The Battle of all* Mothers (or: No Unauthorised Reproduction)

ByMadame Tlank

The UKâs health and social services have become tools of surveillance and control, with working class women the most vulnerable to state intervention. Madame Tlank reviews the Stateâs policies, targets and projects and uncovers the warped logic and fragmenting effects of marketised welfare

> Well Jeff, ... the fact is that you have the luxury of knowing that you will never ever ever ever EVER be faced with the government bossing you around like a child, simply because you have a parasite living in your body.
>
> â The Law Fairy, Feministing.com
>
> By now people have forgotten what history has proven: that âraisingâ a child is tantamount to retarding his development. The best way to raise a child is to LAY OFF.
>
> â Shulamith Firestone, *The Dialectic of Sex: The Case for Feminist Revolution*, 1970

In what follows I wish to consider the effects of recent UK health and social policies on women and their children who are labelled âat riskâ.[1]

The âdifficultâ (i.e. poor) parts of the population have often served as the playground for experiments in socio-biological control by the state and its affiliates. Historically, these experiments have affected women differently from men, whether because of the role ascribed to them, (e.g., their exploitation in wartime industries, or the use of rape as a strategy of warfare) or because of their physical make-up (as in the testing and developing of modern methods of contraception on women in occupied territories, in prison or on social benefits).

State intervention tends to concentrate on those women who cannot afford invisibility, i.e. those who cannot buy their way out of dependence on state administered medical and social âservicesâ.[2] Women are often more visible than men to government agencies because of their physical capacity to reproduce. Professional medical involvement is required for, amongst other things, contraception, prescriptions, abortions, sterilisations, antenatal check-ups, giving birth, postnatal treatment, hysterectomies, and menopausal issues, smears and breast-cancer checks, etc. Thus most womenâs physical reproductive capacity remains under medical control throughout their lives.[3]

[IMAGE]

Images: Adam Vass

In most countries with a semblance of a social-democratic welfare system, many women register with some form of state agency if they are about to have or have had children, in order to get at least some financial support in the form of child benefits. In the UK 94 percent of lone parents claim benefits; most lone parents are women.[4] Once registered with the state as a âclaimantâ for survival purposes, many mothers are obliged to sign up for training or âsupportâ programmes (i.e. social experiments) of one kind or another, as proof of their willingness to âintegrateâ into âeconomic activityâ and to make sure their children do likewise, miserable dependency notwithstanding. Those who refuse risk losing financial support. âSocial integrationâ services in the UK target âhard-to-reachâ families, requiring that those who would prefer to remain as invisible as possible be identified and made available to state

and private institutions. Armâs length private charity initiatives âhelpâ mothers back to work, while youth teams monitor their children to make sure they donât offend, and blame the mother if the kids turn delinquent anyway.

Under recent UK policies â the new GPâs contract (2004), the Children Act (2004), Every Child Matters (2004), the gradual privatisation of the NHS and social services â frontline services have been cut while a general patient/âclientâ database is built up. The cuts, which limit the availability of services, effectively force patients to assent to the data-sharing, lest (already scarce) treatment be withheld.[5] The claimantâs claim is turned against her ever more directly, making her responsible for conditions imposed by economic factors and by the institutions themselves, which attempt to âcureâ the problem by âeducatingâ her to change her behaviour so she no longer fits the âclaimantâ profile. The criteria used for such profiling are often discretionary, with ever-changing parameters used to measure each âcaseâ as if it were self-contained. Such an approach systematically refuses to acknowledge the socially structural, *institutional* reasons for the deterioration of lives within the non-asset owning, working and claimant class (henceforth âdependent classâ).[6]

Mechanisms of this kind exist to varying degrees, always complicated and qualified by local factors, in most of the âdevelopedâ world. As the examples already mentioned suggest, the process is at an advanced stage in the UK, where medical and social âservicesâ have undergone continuous transformation under the Labour governments since 1997. Here the rhetorical signposts along the way are âriskâ, âresponsibility/empowermentâ and âpreventionâ. In practice, the key elements are computerised control and data collection, along with funds poured into training the poor to âhelp themselvesâ. In what follows I will use a few examples from UK institutions to consider the effects of these policies on the women and children directly concerned, with particular attention given to encroachments upon the âunofficialâ, independent and increasingly illegalised reproduction strategies of the dependent class. The result will not be an exhaustive or systematic survey, but an exposure of the perverse logic running through the cases described which seems to be taking hold ever more widely as capital attempts to transfer the cost of reproducing labour power downwards onto labourers.[7]

Women and the NHS

Letâs start by looking at some of the things that directly affect womenâs control over their own bodies.

Women seeking treatment in relation to reproductive health are subject to the laws of whichever state they so happen to be in at the time. Of course the treatment they receive depends on the financial situation and organisational structure of the given health system. If a woman wants to have an abortion in the UK she discovers that, as in most âadvanced democraciesâ, abortion has never been fully legalised. The 1967 abortion law granted exceptions, giving the power of decision making not to the women affected but to doctors. Two doctorsâ signatures are required for an abortion on the NHS. According to a GP I spoke to, âthere are still a lot of GPs around who think itâs not right that terminations should be available through the NHS.â[8] There are also far too few abortion facilities available, meaning that a lot of women get referred to Marie Stopes or another private provider, with the operation paid for by the NHS. The waiting time for an NHS operation is often critical and, therefore, those who are able to do so often raise money for a private operation (about Â£350 - Â£750, depending on how many weeks into the pregnancy you are). The laws governing sterilisation are shocking: if you want to be sterilised before the age of 30 your doctor has to give his consent, with the rate of refusal much higher than for abortions. The operation does not constitute a health risk, so the *doctors* decide according to what *they* think a woman should do with her body, which in many cases is simply: reproduce!

With fertility treatment on the NHS, it is ultimately also the doctor who decides. IVF is only slowly picking up state funding (although it has proved to be very lucrative for the private sector), and is currently only available on a highly restricted basis. There are long waiting lists with set age limits, and the doctorâs subjective judgment decides who may not receive treatment. Usually those excluded in this way are the âoverweightâ, smokers and people who already have children living with them.

Pregnant women are severely affected by a tendency to view the motherâs and childâs health as conjoined. Although it is of course desirable for a woman to know about the relation between her body and the foetus living inside it, the problem is the way such knowledge is imposed and in whose interest. Most women trust what they learn from other women who have had kids; but in relation to a health system embodied in the authority of the (usually male) doctor, the pregnant woman can make few autonomous choices. There are various health check-ups which, though not compulsory, are âstrongly encouragedâ (foetal scans for example, which can identify disabilities, yet are not without potential harm to the unborn child), a barrage of moralistic lifestyle prescriptions and health advice that can be confusing and contradictory, such as how much wine you may drink, which side to sleep on, which medicines to take or not to take, etc.

Meanwhile, birth services in London hospitals seem to be among the worst in Europe. Post-natal services in particular lack facilities and staff (no check-ups after having given birth, mothers sent home right away, no space for the baby to lie next to the mother, etc.). Birth is one of the most critical and dangerous moments in the motherâs life, and a check-up afterwards seems an obvious necessity. On the other hand, an increasing obsession with risk (and fear of litigation) has led to many practitioners performing caesarians as a matter of routine, just to make sure everything remains in the doctorâs control. Many women do not want a caesarian (they will be incapacitated for longer, it might present complications in the event of any subsequent births, etc.), yet unwanted caesarians are often performed.

Speaking of risk and preventive measures, hysterectomies are among the most commonly performed operations in the western world, very often without any real need for the removal of the organ, on the pretext that some future risk might be slumbering inside it.[9] As is finally coming to be recognised, many conditions that lead to the removal of the uterus can often be treated by other, less drastic means.

Such dismissal of an organ that is part of oneâs body and continues to perform certain functions considered âuselessâ once the woman can no longer reproduce goes hand in hand with the prevailing attitude towards menopausal symptoms, which could be summed up as: âWe donât give a shit because you canât reproduce any moreâ. There is no funding plan for menopausal treatments, and the new contract for GPs, which introduced bonus pay for the âsuccessful management of diseaseâ, actively undermines any interest in dealing with such possibly lengthy and complicated cases.[10] (Meanwhile, private clinics specialising in menopausal symptoms are flourishing.)

[IMAGE]

NHS and SS

> The aim is to achieve effective monitoring of under achievement by specific groups. The matter is technical, and to enable the proper monitoring and evaluation to take place such detail is necessary.
>
> â Stephen Byers, MP[11]

Two tendencies can be seen as central to recent UK health and social services policy. One is partial privatisation on an âinsuranceâ model, in which the state sheds direct responsibility for provision of treatment it continues to pay for, causing overall spending on the NHS to *increase* drastically even as services atrophy. The second, closely related tendency is expansion of information-sharing across the two departments, which already overlap to a great extent.[12] Witness the current attempt to co-ordinate medical practice and âwelfare-to-workâ contractors in the attack on Incapacity Benefit. Databases already exist within the NHS (patient registration, drug prescriptions and SUS [Secondary Uses Service â a summary of all secondary care episodes such as terminations, pregnancy and HIV tests]) as well as within the social services (through claims for Child Benefit, Income Support, Incapacity Benefit, Housing Allowance, Working Tax Credits, etc.).[13] One department can easily obtain the otherâs data if a concern is expressed: for instance social services may check the health record of a truant child and a hospital can check a patientâs registration with social services (henceforth SS).

Of course perceptions of health and illness *are* social, they constantly change and are also subject to government targets. Green Papers, White Papers and âvision outlinesâ alert professionals to the newest problems to be âsolvedâ. Thus hyperactivity in children and stress in adults are now things to watch out for; compare this with the emphasis on lower back pain ten years ago. The latter is purely physical, whereas the former imply that the patients might be able to do something about their condition, like eat 5-a-day and think good thoughts or take anti-depressants at least. What back pain and stress have in common, of course, is their successive status as the most popular âexcuseâ for absenteeism from work.

Women and men who drink, smoke, or are âtoo fatâ or âtoo skinnyâ are currently the main target of health action plans. For pregnant women belonging to these ârisk groupsâ means facing much greater scrutiny by the health services and the social services than other women. That is, a pregnant womanâs body is placed under surveillance because behaviour that is otherwise legal and (still) seen as a âpersonal lifestyle choiceâ somehow changes status when she becomes pregnant. European liberals are shocked to hear of the âfetal rightsâ campaigns and legislation in the US, but practice here is not so far off. For instance, when the welfare of a foetus is apparently endangered by conditions in a pregnant woman which are regarded as self-inflicted, a report must be filed by health practitioners and be made available to social services. Women in this ârisk groupâ who are seeking to conceive may be refused IVF treatment. Pregnant women who come to police notice (e.g. for reasons relating to the consumption or sale of drugs, domestic violence incidents, mental health issues etc.) might end up with a police record *relating to the welfare of their unborn child*. The relevant system, MERLIN CTN, is operated by the Metropolitan Police and records every instance of a child âComing to Noticeâ (CTN). âFetal rightsâ ahoy![14]

The NHS and SS also work closely together on the âproblemâ of teenage pregnancies and reducing their occurrence remains a high government priority. The discourse runs something like this: âA single mum on benefits forever! Scientific research shows they are more likely to be depressed! She will have no chances in later life!â, etc. If the teenage girls manage to have and keep their babies theyâll have to deal with imposed further training (in motherhood, in getting work) and SS supervision of the child(ren).[15] Such âsupportâ is officially voluntary but youâll end up on the âcause for concernâ list if you donât participate. Who would not be depressed to find that what state support really means is the social services policing and maintaining the poverty that state benefit levels force you into. And as for âno chances in later lifeâ, a couple of statistical studies recently quoted in *The Guardian* found that the âchances in lifeâ for girls having grown up on the same estate, whether with or without kids, are the same.[16] A glowing example of political discourse on the issue:

> We need to educate and instill young girls with [sic] the self esteem to resist the pressures which are clearly placed on them at such young ages, and equip them with the confidence to say no.[17]

Well, maybe they want to say no to the supermarket cashier job and yes to bringing up a child? Telling girls theyâre not competent to raise children is of course a great way of giving them âself-esteemâ.

Teenage mums are in fact the most embattled by current schemes. Social services get involved during pregnancy[18] and the government wants to establish strong links between (the data held by) Teenage Pregnancy Units, Childrenâs Centres, schools, colleges, Connexions and job centres.[19] With the help of this kind of teamwork, young mothers get checked up on from all sides and ushered back into work ASAP. This way it can be ensured that their âat riskâ children are brought up with as little âdisturbingâ influence as possible.

At Risk

> The only children who have the slightest chance of escaping from this supervised nightmare â but less and less so â are the children of the ghettos and the working class where the medieval conception of open community â living on the street â still lingers.
>
> â Shulamith Firestone, *The Dialectic of Sex*

> We cannot believe that a police force is justified in sharing information without consent about a nine-month-old baby on the grounds that it might grow up to be a villain. Measures that may be justified in the face of specific and identified threats lose their justification when they become statistically-based measures against subpopulations.
>
> â âChildrenâs Databasesâ report20

Procedures of this kind are legitimised by the governmentâs most recent definitions of what it means to be âat riskâ, with a new emphasis on preventing this terrible condition from spreading. The policing and containment of a large chunk of the population is what it boils down (or up?) to, with agendas such as Every Child Matters (ECM) and cross-departmental special task forces driving social inclusion home for those who remain âhard-to-reachâ. Reading through the relevant publications, the suspicion grows that this is only the beginning of a much larger attack on the remaining elements of independence within dependent class life.[21]

âRiskâ has proved a useful category in transferring responsibility downwards from institutions onto the individuals they deal with: if you know youâre at risk then you must do something about it, otherwise you are willfully causing trouble. This logic can be seen at work in the NHS approach to cutting the *potential* cost of *future* illness, which once again means targeting the obese, smokers, and the âunfitâ. GPs have an obligation to hassle whoever they think falls into these categories, and to spell out to them that all they lack is âwill-powerâ. (Quite *whose* âwillâ is âempoweredâ by obedience to such top-down orders is another question.)

But this approach blossoms in public propaganda on social services, whether published by the Home Office (and the Social Exclusion Taskforce as its subsidiary), the Department of Work and Pensions or the Department for Children, Schools and Families. The latter has published a list of risk factors to help councils (specifically their Teenage Pregnancy Strategic Management Groups) identify girls who are âat high risk of teenage pregnancyâ! Among the factors listed are: early onset of sexual activity, conduct disorder, alcohol and substance misuse, being the daughter of a teenage mother, disengagement from school, ethnicity (!), etc. Any subjective intention on the part of the mother is institutionally disregarded, unless it also counts as a âpregnancy risk factorâ. Of course, keeping an

eye on all teenage girls who fit the categories and âpreventingâ them from becoming pregnant is going to be quite a handful (of data).

Perhaps the most effective definition of âat riskâ from the agenciesâ point of view â because it is the vaguest, and it targets âvulnerableâ children in a way that automatically implicates their families â is the one set out in the Every Child Matters (ECM) agenda. ECM is part of the Children Act (2004) and has the ultimate aim of collecting the data of all children in the country on a single database covering social services, education, crime and health. (Apparently ECM also aims to reduce teenage pregnancies, substance misuse, crime and anti-social behaviour. Itâs not just surveillance, you know, thereâs some policing in it too!). Of course, data held will also relate to the childrenâs families and friends:

> [I]f a child caused concern by failing to make progress towards state targets, detailed information would be gathered. That would include âsubjectiveâ judgment such as âIs the parent providing a positive role model?â as well as sensitive information such as parentsâ mental health.[22]

The justification for such crass procedures is âpreventionâ. Preventing children from being neglected and abused, preventing them from turning into criminals. Thus a childâs data will be made available cross-departmentally, with the child and his/her family being made subject to regular checks by various agencies if she/he fits the following categories:

> Low income and parental unemployment, homelessness, poor parenting, poor schooling, postnatal depression among mothers [!] and low birth weight [*in this way mothers are implicated immediately*], substance misuse, individual characteristics such as intelligence [!!], and community factors, such as living in a disadvantaged neighbourhood.[23]

The conditions presented here as âcausesâ for being at risk are clearly inseparable from the ongoing economic and governmental attack on the dependent class. Homelessness, poor schooling, low income and unemployment are not âpre-givenâ conditions inherent in certain individuals, they are among the concrete achievements of âsupply-sideâ policy and financial asset-oriented accumulation over almost 30 years.[24] Basically, you ask for housing and you get nothing, but you are registered as homeless, which categorises you as âat riskâ and thus liable to be checked up on according to agency whim, simply because you were foolish enough to ask for something in the first place.[25]

Once any of the risk-of-risk factors listed above is ascribed to a child (on the basis of existing files on the parent/s, rather than direct observation of the kid), he/she is presumed to be in danger of âabuse, neglect, offending and social exclusionâ.[26] (Note the failure to differentiate between things the child might *undergo* and acts s/he could *commit*. The logical promiscuity is no accident: the whole drive to hold claimants âresponsibleâ for their âexclusionâ from income is founded on this willful confusion of categories.) The threat of these undesirable âoutcomesâ legitimises interference with the whole family by the cross-departmental state taskforce. Intervention is not a response to the familyâs non-professional perception of its own needs: it is strictly preventative. In most cases this means action to prevent family members breaching the boundaries of legal and âsocially acceptableâ behaviour, even as these semi-codified bounds narrow to the point that life within them becomes impossible in practice.

[IMAGE]

ECM has vastly expanded the field of targets for prevention, with the formulation of The Five Outcomes designated as necessary for all children. Failure to âachieveâ them means automatic âat riskâ status for the child and the family, and further increases the pressure on the council to intervene. The extremely vague phrasing of The Five Outcomes leaves ample room for discretionary interpretation â on the professional side only, of course: âBeing healthy; Staying safe; Enjoying and achieving; Making a positive contribution; Achieving economic well-being.â These pieties only become concrete, impossible-to-obey instructions[27] in sub-headings such as: âlive in households free from low incomeâ (well itâs not like anyoneâs doing anything about low income per se... must be the low-incomedâs fault then?!); âParents, carers and families promote healthy choicesâ (well, people have different ways of eating. If there are no bloody shops, then yes, the newsagent will be your nutrition centre â try finding any amenities âround ungentrified areas of the East End such as Homerton or Canning Town); âSafe from crime and anti-social behaviour in and out of schoolâ (with more than 3,000 new criminal offences created under New Labour, âsafe from crimeâ is hardly an option); âAttend and enjoy schoolâ (As Shulamith Firestone put it: âThe child is forced to go to [school]: the test is that he would never go of his own accord.â)

The way The Five Outcomes are to be achieved is, unsurprisingly, by âengagingâ with the children and their families, rather than actually changing any of the material causes to do with housing or schools etc.. The non-negotiable premise is that the causes of ânon-achievementâ are located *within* those who insist on remaining âhard to reachâ. The Social Exclusion Task Force (SETF, as in Sod âEm Total Fuckwits) encourages: âpersonalisation, rights and responsibilitiesâ, as in: âit is your personal problem, you have the right to identify with it and you are responsible for getting out of the at-risk groupâ.

As with the NHS, so with SS. In the former, illness-risk and its management are personalised, even though accounting norms for staying healthy are rigid â â*your* 5-a-dayâ, pedometer quotas, etc. â and conflicting ideas about who is at risk of what keep proliferating. Likewise, in social services, responsibility is devolved downward from the institution to the individual, and the point of intervention has moved as far âintoâ the subject as possible. The ubiquitous language of âchoiceâ and âempowermentâ (as in âyou can choose which hospital you want to be operated in, a super-bugged non-waiting list one or a non-super-bugged endless waiting-list oneâ, or, âyou can choose between welfare-to-work options: go freelance or work on a two week contractâ) is the punchline to the bad institutional joke of imposing coercive âsolutionsâ on claimants while retrospectively blaming them for the problem.

In effect, anyone who is financially dependent on the state has to pay for it by being obliged to open up their lives to scrutiny and âinterventionâ.[28] This interference is notoriously random (and increasingly so as the number of âservicesâ involved multiplies) as well as being disruptive, destructive and threatening. As some dissident social workers put it,

> [W]orker-client relationships are increasingly characterised by control and supervision rather than care ... Too often today social workers are doing little more than supervising the deterioration of peopleâs lives.[29]

Might this not be precisely the point? Because if you donât know whoâs dealing with which aspect of your life where basic elements of survival are at stake, you end up depending on an unknowable structure that encompasses you from all sides, with no way of knowing how to âdisappearâ from its radar or at least to ditch the âat riskâ tag. Parameters change non-stop so you have to remain constantly alert. If you mistake them you will be held responsible.[30] If you try to evade them, welcome to overcrowded prisons, mental hospitals, foster homes and so on.

This tendency goes hand in hand with the financing and organisational structure of the social services themselves (as is increasingly the case within the NHS): many functions are outsourced to private companies (even care homes and foster homes have been sold off to private equity outfits), and what remains in state control is increasingly staffed by temporary, underpaid workers:

> [O]ur work is shaped by managerialism, by the fragmentation of services, by financial restrictions and lack of resources, by increased bureaucracy and workloads, by the domination of care-management approaches with their associated performance indicators and by the increased use of the private sector.[31]

Under pressure to reach set government targets, which often lead to disjointed and conflicting procedures in relation to a âclientâ, a great deal of social workersâ time is now devoted to reporting potential risk-situations (adding to the database). Often they lack the funding to do anything else. Yet overall spending on SS *management and IT* has increased, even as frontline services are recklessly cut.

A GP who was worried about the well-being of two mothers in separate incidents says:

> quite often in borderline situations, you canât get social services support. There is only something like Children in Need; you get risk categorisations.[32]

And with it stigmatisation. There is no way out of the child protection register other than ceasing to be a âchildâ.[33]

What Involvement Looks Like

> The mother who wants to kill her child for what she has had to sacrifice for it (a common desire) learns to love that same child only when she understands that it is as helpless, as oppressed as she is, and by the same oppressor: then her hate is directed outwards, and âmotherloveâ is born.
>
> â Shulamith Firestone, *The Dialectic of Sex*

The National Service Framework for Children, Young People and Maternity Services (NSF) throws women and their children into one pot for the provision of health and social services.[34] It is of course much cheaper to target kidsâ health through mothersâ health, but it implies the presumption that what is beneficial to womenâs health is automatically good for childrenâs health and vice versa. The issue of breastfeeding is a good example: many women suffer pain when breastfeeding their children but are âstrongly encouraged to continue doing soâ by the relevant health departments. They might also simply not want to be the exclusive feeder of the baby for months on end.

The âAction Planâ for the Social Exclusion Taskforce (SETF, as in, See âEm TransFormed) had at its heart ten pilot projects engaged in testing intensive health-led parenting support given to first-time mothers from pregnancy up until the babyâs second birthday. Apparently it was a success (i.e. it hit targets, the babiesâ neurones presumably grew rapidly) although no response from the targeted mothers has been made publicly available.[35] The programme clearly presupposes the âat riskâ mother to be nothing but a birthing and feeding machine, attached to her child as its unwaged carer and at the convenience of state observation. A GP I interviewed was less blunt but regarded this programme as useless because it kept mothers *away* from community services and isolated them, together with their assigned health workers, for more than two years. To prevent subsequent independent child-rearing by the âat-riskâ mothers, the âGovernment bid to reshape childhoodâ (*The Guardian* headline, 8 December, 2007) âaims to bring children under state education control from age 2 and get parents involved through âparent support workersâ.â

The drive to institutionalise the upbringing of dependent class children, coupled with control of their parents, was also evident in the test phase of the Sure Start project. The scheme was intended to help women from âdisadvantaged backgroundsâ back into work, while also supervising and training them in proper British motherhood (how to interact with babies âto make their brains growâ, how to talk to them and play with them, what to feed them â with breastfeeding, of course, top of the agenda).[36] Unemployed single mothers were specifically targeted. Nursery (the oddly medicalising British name for âkindergartenâ, the oddly German-Romantic term used elsewhere in the anglophone world), health centre and job centre were to be combined under one Sure Start roof. Participation in supervised mother-child playing sessions was strongly encouraged.

Central government money for the initial phase of the project has now run out and it has been handed over to councils to manage and pay for themselves. The nurseries are now called âChildrenâs Centresâ. But whether Sure Start nursery or Childrenâs Centre, if you want to send your child there you have to sign a paper agreeing to the involvement of social work teams if there seems to be any cause for concern about your child. Thus, in order to be able to use the service at all, one has to give oneâs consent to information sharing with social services. Official guidance states that âdata and information on the most excluded families should be collected and more emphasis be placed on outreach and home visits to support these families.â[37] No wonder, then, that (aside from their unaffordability for those not in work) the services have not been popular among the âhard-to-reachâ target group who have good reason to be worried about Sure Start workers watching them and their children, with a direct line to social services should anything seem âout of orderâ. Home visitors and outreach workers attempt to push their way into peopleâs homes without seemingly realising that keeping your door closed keeps the state out; something that is especially desirable for anyone in any way dependent on state services and aware of the level of surveillance that comes with it. (âWe will track down benefit thievesâ [formerly âcheatsâ, now upgraded] â the posters are all over town!).

Even during the Sure Start test phase,

> some surmised that the registration of families by their local Sure Start was simply about gathering information, especially as no services seemed to follow [...]. Participants described encounters with welfare professionals who had information about them from other agencies, for example Sure Start staff revealing information which could only have been sourced from the Social Services department or community nurses. Other participants expressed fear about confidentiality being broken and not having any power to do anything about it [...]. Although none of the participants described being referred to social services by Sure Start, several Sure Start workers admitted doing so.[38]

Now that Sure Start has to get by on what little funding it receives from local authorities, management concerns (or simply trying to keep your job, a pressing issue for many of the workers in former Sure Start centres) have fully taken over.[39] With the high cost of nursery fees (around Â£200 per week in London), the focus on poor families has largely subsided. You can only get this fee reduced through Working Tax Credit, meaning youâd have to be in work to begin with. One probably unplanned effect of all this has been that middle-class parents who can get by on part-time work or who work from home happily take advantage of the âtraining courses in child careâ, the resident psychologists and the health professionals still offered at Childrenâs Centres. At the same time things have changed for the worse for poor families in Sure Start areas. The perceived improvement in the standard of childcare provision has contributed to the influx of middle-class families as inner-city neighbourhoods are gentrified, making it harder for poorer families to maintain the way they organised their daily lives. Checks are made to prevent childminders working âillegallyâ, behaviour clauses are written into âsocialâ housing contracts, and âchild protectionâ activity by social services is out of all proportion to the actual number of cases âuncoveredâ. (The latter development may have something to do with the

fact that councils fund the Childrenâs Centres according to the number of kids on the protection register.) Overall, funding has been cut for necessary services (including âtraditionalâ nurseries), while surveillance of working class behaviour outside work has constantly increased.

If ârisk of social exclusionâ continues to be discovered everywhere in the UK, it is largely because the dependent class goes on finding ways to organise life that elude the discipline of the state and its âarmâs lengthâ agencies. These survival strategies are wide-ranging and include: babysitting without Home Office vetting, fare dodging, âsick note cultureâ, squatting, council flat sublets, tricks to thwart bailiffs and debt collectors, various kinds of âgrey marketâ trafficking, and the sharing of knowledge (or secrecy) to beat the benefits, tax and immigration systems. In response, methods of âinterventionâ refined over years in countless Green and White Papers set ever-more intrusive âtask forcesâ on communities, families, lives and bodies, âhelping them to be socially includedâ, so that both task force professionals and âclientsâ will âachieve the targetsâ.

The very real threat of services being taken away ensures that it becomes the dependentâs personal responsibility to remain within the (ever-changing) boundary drawn by the accountancy of risk, effectively forcing her into her own continuous risk-management operation to minimise the dangers of benefits withdrawal or the confiscation of children. Find yourself labeled âhard-to-reachâ and a lot of agencies will start getting involved with you, seeing as they also get in trouble if they donât. This pressure is there to make survival conditional on responding to labour, consumer and credit market needs.

What âCaringâ Feels Like

> What we ought to be protesting, rather than that children are being exploited just like adults, is that adults can be so exploited.
>
> â Shulamith Firestone, *The Dialectic of Sex*

Women now make up the largest part of the workforce worldwide. Most of this work is low-paid and insecure; traditionally women have been kept out of organised workersâ struggles and have been used as an industrial reserve army to keep wages down (just as immigrants have). This strategy still very much holds true: women are still paid less than men and, more importantly, now occupy whole industries (small part assembly factory work, cleaning, care work, etc.) because the pay is so low only women will accept it. Work that might earn them more, such as prostitution, remains illegal, meaning that prostitutes need keepers (police bribers) who get the biggest chunk of their income. In general, women often work in unstable conditions with, if any, only temporary contracts â they might get pregnant after all. Currently there are more female than male migrants worldwide, yet womenâs immigration status is far more precarious. Almost everywhere in the world they are still classified as untrained dependents, that is, they are seen to be following their families. Thus, women migrants often work illegally, which means they are completely exposed and vulnerable to their employerâs whim. Also, in the UK (as elsewhere) a lot of women are employed in so-called âcare workâ, meaning health and social policy affect them both at work and at home. Under constantly changing regulatory regimes, they must frequently renew qualifications in order to work âlegallyâ, conform to departmental guidelines regardless of what experience tells them, and above all (unless privately employed) âachieve the targetsâ.

Women are under scrutiny both as workers and as (potential) mothers. âParentingâ as unpaid âcare workâ is increasingly subject to the same measures, targets and supervision devised in the professional sector. In their double-loser role (either dependent on boss and their husband, or on boss and the state, or on all of them), low-income and unemployed mothers, along with their children (whose loser status is assured by their absolute economic dependence), are uniquely exposed to the way capital shapes our

lives.

Recent state moves to ensure womenâs active participation in adjusting themselves and their lives to capitalâs needs are no more than a pioneering experiment in what is shaping up to be a full frontal assault on the dependent class. The disjointed forms of health and social services intervention I have tried to identify seem to be regarded by policy makers as the âcheap routeâ to one of the main aims of âsupply-sideâ social policy everywhere: maintaining and extending stratification and competition between and within classes. Thus, while neighbours are encouraged to inform on one another and families and individuals who are singled out for âhelpâ take on personal responsibility for their deteriorating circumstances, transformation of the essential, underlying conditions is experienced in contradictory ways by various class sub-groups, with some people even able to imagine that *certain* initiatives make them better-off.[40] Cut-throat individual labour-market competition, transfer to the market of formerly subsidised housing, asymmetrical attacks on benefits and partial or full criminalisation of previously legal activities will no doubt look like âopportunityâ to some of those affected, even as they dilute the income and undermine the freedom of their class in general.[41] The common interest of people vulnerable to market blackmail and state coercion is obscured by personalised state action to foster individual economic âcompetitivenessâ. This inevitably diminishes the prospects of any counter-attack, not only against the material deterioration of lives, against data collection, surveillance and control, but against being turned into a pool of miserably dependent bodies, available whenever and however capital might need it.

[IMAGE]

Footnotes

[1] This text was mainly researched during 2007 â by now various changes may have been introduced

[2] That such services never are class-neutral is perfectly exemplified by UK legal practice regarding âanti-social behaviourâ: among the most commonly-threatened sanctions is the loss of your council house, i.e. enforcement applies to the council-housed income bracket only.

[3] This of course was not always the case (cf. Silvia Federici, *Caliban and the Witch*, 2004). Several noteworthy attempts to reclaim control of their reproductive capacity were made by womenâs groups in the US during the 1960s and â70s. Most famously Jane (officially known as the Abortion Counseling Service of the Chicago Womenâs Liberation Union), which performed numerous illegal abortions between 1969-1973. The Black Panthersâ social and health care programmes also eventually included family planning, after the women in the party had overturned the prevailing anti-abortion stance. Until then, abortion was seen as the white manâs attempted genocide of the black people. The pro-life case had been argued on the grounds that African-American women were not only widely used as guinea pigs in contraceptive research, but had, throughout their history as (waged or unwaged) slaves, often been prevented from having the kids they might have wanted, either because they did not want to carry them into slavery or grinding poverty made it absolutely impossible (cf. Angela Y. Davis, *Women, Race and Class*, 1983). The ânewâ Black Panther Party is now in charge of some family planning clinics.

[4] And how much harder it is if the father is the claimant! Two male single parent friends report that agencies regularly demand to know âwhere is the mother?â, and sometimes threaten to take the child away if the father really goes ahead with, say, an application to be housed.

[5] Because it is becoming increasingly difficult to get real support from health or social services, those who need it only have two options, which both lead to the same result: they can either overstate their case, which will initially lead to a risk report being filed, containing data which will be widely shared, or theyâll be made to wait for ages, then visited by a health and/or social worker, who will take their details and signature consenting to the data being shared. Otherwise no help will be offered. If itâs urgent you wonât refuse. An example on the data sharing policy of social services in the UK can be found here: http://linkme2.net/ec

[6] âDependent classâ as in dependent for survival on selling labour-power to others, and/or on state-administered supplements, whether in the form of benefits or âservicesâ. All those, in other words, who are not able to live off the asset price bubbles blown in the Brown/Bush âownership societyâ.

[7] âReproductionâ as used here refers to sexual reproduction, but is NOT limited to its biological component. By extension, the term also includes all the activity by which individuals and social groups attempt to maintain their physical and socially subjective existence. From the point of view of capital this is restricted to reproducing the ability, along with the need, to sell labour (regardless of whether a corresponding demand for it exists at a given moment). The cost of âreproductionâ in this latter sense is theoretically covered by the wage (and its various state supplements), but historically and now, perhaps more than ever, this payment falls short of the minimum necessary leaving the burden of reproduction to fall on dependent workers in general and women in particular.

[8] During my research I interviewed several professionals working in the health- and social services. Their reasons for wishing to remain anonymous are obvious. I also spoke to some women using the services but, presumably for related reasons, I was unable to speak to those women who are most exposed to institutional action. Thus a lot of my material comes from a broad sweep of officially endorsed and dissident UK-published sources.

[9] Cf. Mariarosa dalla Costa, *Gynocide: Hysterectomy, Capitalist Patriarchy, and the Medical Abuse of Women*, New York: Autonomedia, 2007.

[10] Thus, self-help prevails. I overheard a Jamaican woman in the launderette sharing her treatment method: âI just eat ice-cream and pray to Jesus.â

[11] Quoted in âChildrenâs Databases â Safety and Privacy: A Report for the Information Commissionerâ, Foundation for Information Policy Research, http://www.fipr.org/childrens_databases.pdf

[12] Cf. Damian Abbott, âThe Spineâ, *Mute* Vol 2 #7, http://www.metamute.org/en/The-Spine

[13] The government departments comprising the social services in the UK are the Department for Work and Pensions, the Inland Revenue, the Department of Health, the Department of Home and Community, and the Department for Children, Schools and Families. It is important to note, however, that these ministerial allocations change frequently and many of the departmental responsibilities are newfangled, while the tendencies discussed are longer-term.

[14] In the US, the vilification of pregnant women presumed to be living unhealthily has developed yet further: under a fetal protection banner, women can be tested for drugs and, if positive, prosecuted for âdelivery of drugs to a minorâ or âchild endangermentâ, http://linkme2.net/ed

Many pro-lifers would like to see their moral indignation at pregnant women who drink or smoke turned into a statute. This of course would in effect see women being criminalised for being pregnant (seeing as, when not pregnant, they may smoke and drink with impunity). Incidentally, such additional punishment based on oneâs *status* already exists in the UK when it comes to criminal offences committed by foreigners: nominally the same penalties apply to everyone, yet foreigners are additionally subject to deportation when they get out of prison.

[15] Current tabloid story-telling has it that children are snatched from their mothers by social services because they have to meet government targets for adoption; seeing as no-one seems to want to adopt kids who have already lived in foster care, newly born babies are a safe bet. See: Sue Reid, âHow social services are paid bonuses to snatch babies for adoptionâ, *The Daily Mail*, 31 January 2008, http://linkme2.net/ee

[16] âIt isnât babies that blight young livesâ, Madeleine Bunting, *The Guardian*, 27 May, 2005, http://linkme2.net/ef

[17] http://news.bbc.co.uk/1/hi/health/4720813.stm

[18] Thus, according to a GP I spoke to, a teenager who was trying to conceal her pregnancy from her parents was contacted by social services at home. The hospital had passed her information on, ignoring the fact that her files had âdo not contact at homeâ written all over them.

[19] Connexions is a âserviceâ targeted at 13-19 year-olds who are âat risk of social exclusionâ, it aims to encourage participation in education, and deal with personal problems that might present âbarriers to learningâ. The model is of an information-sharing multi-agency team; Connexions introduced a âsmart-cardâ for 16-19 year olds, which was scrapped this February, because the kids were too smart to let themselves be card-traced in return for shop discounts (take-up was 3.7 percent).

[20] âChildrenâs Databases â Safety and Privacy: A Report for the Information Commissionerâ, op. cit..

[21] See, for example, the research published on the Every Child Matters site, http://www.everychildmatters.gov.uk/publications and on the Social Exclusion Task Force site, http://linkme2.net/eg

[22] Stuart Waiton, âThe Enemy Withinâ, TES, 26 September, 2003, http://linkme2.net/eh

In order to collect the relevant personal details, the governmentâs vision is to be able to browse through a vast array of public services data such as personal medical information (with a diagnosis of hyperactivity being considered a risk), school results, social workersâ case files and information from police and youth-justice systems. Access to the resulting database would be granted to education, early years and childcare services, Connexions, health, social care, Youth Offending Teams, police, probation, prisons, and secure training centres. Some agencies are currently actively collecting data. Connexions, for example, seeks out data from the National Pupil Database and other services to âidentify vulnerable young peopleâ (their powers for requesting data extend across educational records, welfare claims, revocation of benefits and attendance at âJobcentre Plusâ). The Connexions Customer (!) Information System is the intended database, covering all young people over 13 in the area and their parents, siblings and friends. The assessment document used by Connexions includes information on the parenting skills of parents and on substance abuse amongst the family and friends of the child. Of course no consent is sought in relation to this information. (And, obviously, the data canât be cross-checked by those it refers to, even for something as âbasicâ as truth value.)

Other databases involved in the policing of young people âat risk of offendingâ are Reducing Youth Offending Generic National Solution (RYOGENS), Asset and Onset. All three of these include information on the family and possibly also friends of each risk-subject. Very often, the family has no idea that this data exists since it has been obtained from the child, who may not even know that they have given consent to the collection of family data, or that the data is used to identify whether or not they are âat riskâ and to track them over time. Included in the data will be causes for concern such as ânegative home influence on educationâ, âdangerous behaviourâ, âsocial isolationâ, ânon-constructive spare timeâ, âliving in high-crime areaâ, âfinancial and/or housing difficultiesâ, âparenting difficultiesâ, âfamily and/or peers involved in anti-social behaviourâ, etc.

Data is also collected by local spies, so-called YIP (youth inclusion and support programmes) workers. They should âassume the role of an identifying agency by collating information about these young people [not yet on their databases] from local contacts, residents, tenancy associations, community groups, street wardens etc.â¦â That is, they encourage residents to inform on one another and/or on one anotherâs children, a project already well underway with ASBOs. Information held on Child Benefit or any other social security system may be passed on to âany civil servant or other personâ involved with the provision of protective services. Collected data can be passed around quite freely between the different databases as long as the recipient of the data is somehow involved with child services.

[23] âChildrenâs Databases â Safety and Privacy: A Report for the Information Commissionerâ, op. cit..

[24] âSupply-side economics is a school of macroeconomic thought that argues that economic growth can be most effectively created using incentives for people to produce (supply) goods and services, such as adjusting income tax and capital gains tax rates. This can be contrasted with Keynesian economics (or âdemand side economicsâ), which argues that growth can be most effectively managed by controlling total demand for goods and services, typically by adjusting the level of government spending. Supply-side economics is often conflated with trickle-down economics, now a derogatory term given to right-leaning economistsâ views. The term supply-side economics was coined by journalist Jude Wanniski in 1975, and popularised the ideas of economists Robert Mundell and Arthur Laffer.â A neutrality-disputed gloss from Wikipedia, http://en.wikipedia.org/wiki/Supply-side_economics

[25] It is an understatement to say that these categories hardly constitute âobjectiveâ states: âintelligence and community factorsâ! âPoor parentingâ! âIndividual characteristicsâ! Here as elsewhere in social legislation, the criterion of âobjectivityâ seems to be that real institutional intervention follows whenever a flimsy concept is invoked.

[26] My personal favourite! âAt risk of social exclusionâ â as if definitions of this kind didnât *create* the risk! In any case it is clear that the child concerned (or, more commonly, its mother) will be held responsible for being âhard-to-reachâ.

[27] A negative thinker reading a draft of this text wondered whether the dialectic of â68 utopian radicalism is fully played out when the *state* demands the impossible of the workers, rather than the other way around.

[28] âOne of the illustrative examples [of a non-communicative child attending a playgroup] is particularly objectionable. It suggests that the playgroup leader should seek consent to share her concerns with health practitioners and she should indicate in any letter she wrote âthat her concerns would increase if this is refusedââ, âChildrenâs Databases â Safety and Privacy: A Report for the Information Commissionerâ, op. cit.

[29] Chris Jones, Iain Ferguson, et al., âSocial Work and Social Justice: A Manifesto for a New Engaged Practiceâ, http://www.liv.ac.uk/ssp/Social-Work-Manifesto.html

[30] This idea is confirmed by a friend who was constantly harassed by a nurse after having visited the hospital with her daughter. She had no idea how to make it stop. Another friend commented on giving birth: âon the one hand youâre treated like a birthing machine, on the other hand you are completely held responsible for what happens even though you canât possibly know the parameters.â

[31] âSocial Work and Social Justice: A Manifesto for a New Engaged Practiceâ, op. cit.

[32] A UK child sponsorship charity.

[33] However even this may not be enough: the ContactPoint database, containing regularly updated details of every child born in the UK, promises to converge smoothly with the national ID system, so that no-one would be cut loose from observation even on becoming a nominally independent adult.

[34] There are 21 âstandardsâ in relation to childrenâs and young peopleâs well-being, and 203 âkey actionsâ for achieving them. The multi-agency taskforce (PCTs, LEAs and âother partnersâ) responsible for implementing the management programme educates mothers as to how they have to live and how to feed and educate their children.

[35] A wild guess: they might have preferred someone to help them with the cleaning, shopping and nappy changing, rather than someone standing around giving them health advice.

[36] âLooks and smiles help the brain to grow. Baby looks at mother; sees dilated pupils (evidence that sympathetic nervous system aroused and happy); own nervous system is aroused â heart rate increases. Lead [sic] to a biochemical response â pleasure neuropeptides (betaendorphin and dopamine) released into brain and helps neurons grow. Negative looks trigger a different biochemical response (cortisol) stops these hormones and related growth.â From âHealth-led Parenting Project: Family Nurse Partnershipâ â a powerpoint presentation given at primary care trusts nation wide, http://linkme2.net/ei

[37] Mark Gould, âUnsure Futureâ, *The Guardian*, 24 May 2006, http://linkme2.net/ej

[38] Krysia Canvin, Chris Jones, et al, âCan I risk using public services? Perceived consequences of seeking help and health care among households living in poverty: qualitative studyâ, 2007, http://linkme2.net/ek

[39] From an interview with a Childrenâs Centre manager: âIf we donât meet the figures, no-one can bail us out, weâll be made redundant.â

[40] â... neighbours had referred some participants to social services, and family social workers confirmed that referrals from neighbours were quite common. Participants understood that this aspect of their social and physical location was intensifying and inescapable.â In, âCan I risk using public services?â, op. cit..

[41] âAsymmetricalâ in the sense that single adult claimants have been significantly impoverished in real-terms in the UK since 1997, while *cumulative* family eligibility, *if all conditions are fulfilled*, has at least kept pace with inflation. Only at first glance could this seem to run contrary to the argument of the article. In fact what has happened is perfectly in keeping with the other trends described: monetary payments *have been allowed to rise where accompanied by intensified observation and intervention*. What is actively disincentivised is claiming anything while eluding observation and âsupportâ: hence single adults, particularly long-term incapacity claimants who only have to sign on once every few

months, have to be hounded out of their quasi-hard-to-reach condition.

Madame Tlankâs profile as a suspect non-breeder can be found here: http://www.homeoffice.gov.uk