

**A Survey of 23
Women With Children
in Methadone Treatment
in Perth, Western Australia**

by

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1. Introduction

A review of the literature shows that most of the research on heroin addiction involves male samples and male-oriented treatment programmes. The reason for this is that the stereotype addict is male. Consequently, female heroin addicts, "the forgotten minority" (Eldred and Washington, 1975), received little attention in the past.

The image of the stereotype addict as a male, however, is being eroded with the rise in the rate of heroin addiction among women. In the United States, this trend was recently noticed in the increase in women presenting themselves for the methadone maintenance treatment programme.

The high frequency of female heroin addicts caused great concern in the various treatment centres and produced an awareness of the problems women addicts may encounter and that are at great variance to their male counterparts (Eldred and Washington, 1975).

Among women's problems are the ill effects of drug use during pregnancy and on the newborn, and the difficulties some would face with the caring of their children. Since the addict is greatly at risk for infectious disease this could be detrimental not only to the health of the pregnant woman but also to the foetus.

There is conclusive evidence that the use of drugs during pregnancy increases "foetal wastage and neonatal death" and causes neonatal drug dependency. It is known that infants born to drug addicts show withdrawal symptoms. (Tudehope, 1980). In addition to problems relating to physical care and physiological difficulties of children born addicted there is the psychological and emotional aspect of child rearing (Fraser, 1976).

Preparation for parenting occurs during childhood. Care received by the child serves as an emotional and physical model for parenting (Black and Mayer, 1980). These authors have noted that in many of the cases, opiate addicts are young parents who have had little opportunity to observe and learn adequate parenting models.

Furthermore, the addicts' lifestyle centred on obtaining drugs, is generally assumed to act as a barrier to proper mothering that can sometimes lead to child neglect and abuse (Black and Mayer, 1980). Therefore the need for additional treatment programmes was recognised.

In the United states, programmes to help female heroin addicts have been established and results from follow-up surveys proved their success (Suffet, Bryce-Buchanan and Brotman, 1981).

An example of such programmes is the Pregnant Addicts and Addicted Mothers Program (PAAM) in New York City, in a low income area of endemic heroin use. This programme focuses on three aspects that Suffet et al (1981) describes as follows:

"(1) Medical care which provides continuous health care from pregnancy through childbirth. Pediatric care for the baby and any other children of the patient, as well as general medical care for the patient and any other adult members of her family."

(2) Counselling to help the patients with their practical problems. Strong emphasis is placed upon drug use, health and family relationships. The patients are urged to restrict drug intake during pregnancy and to have proper nutrition. Family counselling is encouraged to address any problems encountered in family relationships as well preparing the family for childbirth and infant care."

(3) Parent education involves prenatal classes to cover the nature of pregnancy, self health care, nutrition and preparation for childbirth. Postnatal classes are also held to assist the patients with the various stages of child development, child care and child rearing."
(pp. 298 - 299).

The William Street Clinic (WSC), an out-patient facility of the Alcohol and Drug Authority (ADA), in Perth, Western Australia (WA), has conducted a methadone maintenance programme since 1974. This is the only agency in WA offering an opiate substitution therapy. The ADA has recently recognised an increase in female addicts who have children, as reported in its annual report for the year ending 30th June, 1982.

Because of the positive outcome of the above mentioned programmes developed in the United States a question arose as to whether similar programmes should be established in Perth. To address this question, a survey of female clients who are participants in the methadone maintenance treatment programme was conducted at the request of the ADA. This was made possible with the co-operation of the staff and clients of the ADA.

The survey sought to establish some of the common problems and circumstances of female addicts with children attending the William Street Clinic (operated by a public methadone program by the Alcohol and Drug Authority).

It involved obtaining a detailed account of the female addicts including: marital status, family background, circumstances of pregnancy (age of mother at birth of first child; number of abortions and miscarriages; breastfeeding), extent of family support they receive for their children, care of children, financial circumstances, types of services they use in the community and the services they would like to have provided.

2. Method

2.1 Subjects

A total of 23 female addicts with children who were on the methadone treatment programme at the Perth William Street Clinic as at June, 1983 were invited to participate in the study. This was done by an introductory letter informing the clients about the project and asking them if they were willing to participate.

Out of the 23 clients, 12 accepted and signed the consent letter; 2 ceased treatment and could not be contacted; 4 accepted but repeatedly postponed their interviews and were eventually excluded because of lack of time; 3 refused; 2 were impossible to contact during the times available because of their weekly and weekend attendance at a chemist and the clinic respectively.

The final sample included 12 participants, which represented approximately 60% of the total available subject pool of 21.

The mean age of the participants was 29 years, ranging between 22 and 35 years. They had between them 23 children with a mean age of 7, the age range being between 18 months and 17 years.

2.2 Procedure

Interviews were jointly conducted by two female undergraduate students from the Department of Psychology of the University of Western Australia. The interviews were conducted over a period of four weeks, between June and July 1983.

A week preceding the interviews, the interviewers spent time at the clinic's dispensary establishing rapport in an attempt to gain the trust of the clients. The clients were reassured of the confidentiality of the results and were told that although a written report had to be issued to the ADA no names would be mentioned, and only group results were to be submitted.

The subjects were interviewed at the clinic after they had received their dose of methadone. They were administered an unstructured interview which permitted open-ended responses dealing with many aspects of their lives.

Some areas of inquiry that were relevant to the present study included the addicts' current life circumstances, care of their children, family background, services used in the community and services needed. The responses were grouped into categories and coded accordingly. The interviews ranged from two to three hours, which proved of no inconvenience to the subjects.

3. Results

3.1 Social characteristics

The findings on the social characteristics of female addicts are presented in Table I, and are described as follows:

Seven of the subjects had been reared by both parents. Three were brought up in a broken home. Two were raised away from both parents, at an orphanage and by adoptive parents. Among the female addicts who had been reared by both parents, two reported to have been separated from their parents at the ages of 10 and 13 respectively when they attended boarding school.

The majority of the addicts did not have good relationships with their parents during their childhood and left home at an early age (15 to 18 years).

The socioeconomic backgrounds of the addicts are divided into two distinct categories. Half of the subjects reported their fathers had worked in white-collar roles and the other half in blue-collar roles.

Among the twelve subjects, two were married, one was single, one had never married but was cohabiting, four were separated and three were divorced. Among the addicts who reported their marriages had been broken, four were cohabiting.

Equal numbers of addicts completed high school and terminated their education before completing high school. Of the twelve addicts, only five pursued further education. One obtained a degree in education, two pursued at least one year of undergraduate studies in education, and two undertook an apprenticeship in hairdressing. The female addicts who completed their high school and attended a tertiary education institution came from a white collar socioeconomic background.

The occupational status of the addicts was examined in terms of their present occupation and their usual occupation.

Present occupation: Six of the addicts reported their occupation as 'home duties', three were prostitutes and three were unemployed.

Usual occupation: While half of the addicts reported their usual occupation as home duties, the other half was diversified. Three were prostitutes, one was a receptionist, one a teacher and one a waitress.

Two cases in the occupational data are misleading for the following reason. One female addict whose present occupation was reported as home duties was usually employed as a prostitute, and the reverse applies in the other case. Of the women who worked or had worked as prostitutes, only one talked openly about her experience. She said that it made her feel bad but she had to do it to payoff her debts.

The primary source of income reported by the addicts was supporting mothers' pension and unemployment benefits. Two were financially dependent on their spouse and one received her primary means of support through full-time employment.

3.2 Extent of family support received for children

Child minding was claimed by five of the addicts to be the extent of family support received for their children. Five reported receiving no support. One received financial aid for the schooling of her children and one reported that her family had regular contact with her children (Table 2).

3.3 Care of children

Most of the children were living with the clients. The three cases who reported having children not living with them are described as follows.

Two have two children, one in their care and one living with their ex-husband and mother respectively.

In the case where the child is living with the addict's mother, the client stated that she could not cope with the hyperactivity of her child and therefore gave the child, who was twelve months old, to her mother.

In the third case, the addict had three children, one in her care, one cared for by relatives and one in an orphanage. The most commonly reported caretaker other than the addicts was the spouse (Table 3).

The female addicts were asked what effect their drug use had had on their children. They all reported no negative effects except for their inadequacy of care or time spent with the child when they experienced withdrawal symptoms.

The addicts stressed that they made sure that their children were properly catered for. Most of the addicts, however, expressed some concern about their child becoming a drug addict; only two showed no concern.

The addicts were also queried about their feelings when using drugs in front of their children. They all reported a feeling of shame. Two addicts, however, stated that they never used drugs in the presence of their children.

3.4 Circumstances of pregnancy

The majority of the addicts had their first child between the ages of 18 and 21. Reported cases of abortions were frequent. When questioned about the circumstances of their abortions, various reasons were given.

Some addicts reported they already had two or more children and did not want to increase their family; some felt they were too young; others reported they were on heroin at the time and did not want a "heroin child". In one case, the addict was forced by her father to have an abortion because the child was illegitimate.

A large number of addicts breastfed their children for a substantial period of time, ranging from three to forty-eight months (Table 4).

3.5 Services

Of the services used in the community, playgroups, general practitioners and babysitters were the most frequent. Most of the addicts reported that they would like to be provided with more playgroups and babysitting facilities. Parenting courses and counselling were also quoted by some addicts (5) as additional needs (Table 5).

The addicts were also queried about the services they received at WSC. Of the twelve addicts, only three rated the services as unsatisfactory.

All the addicts, however, showed a strong feeling of resentment having to come daily to the clinic, during the specified dispensary hours, to receive their dose of methadone. They said it was difficult sometimes to get to the clinic during the opening hours of the dispensary, and also it restricted their lifestyles, for example they could not go away on weekends. They also mentioned that some staff members could be more co-operative.

4. Discussion

The present survey sought to establish some of the common problems and circumstances of female addicts who have children in an attempt to address the needs for additional treatment programmes.

The social characteristics of the female addicts in this survey differ, in some aspects, from those who participated in the PAAM programme reported by Suffet et al (1981). The clients of the William Street Clinic come from a higher socio-economic background, are older, and have a higher education level than their American counterparts.

Both groups, on the other hand, derive their income from the same sources - government aid or illegal employment. This comparison, however, should be interpreted with caution because of the discrepancy in sample size between both groups. The WSC sample involved twelve subjects compared to one hundred subjects in the PAAM sample.

Many of the addicts in this survey stressed they had poor relationships with their family, yet the results on the care of children show that the addicts commonly receive family support for their children, child minding being the most prevalent form.

This finding suggests that the addicted mothers can rely on their family at times when they cannot care for their children, for example, if hospitalised or working. To support this notion, the data also show that the spouse ranks among the most frequent caretakers used other than the clients, so that the burden of bringing up a child is not left to the mother alone. Often the father of the child took a certain amount of the responsibility even if he was not living with the mother at the time.

Responses from the clients on the effect their drug use had had on their children showed they encountered some difficulties in caring for them when experiencing withdrawal symptoms. The need for help then was acknowledged by the mothers. The addicts stressed, however, the problems they have in raising their children are not different from non-addicted mothers.

This may be true, however, while not undermining their responses, it is possible that they do have more problems than the non-addicted mothers and are not aware of them. For example, during the course of the interview, it was possible to pick up various problems; children who

were very disruptive in class, those who got into trouble with the police, those who were very quiet, reserved and non-responsive.

Often there appeared to be a lack of communication investigated further through direct observation of the mother-child interaction in their natural setting.

They may also have felt threatened by such interrogation, assuming their children may be taken away from them and therefore were reluctant to acknowledge their inadequacy, if any, in child rearing. Through the course of the interview, the mothers expressed their concern about their children who play an important role in their lives. Most of the addicts reported that such concern acted as a motivator for them to give up drugs.

The addicts were relatively mature when they gave birth to their first child. The mean age for this group was 20, which is quite a substantial difference from the mean age of the U.S. population which was 16 (Suffet et al, 1981).

The data obtained from the addicts when questioned on the services used in the community and on the services they would like to be provided suggest the need for more playgroups and babysitting facilities.

It is pointed out, however, that the addicts reported they could not think of any services that could assist them in caring for their children. The mothers mentioned they were helped in their parenting role by their family, spouse and friends. They admitted, however, that if they did not receive any support they would have liked more babysitting facilities. Babysitters, especially those who understand the addicts and their situation, would be a great help when the mother experiences withdrawal symptoms.

To attempt to come off drugs and manage a family at the same time is very difficult. Going into hospital to withdraw may not be feasible without full-time babysitters. Many children, especially young ones, do not react well to separation from their mother. Among the addicts, five reported that parenting courses and counselling would be valuable.

While most addicts were, in general, satisfied with the services received at the clinic, they expressed negative feelings in some areas. They felt that some staff members could be more co-operative.

Apart from the nursing staff, which they find most helpful, they said they would like more informal interaction with the other staff members - general practitioners and social workers. They feel that the present atmosphere of the clinic is too formal. The clients, also, reported it was most inconvenient having to come to the clinic during the specified hours to obtain their methadone.

Some addicts mentioned it was difficult, because of transport problems, to present themselves at the clinic during the opening hours of the dispensary. They also feel it restricts their lifestyles.

The evidence of the present survey has suggested some of the services needed by the addicts. Compared with the PAAM study where the women's problems and needs were very apparent, the Australian groups seems to function adequately. This might be because the services already provided are adequate or it may mean that their problems are better hidden by their social circumstances or by some other factor.

This survey has some limitations. The data provided in this study was insufficient because of the small sample size (12) and other methodological shortcomings, for example the inexperience of the interviewers. Some of the data was incomplete; for example, birth control was not

investigated. Before any decisions can be made to address the needs for additional programmes, it is recommended that further research be conducted.

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7. Appendix 1 – Tables

Table 1: Frequency distribution of social characteristics of female addicts

(n = 12)

1. Childhood home experience	
(a) Reared by both parents	7
(b) Reared in broken home	3
(c) Reared in orphanage	1
(d) Reared by adoptive parents	1
2. Relationship with parents	
(a) Father	
Very good	2
Good	2
Non existent	2
Poor	1
Very poor	5
(b) Mother	
Very good	2
Good	4
Non existent	1
Poor	1
Very poor	4
3. Father's occupational status	
(a) White collar	6
(b) Blue collar	6
4. Marital status	
(a) Married	2
(b) Never married – not cohabitating	1
(c) Never married – cohabitating	2
(d) Separated – not cohabitating	3
(e) Separated – cohabitating	1
(f) Divorced – cohabitating	3
5. Education	
(a) High school	
Completed	6
Not completed	6
(b) Further education	
University qualification	1
Attended university/technical college	2
Undertook apprenticeship	2
(c) None	7
4. Occupation	
(a) Present	
Home duties	6
Prostitution	3
Unemployed	3

(b) Usual	
Home duties	6
Prostitution	3
Receptionist	1
Teacher	1
Waitress	1
7. Source of income	
(a) Spouse	2
(b) Pension	3
(c) Pension + part time employment	3
(d) Full time employment	1
(e) Unemployment	3

Table 2: Frequency distribution of family support received for children

	Frequency
Child minding	5
Financial	1
Regular contact	1
Nil	5
Total	12

Table 3: Frequency distribution of care of children

	Frequency
Number of clients having children living with:	
Client	12
Child's other parents	1
Client's parent(s)	1
Other relatives or orphanage	1
Most frequent caretakers used other than client:	
Family	2
Spouse	5
Babysitter	1
Combination	4
Total	12

Table 4: Frequency distribution of circumstances of pregnancy

	Frequency
(1) Age of mother at birth of first child	
15	1
18	3
20	2
21	3
22	1
23	1
26	1
(2) Reported cases of abortion	8
(3) Reported cases of miscarriage	3
(4) Reported cases of breast feeding	8

Table 5: Frequency distribution of services in the community used and services clients would like to be provided

Services used		Services to be provided	
	Frequency		Frequency
Counselling	1	Financial aid	2
Health care	1	Counselling	5
Parenting courses	1	Health care	1
Play groups	8	Parenting courses	5
Babysitters	4	Play groups	10
General practitioners	5	Babysitters	8
		Social clubs	4