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WESTERN AUSTRALIAN
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Submission to Task Force to Review the Obstetric, Neonatal and Gynaecological Services in Western Australia

Please find attached our submission to the above inquiry.

We would be pleased to provide additional information if this is desired.

Greg Swensen (Social Worker)
Julie Murdoch (Social Worker)
Lindy Porter (Social Worker
Michael Charlton (Medical Officer)

26 June 1989

SUBMISSION TO TASK FORCE

In the month of May 1989 methadone was provided to 491 persons in this State, of whom 211 (43%) were females. It has not been possible to accurately count the number of pregnant female clients who have participated in the WA methadone program, as there is not an adequate statistical reporting system. However we can state that our experience indicates that many of the women in treatment have children, and that the women we treat regularly have babies.

The most recent age distribution available indicates female clientele are in the prime child-bearing age groups

	Males	Females	Total
15 - 19	-	-	-
20 - 24	22	25	47
25 - 29	73	88	161
30 - 34	108	60	168
35 - 39	47	13	60
40 +	12	7	19
	262	193	455

Age and Sex Distribution of Methadone Treatment Population as at 31 March 1989

It is our experience and opinion that women who use heroin and other illicit opiates require services which are sensitive to their unique circumstances and difficulties. In spite of a lack of data, it is clear that the number of women who use heroin and have been presenting for treatment in Perth has steadily increased up to the present. A similar phenomenon in Sydney is noted in the paper by Cathy Waldby (1988). Our experience in Perth confirms as reported elsewhere that women often

- have a partner who also uses heroin
- work in low skilled service occupations, particularly prostitution, which produces daily income to support the woman and her partner
- live with a partner who is not related to her children
- have traditional and sex-role based relationships with partners
- are ambivalent and careless about birth control practices
- adopt unrealistically high expectations for themself during treatment due to guilt and perceived inadequacies as a parent-to-be
- have meagre social supports, particularly a history of poor relationships with family of origin.

Pregnancy for the heroin-using woman usually constitutes a crisis - the pregnancy is unplanned and discovered some months after conception. By the time the woman may present for treatment there has often been ambivalence about the pregnancy, and this is compounded by guilt of using drugs which the woman believes may have harmed the feotus. A number of women express the intention to be opiate-free during pregnancy, however this is often a difficult decision to sustain unless the woman has sufficient interpersonal skills to negotiate such a lifefstyle with a partner's support.

It is our experience that a number of women present late in pregnancy without a history of antenatal care. We attempt to stabilise the woman on a low dose methadone support program rather than detoxification as this may compromise the baby and is usually beyond the woman's resources to sustain. We also actively encourage pregnant women to attend King Edward Memorial Hospital for Women, or alternatively attend a private practitioner. We have been fortunate in establishing a good working relationship with a private gynaecologist/obstetrician who provides a personalised service to this group of women.

The advantages of a low dose methadone support program include minimal withdrawals experienced by the baby at birth and the reduction in the possibility of premature labour as well as providing the woman with a sufficient degree of intoxication to reduce craving for heroin. We also strongly encourage women to continue with methadone treatment after the birth to ensure parental stability and social functioning is maximised. Breast feeding is strongly encouraged for women on methadone.

There is a tendency for our clientele to have premature babies and babies of low birth weight. A similar phenomenon has been noted elsewhere. It is to be noted that clientele, male and female, are heavy users of tobacco - about 80% - 90% smoke. Besides the risk this poses to a feotus, babies and children face risks to their health through passive smoking. We also find that heroin users frequently have histories of heavy use of other substances, particularly cannabis, alcohol and benzodiazepines. Effective treatment of such drug users needs to be seen as sequential and incremental. The initial stages are concerned with engagement and support, development of a working relationship and elaboration of modest goals that improve social and psychological functioning. Abstinence as an outcome should be regarded as a long-term goal and always as a choice behaviour that may be adopted by the user as a consequence of joint negotiation with a helper.

Pregnant heroin users are reluctant users of health services and when they do use services they frequently report stigmatisation. It would appear that clients' poor social skills in negotiation are exposed by formal systems as exist in hospitals. Clientele are also extremely sensitive to remarks and attitudes of staff they have contact with in hospitals, indeed they invest a lot of energy in avoiding situations in which their problems and shortcomings could be exposed.

It is our view that a specialist service for drug-using women should be established within the King Edward Memorial Hospital setting, which involved selected staff with a special interest in the client's range of problems. We understand King Edward Memorial Hospital does have contact with a number of women known or suspected to be users of heroin and other drugs, and who do not attend a drug treatment agency. Our experience also suggests that William Street Clinic is not an entirely satisfactory setting for women who are pregnant and/or have babies and young children.

We would strongly recommend that such a specialist drug treatment program at King Edward Memorial Hospital incorporates admission to methadone treatment provided to the women by the hospital on an outpatient basis throughout the pregnancy. Such an arrangement would maximise the period of antenatal care and provide the women with opportunities to better respond to the hospital's breadth of support facilities. The focus of the program would be to initially stabilise the woman during the pregnancy and build a foundation for longer term support in conjunction with methadone.

It is essential that post-delivery this population of women remain in treatment in a service that is specifically oriented to the care of the woman and her child. Many women appear to relapse after the delivery of a baby because of the stress, and also because of meagre and inadequate resources and social supports that do not involve heroin use.

It has been observed elsewhere that methadone poses some difficulties for women who use heroin.

> "On the one hand, a controlled methadone dose is the treatment most likely to ensure the health of the baby in utero and entry into the program ensures antenatal care ... and (is a) general help in creating a stable environment for the baby. On the other hand, the methadone program exercises a considerable amount of power over the lives of its clients. When entering a program it is necesssary to volunteer a great deal of personal information; ... the program has the power to discipline clients ... (and) entry into a program brings women and their children into contact with other services that have some power of intervention in their lives." Waldby (1988 : 42-3)

It is our view that King Edward Memorial Hospital would be a most suitable health facility best able to detect heroin using pregnant women and encourage them to enter a support program that was specifically tailored to their needs. There is ample precedent for such a service elsewhere. Such a service has been offered in Sydney since 1979, originally from the Crown Street Women's Hospital. The program has operated since 1982 from the King George Hospital, and by 1986 there were 150 women participating in the program : Waldby (1988).

As has been reported elsewhere by Collins (1982), surveys of pregnant women's drug use by objective measures, such as by urine scan, indicates the prevalence of drug use in this group of women. Such a survey of King Edward Memorial Hospital would be invaluable in establishing the need for a service, and would also sensitise staff to the existence of this problem.

Secondment of staff from William Street Clinic would ensure a connection exists with the larger WA methadone program. Given the number of women's partners who are also heroin users would also ensure appropriate joint management was maximised. We regard that the present form of drug treatment has generally neglected women's needs - this is understandable given that historically men have outnumbered women in the heroin using population. Women's needs with respect to pregnancy and gynaecological health indicates the need for a specialist service located within a mainstream women's health care service.

This submission has emphasised methadone treatment because this form of treatment has proven to be very effective in attracting large numbers of heroin users into a treatment environment. We believe that many users are resistant and ambivalent about treatment, and objectively many users are unlikely to be able to develop a drug-free lifestyle except in the long-term. The presence of children severely limits an adult user's options and it is necessary therefore to maximise parental competence as a treatment goal. It is in our opinion unrealistic to measure the successful treatment of heroin users by the criterion of abstinence.

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381 → 1/2/10

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Dear Ms Lee

RE: SUBMISSION TO TASK FORCE TO REVIEW THE OBSTETRIC, NEONATAL AND GYNAECOLOGICAL SERVICES IN WESTERN AUSTRALIA

Please find attached a submission from the Western Australian Alcohol and Drug Authority. My apologies for the delay in sending this submission, however, the submission represents the collation of a number of papers prepared by staff members, and this editorial task has taken some time.

Yours sincerely

Kevin P Larkins

KEVIN P LARKINS
DIRECTOR

13 July 1989

attachment

381

Confidential

WESTERN AUSTRALIAN ALCOHOL & DRUG AUTHORITY

SUBMISSION TO TASK FORCE TO REVIEW THE OBSTETRIC,

NEONATAL AND GYNAECOLOGICAL SERVICES IN WESTERN AUSTRALIA

In spite of a lack of comprehensive data, it is clear that the number of heroin using women presenting for treatment in Perth has steadily increased. The Authority's experience is that women often:

- have a partner who also uses heroin
- work in low skilled service occupations, particularly prostitution, which produces daily income to support the woman and her partner
- live with a partner who is not related to her children
- have traditional and sex-role based relationships with partners
- are ambivalent and careless about birth control practices
- adopt unrealistically high expectations for themself during treatment due to guilt and perceived inadequacies as a parent-to-be
- have meagre social supports, particularly a history of poor relationships with family of origin.

In the month of May 1989 methadone was provided to 491 persons in this State, of whom 211 (43%) were females. Many of the women in treatment either have children or give birth whilst participants in the methadone program.

The most recent age distribution available indicates female clientele are in the prime child-bearing age groups

	Males	Females	Total
15 - 19	-	-	-
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Pregnancy for heroin-using women often constitutes a crisis - the pregnancy is usually unplanned and discovered some months after conception. By the time the women present for treatment there has often been ambivalence about the pregnancy, and this is compounded by guilt of using drugs which the woman believes may have harmed the foetus. A number of women express the intention to be opiate-free during pregnancy, however this is often a difficult decision to sustain unless they have sufficient interpersonal skills to negotiate with their partner, who is usually also using drugs, a lifestyle change.

It is the Authority's experience that a number of women present late in pregnancy without a history of antenatal care. The staff of the William Street Clinic attempt to stabilise these women on a low dose methadone support program as it is usually beyond the womens' resources to detoxify and remain drug-free. The Clinic also actively encourages pregnant women to attend King Edward Memorial Hospital for Women, or alternatively attend a private practitioner. The Clinic has been fortunate in establishing a good working relationship with a private gynaecologist/obstetrician who provides a personalised service to this latter group of women.

The advantages of a low dose methadone support program include a minimal withdrawal syndrome being experienced by the baby at birth and the reduction in the possibility of premature labour as well as providing the woman with a sufficient degree of intoxication to reduce craving for heroin. The Clinic also strongly encourages women to continue with methadone treatment after the birth to ensure parental stability and social functioning is maximised. Breast feeding is strongly encouraged for women on methadone.

There is a tendency for the Authority's clientele to have premature babies and babies of low birth weight. A similar phenomenon has been noted elsewhere. It is to be noted that clientele, male and female, are heavy users of tobacco - about 80% - 90% smoke. The Clinic also has found that heroin users frequently have histories of heavy use of other substances, particularly cannabis, alcohol and benzodiazepines. Effective treatment of such drug users needs to be seen as sequential and incremental. The initial stages are concerned with engagement and support, development of a working relationship and elaboration of modest goals that improve social and psychological functioning. Abstinence as an outcome should be regarded as a long-term goal and always as a choice behaviour that may be adopted by the user as a consequence of joint negotiation with a helper.

Pregnant heroin users are reluctant users of health services and when they do use services they frequently report stigmatisation. It would appear that clients' poor social skills in negotiation are exposed by formal systems as exist in hospitals. Clientele are also extremely sensitive to remarks and attitudes of staff they have contact with in hospitals, indeed they invest a lot of energy in avoiding situations in which their problems and shortcomings could be exposed.

SUBMISSION

In response to these concerns about the problems facing pregnant drug using women, the Authority has established a Pregnancy Information and Support Program based at the William Street Clinic. This program, which has the aim of reducing drug related harm to the pregnant mother and foetus, is coordinated by one of the Authority's Clinical Nurse Specialists. The program consists of 4 x 1 hourly sessions held at weekly intervals.

1st Week: Film on Development of Baby

2nd Week: Pregnancy Safety
How to reduce the harm of drug use on your baby.

3rd Week: Good Nutrition
For you and your developing baby.

4th Week: Bonding, Breastfeeding and Contraception

This service has been well received by clients. However, the staff feel that the William Street Clinic is not an entirely satisfactory setting for women who are pregnant and/or have babies and young children.

The Authority would strongly support the establishment of an Obstetric Hospital based service for drug using women. This service could provide methadone treatment on an outpatient basis throughout pregnancy. Such an arrangement would maximise the period of effective antenatal care and provide the women with opportunities to link-up with the hospitals' other support services. The focus of such a methadone program would be to initially stabilise the women and build a foundation for longer term support so that the outcome of the pregnancy and subsequent parenting competence is maximised. It is essential that post-delivery this population of women remain in contact with a treatment service that is specifically oriented to the care of the woman and her child. Many women appear to relapse after the delivery of a baby because of the stress, and also because of inadequate resources and social supports.

There is ample precedent for such a service elsewhere in Australia. A program was established in 1979 at the Crown Street Womens' Hospital and since 1982 a service has been provided from the King George Hospital. By 1986 there were 150 women participating in this program. The Westmead Hospital in Sydney has a special methadone program for pregnant women.

This submission has emphasised methadone treatment because this form of treatment has proven to be very effective in attracting large numbers of heroin users into a treatment environment. Many heroin users are resistant and ambivalent about treatment, and are unlikely to be able to develop a drug-free lifestyle except in the long-term. The presence of children severely limits an adult user's options and it is necessary therefore to set realistic and achievable treatment goals. An improvement in general health and social competence can often be achieved very rapidly with methadone treatment.

Surveys of pregnant women's drug use by objective measures, such as by urine scan can indicate the prevalence of drug use in this group of women. A survey of pregnant women attending King Edward Memorial Hospital would be invaluable in establishing the need for a service, and would also sensitise staff to the existence of this problem.