which results in feelings of distance from their unborn babies” (p. 137). Importantly, Carter (2009) argues that men’s integration into the reproductive consciousness “would allow men to mediate contradictions in reproductive consciousness through the process of reproduction, potentially eliminating the need for patriarchy to mediate these conditions” (p. 138). Inviting fathers to share the reproductive process could assist in efforts to “ungender the public and private sectors (O’Brien, 1981) and promote the compatibility of work and family” (p. 138). Yet as Carter (2009) makes clear, this need not, and should not, compromise women’s agency. In reference to addictions theory, research, policy and programs, this process, and caveat in respect to mothers, could unfold, resulting in reduced dislocation, concomitant violence and substance dependence.

**Reconfiguring services for women**

As Alexander (2008) argues, “the best way out of addiction is overcoming dislocation by finding a secure place in a real community” (p. 340). Residential addictions treatment for women takes women out of their community, constructing relationships as ‘codependent,’ and constructing trauma as personal rather than structural. Creating spaces where women are separated from families and communities perpetuates dislocation, rather than the psychosocial integration described by Alexander (2008) as central to healing from addiction.
If women come from communities that lack the social capital to support healthier choices, women in recovery can co-create alternate communities that cultivate a sense of belonging and purpose.

Groups such as Vancouver Area Network of Drug User’s Women’s Group provide a resource for women actively using illicit substances in the Downtown Eastside of Vancouver; resources like these also incorporate recognition of structural factors such as institutional violence, poverty, racism and colonialism. Similar resources could be developed by and for men, and also by and for both men and women who choose to abstain from or reduce problematic substance use. Spaces for women to remain in their communities and cultivate healthy relationships with family and community members could be created and maintained at minimal cost. Safe spaces that promote health and are inclusive of family and community members must be cultivated wherever possible; these are the models that will enhance sustainable change.

In terms of providing care that meets deeper psychological needs of women recovering from problematic substance use, approaches have been developed that do reflect an awareness and acknowledgment of structural factors. “Honouring Ourselves and Healing Our Pasts: A Manual for Support Persons” is one such document (Downtown Eastside Healthy Communities, Mothers and Children, community Leaders Working Group, 2005). This document describes an approach that has “four core components,” and is based on the teachings of the medicine wheel; the four components address spiritual, physical, mental and emotional wellness (2005, p. 3). Developed as a resource guide for practitioners working with women struggling with problematic substance use, the elements of this model
reflect principles that refrain from a pathologizing discourse of ‘expert,’ and support women’s agency while reflecting structural conditions that contribute to women’s struggles. As such this model can function as a guide to policy and practice in women’s addictions services that refrains from empty rhetoric and from imposing theory that masks structural factors contributing to women’s problematic substance use.

Copello and Orford (2002) argue for addictions services to begin to include the families and communities of problematic substance users to increase engagement and retention in recovery. An exclusively gendered discourse and model of treatment prohibits the inclusion of significant others, particularly men, and excludes community apart from the therapeutic milieu. Such a model reflects and perpetuates colonist and patriarchal ideology consistent with individualistic neoliberal values. By including women’s wider social networks in the healing process, psychosocial integration is achieved, and this integration is sustainable, unlike residential, outpatient or other forms of government-sponsored treatment. Family or community members whose behaviours include violence are also in need of healing; as Copello and Orford (2002) suggest, strategies can be developed to offer ways of healing to these community members while maintaining safety. In many cases, these behaviours are re-productions of witnessed violence perpetuated by colonialism and require a helping, not a punishing response (Ball, 2009). Only by maintaining a structural focus can the “roots of addiction in free market society” be fully exposed and compassionately, effectively addressed (Alexander, 2001).
8.5 Implications for research

Clearly we know little of substance-using fathers, a heterogeneous group, and the knowledge of substance-using fathers thus far constructed in the addictions and other social science literature exhibits a considerable, negative bias. It will be important to pursue research with substance-using fathers in an ethically informed manner, mindful of the extant biases against them. Equally important will be consideration of mothers and children in the process of facilitating father inclusion.

Contesting the claims of feminist ideologies that demonize fathers as a group is an important project. Yet contesting these claims is a delicate process that must be based on acknowledging how structural factors such as race, colonization and class contribute to fathers’ problematic substance use and perpetration of familial violence. Further, this effort must be characterized by “more inclusion of the ‘voices’ of women and children in debates on and studies of these questions” (Hearn & Pringle, 2000, p. 376). Gender theory will also be vital to informing this work.

Laying the groundwork for conducting quantitative studies pertaining to fathers will be vital. Currently, the forms included in charts of maternity patients at B.C. Women’s Hospital capture little if any information about fathers. These will need to be revised to include demographic and other information about fathers, in order to gain a picture of who these fathers are.
8.6 Concluding remarks

Supportive, engaged fathers may be able to mitigate mothers’ experience of structural violence through health institutions, an experience common for substance-using mothers (Boyd, 1999; Poole & Isaac, 2001). Further, fathers who are engaged at this pivotal and potentially life-changing point may better assume a fathering role, reducing the burden experienced by lone mothers. As Ball (2009) concluded, by “helping fathers understand what children need and how, concretely and with few resources, fathers can meet their needs” (Ball, 2009, p. 45); the support fathers could provide might enhance opportunities for mothers to participate in the workforce or pursue other opportunities. A treatment industry dividing by gender, offering few family programs, does not afford these opportunities for marginalized parents who struggle with problematic substance use, and who most require support in meeting health, social and economic needs.

We have created a population of poor, single mothers by eschewing those supports they identify as critical. Primary supports, the fathers of their babies, have been ‘throwaway dads;’ these fathers fill our prisons. This ‘divide and conquer’ approach is, intentionally or not, weakening and destroying an entire race and class: specifically poor, marginalized, First Nations families. Poor White families are, of course, included in this destructive paradigm. We have ‘thrown the baby out with the bathwater’ by excluding fathers; a re-aligned, structural, gender-inclusive framework promotes reuniting rather than weakening communities.
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Appendices

| Self-identified ethnicity of mothers: 6/10 Aboriginal; 2/10 Mixed Aboriginal and White; 2 White |
| Employment/income: All 10 mothers were on social assistance |
| Age range: 25-37 years |
| Placement of children: All 10 mothers had at least one child in kinship care; 3 had children in state care or permanently adopted through state care; 2 were parenting infant with infant’s father; 5 had sole custody of their infants |
| Relationship with this partner, length in years: 2-14 (2 couples have been together 14 years) |
| Mothers’ living situation: 5 mothers were in women/children supported housing; 2 mothers were in Portland Hotel Society housing (1 ‘staying’ with partner; 1 own room; 2 mothers were in rented housing with their children and partner |

Appendix A. Mother demographics

| Self-identified ethnicity of fathers: 6/10 Aboriginal; 3/10 White; 1 Black |
| Employment/income: 2 fathers employed at least part time (unskilled labour); 8 on social assistance |
| Age range: 28-44 years |
| Number of children fathers are biological parents of: 1-6 |
| Placement of children: 8 fathers had one or more children in kinship care; 3 had children in state care; 2 were parenting infant with infant’s mother; none of the fathers had sole custody of their infants |
| Relationship with this partner, length in years: 2-14 (2 couples have been together 14 years) |
| Fathers’ living situation: 3 fathers were in Portland Hotel Society housing; 4 fathers were homeless or living in single room occupancy hotels; 1 father had been in provincial jail and was in a recovery house; 2 fathers were in rented housing with children and partner |

Appendix B. Father demographics
Appendix C. Fathers’ analysis
Appendix D. Mothers’ analysis
Appendix E. Interview protocol

I. **Interview protocol for mothers' individual interviews:**

1. **How did you come to receive services from Fir Square?**
   - What was your situation at the time you became involved with Fir Square?
   - Can you describe your living situation at that time?
   - How was your physical health?
   - How was your financial situation?
   - How were you feeling emotionally and mentally?
   - Can you describe your drug use at that time?
   - Can you describe your lifestyle at that time?
   - Can you describe how your drug use affected you at that time?
   - Can you describe your relationship with your partner at that time?

2. **What services did you receive at Fir Square?**
   - How were you affected by your experiences with these services?
   - How did services affect your living situation?
   - How did services affect your physical health?
   - How did services affect your emotional and mental health?
   - How did services affect your lifestyle?
   - How did services affect your drug use?
   - How did services affect your relationship with your partner?
   - How did services affect your relationship with your child?
   - Can you give examples?

3. **In your view, how did other factors affect your experience of services, if at all?**
   - In your view, how did your ethnic background, or race, affect your experience of services, if at all?
   - In your view, how did your economic situation affect your experience of services, if at all?
   - In your view how did your gender affect your experience of services, if at all?
   - Do you think any of these factors play(ed) a part in your drug use? Can you tell me more about that?
   - Can you give examples?

4. **Can you describe the services that your partner received while you were pregnant?**
   - What services were they?
   - Do you know what were they like?
   - Were you involved with these services?
   - Did you receive these services together?
• Were they free? Were they accessible? Were they helpful?
• Were they related to pregnancy/childbirth/parenting?
• Were they related to drug use/recovery?
• How did his receiving services affect your own use of services if at all?
• How did his receiving services affect your own drug use if at all?
• How did his receiving services affect your lifestyle if at all?
• How did his receiving services affect your physical, mental and emotional health if at all?
• How did his receiving services affect your relationship with him if at all?
• How did his receiving services affect your relationship with your child if at all?

5. In your view, how did other factors affect his experience of services if at all?
   • In your view, how did his ethnic background, or race, affect his experience of services, if at all?
   • In your view, how did his economic situation, or class, affect his experience of services, if at all?
   • In your view, how did his gender affect his experience of services, if at all?
   • In your view, do/did any of these factors play a part in his drug use?

6. If your partner did not receive services while you were pregnant, how did this affect you?
   • How did you feel about this?
   • How did this affect your own use of services if at all?
   • How did this affect your own drug use if at all?
   • How did this affect your lifestyle if at all?
   • How did this affect your physical, mental and emotional health if at all?
   • How did this affect your relationship with him if at all?
   • How did this affect your relationship with your child if at all?
   • How did this affect your parenting if at all?

7. In your view, how did his others factors affect his experience of services if at all?
   • In your view, how did his ethnic background, or race, affect his experience (of services), if at all?
   • In your view, how did his economic situation, or class, affect his experience of services, if at all?
   • In your view, how did his gender affect his experience of services, if at all?
   • In your view, do/did any of these factors play a part in his drug use?

8. How did services affect your family?
II. Interview protocol for fathers' individual interviews:
1. How did your partner and/or you come to receive services from Fir Square and Sheway?
   • What was your situation at the time your partner became involved with Fir Square?
   • Can you describe your living situation at that time?
   • How was your physical health?
   • How was your financial situation?
   • How were you feeling emotionally and mentally?
   • Can you describe your drug use at that time?
   • Can you describe your lifestyle at that time?
   • Can you describe how your drug use affected you at that time?
   • Can you describe your relationship with your partner at that time?

2. What services did you receive at Fir Square?
   • How were you affected by your experiences with these services?
   • How did services affect your living situation?
   • How did services affect your physical health?
   • How did services affect your emotional and mental health?
   • How did services affect your lifestyle?
   • How did services affect your drug use?
   • How did services affect your relationship with your partner?
   • How did services affect your relationship with your child?
   • Can you give examples?

3. In your view, how did other factors affect your experience of services, if at all?
   • In your view, how did your ethnic background, or race, affect your experience of services, if at all?
   • In your view, how did your economic situation, or class, affect your experience of services, if at all?
   • In your view, how did your gender affect your experience of services, if at all?
   • Do you think any of these factors play(ed) a part in your drug use? Can you tell me more about that?
   • Can you give examples?

4. Can you describe the services that your partner received while you were pregnant?
   • What services were they?
• Do you know what were they like?
• Were you involved with these services?
• Did you receive these services together?
• Were they free? Were they accessible? Were they helpful?
• Were they related to pregnancy/childbirth/parenting?
• Were they related to drug use/recovery?
• How did her receiving services affect your own use of services, if at all?
• How did her receiving services affect your own drug use, if at all?
• How did her receiving services affect your lifestyle, if at all?
• How did her receiving services affect your relationship with her, if at all?
• How did her receiving services affect your physical, mental and emotional health, if at all?
• How did her receiving services affect your relationship with her, if at all?
• How did her receiving services affect your relationship with your child, if at all?

5. In your view, how did other factors affect her experience of services, if at all?
   • In your view, how did her ethnic background, or race, affect her experience of services, if at all?
   • In your view, how did her economic situation, or class, affect her experience of services, if at all?
   • In your view, how did her gender affect her experience of services, if at all?
   • In your view, do/did any of these factors play a part in her drug use?

6. If your partner did not participate in services while she was pregnant, how did this affect you?
   • How did you feel about this?
   • How did this affect your own use of services if at all?
   • How did this affect your own drug use if at all?
   • How did this affect your lifestyle if at all?
   • How did this affect your physical, mental and emotional health if at all?
   • How did this affect your relationship with her if at all?
   • How did this affect your parenting if at all?

7. In your view, how did other factors affect her experience of services, if at all?
   • In your view, how did her ethnic background, or race, affect her experience of services, if at all?
• In your view, how did her economic situation, or class, affect her experience of services, if at all?
• In your view, how did her gender affect her experience (of services), if at all?
• In your view, do/did any of these factors play a part in her drug use?

8. How did services affect your family?
• How did services affect your relationship with your partner?
• How did services affect your parenting?
• How did services affect your relationship with your child?

III. Interview protocol for focus group with parents:
1. I would like to talk about the results of the individual interviews I did. From these interviews, I found that: (list based on findings of interviews)_____________. Can you tell me more about that?
2. What changes if any would you like to see in services for couples with drug use problems in the pregnancy, birth and post-partum period?
MOTHERS’ STORIES

Mothers’ history, including family, home, poverty

Pregnancy: “I’m high risk”

Fathers excluded: “driving us apart”

“had to do what’s best for my son”

“We stayed together”

“he wasn’t doing anything”

“couldn’t get daycare”

Mothers get services

“when I found out I lowered it [drug use]”

“gave me some stability to live in society”

MOTHERS RE SERVICES FOR FATHERS: “It may have helped”

Appendix F: Poster presentation of findings to parents: mothers’ data
Appendix G. Poster presentation of findings to parents: fathers’ data
### PRIMARY DOCS

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Totals 853 315 455 770 433 295 763 278 271 178 4611

Appendix I: First coding, graphic matrix, fathers' data
FOCUS GROUP QUESTIONS

Fathers:

1. Sometimes fathers talked about getting mandated services, through Corrections, etc. Were these helpful to you? Can you say more about how these services helped or did not help you?
2. When you felt left out, because you were excluded from services your partner was getting in her pregnancy, what did you do? How did you respond?
3. Some of you talked about feeling ‘under watch’ when you were on Fir or at Sheway. Even though you felt left out, you didn’t say anything. What made you feel you couldn’t speak up and ask for what you need, ask to be included? What would you have said/done if you felt free to?
4. A few of you mentioned that you had not had the opportunity to talk to other fathers about fathering. Why is this the case? Mothers talk to other mothers, why do you think fathers don’t?

 Mothers:

1. Some of you described being ‘high risk’ – what does this mean? What difference did it make to you, in your life, to be ‘high risk’? If this resulted in you getting services, do you think these services were offered because of the baby/pregnancy, or just for you? How do you feel about this?
2. Most of you felt that you had to choose between getting services and staying with your partner. How did you feel about this? How do you think services should be set up for mothers and fathers when they are using and get pregnant?
3. What difference do you think it would make if fathers got the same services that mothers did when mothers got pregnant (i.e., housing, food, counselling)?

 Mothers and fathers:

How would you like services to be?

APPENDIX J: DETAILS, FOCUS GROUP QUESTIONS