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for Drugs and Drug Addiction

SELECTED ISSUE 2012

PREGNANCY, CHILDCARE AND THE FAMILY: KEY ISSUES FOR EUROPE'S RESPONSE TO DRUGS

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Contents

Introductory note and acknowledgements 5

Introduction 7

Pregnant drug users 8

- Risks of drug use during pregnancy 8
- Responses to drug use among pregnant women 9
- Policy and legal frameworks concerning pregnant drug users 13

Drug users living with children 14

- Risks related to drug use in the family 14
- Responses targeting drug-using parents 16
- Responses targeting drug users' children 20
- Policy and legal frameworks concerning drug-using parents and their children 22

Conclusions 24

References 26



Introductory note and acknowledgements

In-depth reviews of topical interest are published as Selected issues each year. These reports are based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway as part of the national reporting process.

The most recent Selected issues are:

Mortality related to drug use in Europe: public health implications;

- Guidelines for the treatment of drug dependence: a European perspective;
- Cost and financing of drug treatment services in Europe: an exploratory study;
- Treatment and care for older drug users;
- Problem amphetamine and methamphetamine use in Europe;
- Trends in injecting drug use in Europe.

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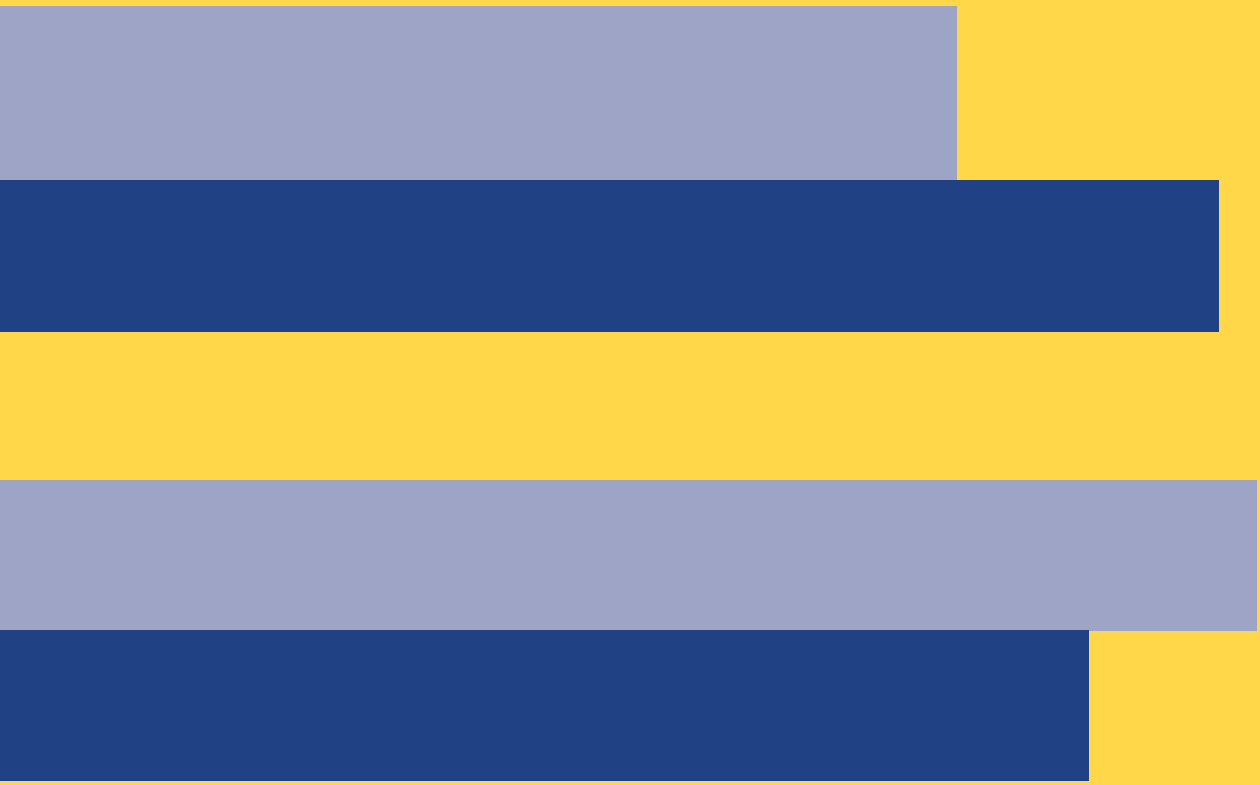
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- the heads of Reitox national focal points, their staff and the national experts on drug-related deaths;
- the services within each Member State that collected the raw data;
- the members of the Management Board and the Scientific Committee of the EMCDDA;
- the Publications Office of the European Union.

Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network is comprised of national focal points in the EU Member States, Norway and the candidate countries and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA.

The contact details of the national focal points may be found at:
http://www.emcdda.europa.eu/about/partners/reitox-network



Introduction

Most drug users are young adults of childbearing age. Indeed, treatment data indicates that almost one in ten of all clients entering treatment live with at least one child. Furthermore, the number of drug users entering treatment who report living with children has been increasing over the last five years. The risks of using drugs during pregnancy have been well documented, and the harms related to drug use in families with children are well known. However, not all pregnant women who use drugs have problems during or after their pregnancies, and not all parents with drug problems have difficulty caring for their children. Still, a common and often well-founded concern of drug-using parents is that they are inevitably viewed as neglectful and their children will be taken away from them. There are, however, an array of programmes to help both pregnant drug users and drug-using parents. To date, though, no comprehensive information has been available on the extent of these problems in Europe, and how they are responded to at European level.

The objective of this Selected issue, therefore, is to provide a European overview of the available responses (interventions, laws and policies) to these problems, along with a description of available European studies on the risks of drug use during pregnancy and for drug-using parents and their children. The information presented here is based on a dedicated data collection exercise that was carried out in 23 European countries (see Figure 1) through the Reitox network of national focal points, supplemented by data routinely collected by the EMCDDA through the Exchange on Drug Demand Reduction Action (EDDRA). This information varied in scope and depth, with several countries reporting extensively on a wide range of interventions available to help families affected by drugs, while other countries were able to provide only limited amounts of information owing to a lack of specific responses, for example, or because these target populations are addressed by general services only. Much of the information presented in this report is based on publications in the national languages of the reporting countries, and on data that were specifically reported by countries for this publication and therefore may be unavailable in this format anywhere else. Information presented here reflects the presence of responses and not necessarily the extent of coverage or the effectiveness or evidence base of these interventions. The systematic assessment of the evidence base of interventions and the evaluation of their impact are important tasks, but are outside the scope of this publication. Based on the input from the responding countries, this Selected issue provides a broad overview, with examples drawn from a wide range of European countries, and constitutes a comprehensive picture of what Member States have done to help these vulnerable populations.

Figure 1: Countries covered in this publication



The first section of the publication deals with pregnant drug users, and the second section describes the situation regarding drug-using parents and their children. Both sections first describe studies reported by the national focal points on the harms of drug use, and then continue by delineating available responses (including prevention, harm reduction, treatment, law and policies). There is often an overlap in responses: in many cases, multidisciplinary care is available from the beginning of pregnancy through early, and in some cases late, childhood; and law and policies sometimes make no distinction between pregnant drug users and drug-using parents, but consider the interest of the child, even if it is unborn.

Pregnant drug users

Data on the prevalence of drug use among pregnant women are not available for most European countries. Where information is available, it often comes from isolated studies using various methodologies, and the results are not readily comparable. A study conducted in an inner-city maternity hospital in Dublin, Ireland, in 1992, for example, found that 4% of antenatal and 6% of postnatal women tested positive for drug metabolites. In a recent study, also using biological specimens, hair analysis showed that 16% of mothers giving birth in an Ibiza hospital had used illicit drugs during the third trimester of their pregnancy (Friguls et al., 2012), although only 2% of mothers reported drug use during their pregnancy. In Latvia, mothers reported drug use in 0.2% of live births and 0.8% of stillbirths. The National Registry of Mothers at Childbirth in the Czech Republic reported a prevalence of 1.8% of illicit drug use among over 1 million mothers between 2000 and 2009.

The true prevalence of drug use among pregnant women, however, is difficult to ascertain, and differences across countries or in certain areas may also exist. Ireland, for example, reported that the proportion of urine samples that tested positive for drug metabolites was higher among women admitted for labour than among women attending scheduled antenatal visits. One reason for this may be that women who use drugs are less likely to receive antenatal care than women who are drug free. In Latvia, for example, antenatal care is received before the 12th week of pregnancy by 90% of expectant women in the general population, compared with 70% of those who had ever used drugs.

Risks of drug use during pregnancy

All psychoactive drugs, including alcohol, tobacco and some prescribed medications, may have adverse effects on the pregnancy, the unborn child and the newborn. Different drugs, however, may act differently (Table 1). This may be a result of not only to the drug itself, but also the poor overall health and the nutritional status of the drug-using expectant

Table 1: Health harms associated with substance use during pregnancy

	Alcohol	Tobacco	Cannabis	Amphetamines	Cocaine	Opioids
Low birth weight	+	+	+	+		+
Miscarriage	+	+	+	+	+	
Perinatal mortality	+	+				+ (a)
Developmental problems in childhood	+		+		+	
Foetal morbidity	+		+	+	+	
Premature birth	+			+		+
Decreased foetal growth	+					
Impaired intrauterine growth	+					+
Neonatal withdrawal symptoms	+					+
Premature rupture of membranes, placental abruption				+	+	
Preterm delivery	+					
Respiratory depression						+

(a) Related to withdrawal.

NB: The effect of these drugs may be confounded by polydrug use and/or other health and lifestyle factors associated with drug use.

Source: *A summary of the health harms of drugs,* The Centre for Public Health, Faculty of Health & Applied Social Science, Liverpool John Moore's University, on behalf of the Department of Health and National Treatment Agency for Substance Misuse (2011).

mother. The degree of the impact of drug use during pregnancy largely depends on the intensity of drug use.

Several studies in the Netherlands have assessed the short- and long-term effects of cannabis use during pregnancy. Short-term effects included reduced foetal growth, smaller foetal head size, reductions in the foetal placental and cardiac blood flow, and low birth weight (El Marroun et al., 2009). The effect of cannabis (usually combined with tobacco) on intrauterine growth seemed stronger than that of antenatal tobacco exposure alone, and heavier use was associated with increased harm (El Marroun et al., 2010). At the age of 18 months, girls – but not boys – who were exposed to cannabis or tobacco in the womb showed increased aggression and attention problems, although the latter association disappeared when controlled for confounders (El Marroun et al., 2011). As the child grows older, however, these effects may disappear.

The vasoconstrictive effect of cocaine and amphetamines, as described by studies in the national reports of Belgium and Germany, decreases the blood supply in the area of the placenta in pregnant women using these drugs. This may result in miscarriage during the first trimester of pregnancy, and placental abruption, intrauterine death and premature birth in the third trimester. In addition, retarded foetal growth and reduced head circumference were also observed. While during the first two years of the child no further teratogenic effects ([1]) were described, some studies found an increased incidence of sudden infant deaths and certain behavioural disorders.

Results of research conducted in Germany and Austria indicate that the teratogenic effects of opioids are fewer than, for example, those of alcohol or tobacco. Anomalies during pregnancy and at birth include insufficient foetal growth and intrauterine development of the bones, intrauterine death, premature birth, anomalies in spontaneous movements, and neonatal withdrawal syndrome. One study in Vienna found prenatal dystrophy and microcephaly in 21% and 14%, respectively, of newborns of women who used heroin during their pregnancies. During the first year of life, elevated risks of sudden infant death and delayed statomotoric development have been observed. In some children, microcephaly at birth remained later on in life, resulting in mild cognitive impairment. A range of eye problems, including strabismus, have been reported by studies in the United Kingdom among children who had been exposed to opioids in the womb.

Neonatal abstinence syndrome

The use of cocaine, opioids and potentially other drugs during pregnancy may lead to withdrawal symptoms in the newborn. Neonatal withdrawal, also referred to as neonatal abstinence syndrome, is characterised by signs of hyper-irritability of the central nervous system, gastrointestinal dysfunction, impaired breathing and generalised symptoms such as yawning, sneezing and fever. Studies in the United Kingdom have found overall neonatal abstinence syndrome rates as high as 68% among the newborns of opioid-using mothers, with a dose–response relationship between maternal drug use and the development of the syndrome (Scottish Executive, 2006). In these studies, about half of the babies who were initially asymptomatic developed delayed onset neonatal abstinence syndrome, and, while many of the babies who received treatment were well by age 20 weeks, about a quarter required long-term follow-up and care.

Injecting drug users have a higher than average prevalence of blood-borne infectious diseases, and these can be transmitted to the fetus (Gyarmathy et al., 2009). The most common blood-borne infection among injecting drug users is hepatitis C, the transmission of which during birth varies depending on a number of factors. Available evidence suggests that mother-to-child transmission of the hepatitis C virus (HCV) occurs only during pregnancy and birth, but not through breastfeeding. A systematic review of worldwide transmission rates found that transmission of HCV from mother to child depends largely on the presence in the mother's blood of viral RNA and whether the mother is co-infected with human immunodeficiency virus (HIV) (Thomas et al., 1998). Among those who are uninfected with HIV, the probability of transmission is 1–3% among HCV RNA-negative and 4–6% among HCV RNA-positive women. Among those infected with both HCV and HIV, the probability of HCV transmission can be as high as 41%, and that of HIV is also high.

Responses to drug use among pregnant women

Interventions involving pregnant drug users include substance use treatment and antenatal and postnatal programmes. Substitution treatment for drug use during pregnancy, however, is available only for opioid users, with the aim to stabilise the users' lifestyle and encourage them to

([1]) Effects that cause developmental malformations in the foetus or later on in the life of the newborn.

use antenatal and obstetric services. Antenatal care reduces the complications of pregnancy and birth – especially those related to neonatal withdrawal – and decreases the probability of birth defects.

Drug treatment

Many opioid users want to cease using the drug when they find out that they are pregnant, but opioid withdrawal is a high-risk option because a return to heroin use during pregnancy can result in poorer obstetric outcomes, and severe opioid withdrawal symptoms may induce spontaneous abortion in the first trimester of pregnancy, or premature labour in the third trimester (WHO, 2009). Therefore, opioid-dependent pregnant women are encouraged to start opioid substitution treatment and those who are already receiving this treatment are advised to continue.

A drug liaison midwife service was initiated in 1999 in each of Dublin's three maternity hospitals to ensure that pregnant opioid users engage in antenatal and drug services, and that they are stabilised on methadone. A preliminary assessment allows immediate admission to treatment. The mainstay of treatment is opioid substitution with methadone: stabilisation of drug use is emphasised, and women are encouraged to remain on oral methadone throughout their pregnancy. The option to detoxify after the first trimester exists, but women are not pressured to reduce dose or to detoxify. Those who had difficulties stabilising are offered inpatient admission to a specialist drug dependency unit. A fast-track system to admit pregnant women into treatment is provided in the United Kingdom, where substitute prescribing can 'occur at any time in pregnancy' as it is less risky than continued drug use.

Guidelines and quality assurance of services for pregnant drug users

Substitution treatment combined with social work and addiction counselling is the standard practice for treatment of heroin use during pregnancy (Mactier, 2011). Methadone is the most commonly available and prescribed opioid substitution medication in Europe, although, in countries where they are available, buprenorphine and slow-release oral morphine may also be prescribed. In a number of countries methadone is reported as the primary substitution medication (e.g. Germany, Ireland, Latvia, the Netherlands, the United Kingdom), whereas in some others buprenorphine is the first-choice medication (e.g. Estonia, Norway). In Germany, in addition to the substitution medications commonly prescribed for opioid-using pregnant women, treatment with diamorphine is also available – though only for high-risk individuals, under strictly controlled circumstances.

Recommendations follow international standards, and in some countries pregnant women receive priority in treatment entry. Treatment protocols for opioid-using pregnant women, however, may vary by country. In many countries, substitution treatment is encouraged at any time during the pregnancy, while detoxification is strongly discouraged; especially during the first trimester, to prevent birth defects and miscarriage, and the third trimester to prevent premature birth.

Guidelines for services for pregnant drug users and their newborn were reported by eight countries, while one country (Portugal) reported that guidelines are being developed. The majority of these guidelines address substitution treatment. In Germany, Ireland, Romania and the United Kingdom, guidance is provided within the general framework for substitution treatment, with pregnant women as a specific subgroup, while Hungary, Norway and Sweden have developed special guidelines.

Three countries (Ireland, the Netherlands, Romania) reported quality assurance documents addressing neonatal abstinence syndrome. In the Netherlands, two specific protocols are available concerning diagnostics, medical treatment, support and multidisciplinary treatment or care of both child and parents. In Ireland, the Irish Prison Service's healthcare standards provide guidance on medical treatment, breastfeeding and psychosocial support. Finally, in Romania, within the general framework of clinical guidelines for opioid substitution treatment, recommendations are provided on treatment choices and on breastfeeding for infants with neonatal abstinence syndrome.

Neonatal withdrawal among newborns of women in substitution treatment

While methadone is the most commonly prescribed substitution medication in Europe, its side-effects commonly include neonatal withdrawal. In a study among mothers who received methadone at delivery, neonatal abstinence syndrome occurred in 28% of infants delivered to women receiving low doses (5–30 mg), rising to 43% for those on medium doses (31–50 mg) and 71% for high doses (51–95 mg) (Scully et al., 2004). Other studies have confirmed the link between maternal methadone exposure and the incidence of neonatal abstinence syndrome among newborns (Binder and Vavrinkova, 2008; Cleary et al., 2011). Given the high rates of neonatal abstinence syndrome among the newborns of women receiving methadone while pregnant, other substitution treatments are of great interest. In a study in which pregnant opioid users received oral methadone, buprenorphine or slow-release morphine, 40% of all newborns did not require treatment for neonatal withdrawal because they showed no or only mild symptoms (Ebner et al., 2007). However, 79% of newborns whose mother received buprenorphine, compared with 32% in the methadone group and 18% in the morphine group, did not need neonatal abstinence syndrome treatment. Another study also found that babies who were exposed to buprenorphine in the womb had shorter hospital stays and shorter durations of treatment for neonatal abstinence syndrome, with significantly smaller doses of morphine, than babies who were exposed to methadone before birth (Jones et al., 2010). While more research is needed to confirm these results, many authors recommend treating opioid-dependent pregnant women with buprenorphine instead of methadone (Binder and Vavrinkova, 2008; Kakko et al., 2008).

Multidisciplinary comprehensive antenatal and postnatal programmes

Several countries reported multidisciplinary comprehensive care programmes ([2]). Doctors, psychologists and social workers follow up drug-using women and their children from early pregnancy into childhood to ensure the well-being and healthy development of the mother and the child. The family outpatient centre of Hvidovre Hospital in Denmark is a specialised unit for pregnant women who use or have used drugs and families with drug problems (where, for example, the father or family members other than the mother use drugs). Children born to these mothers are followed up with comprehensive medical and psychological care until they reach school age. Based on this model, the Danish government has established and funded family outpatient centres throughout the country to help pregnant drug users and children from birth up to school age who were exposed to drugs in the womb. The Danish focal point reported that the occurrence of pregnancy and birth complications and birth defects among drug-using pregnant clients decreased considerably in the country as a result of comprehensive antenatal and postnatal care programmes.

Some of these care services, such as Benniena in Malta, grew over a decade from a consulting service for pregnant drug users to a comprehensive centre for families affected by drug use. Malta responded to the increasing number of pregnant drug users with the creation of a working committee on 'substance abuse mothers', composed of a multidisciplinary panel including social workers, paediatricians, midwives from all obstetrics wards, paediatric nursing officers, antenatal midwives and medical doctors. The remit of the working committee is to follow mothers-to-be who have substance use problems and to ensure that drastic measures, such as care/court orders, can be avoided, and the child is placed within the family of birth if possible.

The HAL ('drugs, alcohol and pharmaceuticals') services in Finland form a multiprofessional treatment model, whereby a network of maternity outpatient clinics – covering the entire country – provides psychosocial approaches with comprehensive medical care. Two-thirds of HAL clients are referred from maternity clinics and the rest from substance-use or other services, such as emergency outpatient clinics. All university hospitals have HAL services, which treat a total of about 400 substance-using mothers each year, providing pregnancy monitoring (including repeated alcohol and drug tests and laboratory tests relevant for at-risk groups, such as hepatitis B, hepatitis C and HIV), psychiatric and psychological assistance, and paediatric assistance. Children born in the HAL system are followed up regularly with health appointments and visits and by child welfare services until they reach school age. Low-threshold agencies called 'family ambulatories' have been established in Norway based on a Danish model, providing – in collaboration with postnatal wards, mental healthcare services and various municipal agencies – preventative health assistance to pregnant substance users and follow-ups of their children until they reach school age.

The 'addictology mobile team' of the Port Royal-Cochin hospital group in Paris, France, aims to help pregnant drug

([2]) In addition to the examples presented in this section, the provision of multidisciplinary comprehensive care was also reported by Belgium, Luxembourg and the United Kingdom.

Prevention of vertical infection among newborns of infected mothers

Compared with HIV infection, no effective and safe method exists to prevent HCV infection from being passed on from the mother to her newborn, although anti-HIV therapy in co-infected women has been shown to somewhat reduce the transmission probability of both viruses (Gyarmathy et al., 2009). Among women infected with HIV only, the transmission through breast milk, during pregnancy and during birth can be reduced to less than 1% with early diagnosis and effective treatment of the mother. The mother-to-child transmission of hepatitis B virus (HBV), another infection common among drug users, can be prevented by a combination of anti-HBV immunoglobulin and a series of HBV vaccines. There are also indications that sexually transmitted bacterial infections, such as chlamydia, syphilis and gonorrhoea, can be successfully treated with antibiotics, and this treatment also prevents vertical transmission.

users to gain or regain parenting abilities. The team, which provides assistance during pregnancy and child birth, and in the postpartum period, consists of five professionals: a psychiatrist and a general practitioner (both specialised in drug addiction), a social worker, a nurse and a midwife. Since 2010, 35 projects to support the well-being of drug-using mothers, mothers-to-be and their young or unborn children have been initiated in France. The projects bring together specialised drug treatment centres, mainstream housing and social reinsertion facilities and low-threshold services, in collaboration with maternity clinics, emergency ward and infant early sociomedical welfare system (including psychiatry).

Several hospitals in Austria (especially in Vienna and Innsbruck) offer a combination of antenatal and postnatal medical, psychosocial and welfare services for this population. After a one-year pilot project, a programme initiated in 2010 at the University Hospital of Psychiatry in Innsbruck consisting of scheduled examinations and assistance by a midwife is available to pregnant women, who receive opioid substitution treatment and additional services by the addiction clinic. Many hospitals in Vienna offer comprehensive care, including outreach activities to contact women at an early stage of their pregnancy. For example, the Comprehensive Care Project at the University Hospital in Vienna is characterised by a multiprofessional approach including physicians, social workers, pharmacists, nurses and psychotherapists, providing both antenatal care and aftercare of the children. Expectant mothers receive psychiatric and psychosocial care, and maintenance therapy with methadone, morphine or buprenorphine. Newborns with withdrawal syndrome receive immediate treatment, and all children are followed up until age six with regular checkups, and receive therapy (e.g. physiotherapy or speech therapy) when needed. The project has also generated a wealth of longitudinal scientific information on pregnant drug users and their developing children.

In the Netherlands, the Precaution (Voorzorg) programme was developed based on the American Nurse Family Partnership, a project that had been found effective in several randomised controlled trials, and adapted to the Dutch situation. The project follows a standardised protocol, and targets drug-using women under the age of 25 who have no other children, and who are at most 28 weeks pregnant, and follows them up until the child is two years old. During this period, participating families receive 60 home visits lasting 60–90 minutes, with a decreasing frequency from once a week after birth to once a month at

Special concerns and populations

One particular concern is drug-using new mothers disappearing and leaving their newborns in the hospital soon after giving birth, often without even naming them. The Bulgarian focal point, for example, reported this practice, especially among young Roma drug-using women. As a response, the non-governmental organisation 'For Our Children' visits the Plovdiv General Hospital for Active Treatment – where many of these abandonment cases have been reported – and provides emotional, psychological and social support and counselling to birthing women who may be at such risk. The organisation aims to promote reintegration of babies into their biological families, or, if that is not possible, to support alternative families, especially those next of kin. Additional assistance to pregnant or birthing drug-using women includes the provision of food and items for the baby, such as nappies, bath lotions and clothes.

A special population among pregnant drug users is those in prison. Comprehensive antenatal services exist, for example, in Mountjoy Prison in Dublin, Ireland, where antenatal care including HIV testing and, if they are infected, treatment is offered to expecting mothers. These services collaborate closely with community organisations to prepare the mother and her newborn for their eventual life outside prison. Another special population is women with HIV, an infection often related to drug injecting; in Estonia, to prevent transmission through breast feeding, infants of HIV-infected women have the opportunity to obtain formula milk for free until the child reaches the age of 12 months.

the end of the project. The Red Cross Assistance in Spain runs a follow-up programme for high-risk pregnant women, with the goal of reducing the harmful effect of their drug consumption on their lives and on the lives of their newborns. In this project, pregnancy is considered an opportunity to initiate medical follow-up and addiction treatment, including substitution therapy, infection control or psychiatric care, if needed.

A large variety of multidisciplinary comprehensive programmes are available in Germany at local, regional and national levels. The WIGWAM outreach programme in Berlin, for example, is an interdisciplinary cooperation available for pregnant drug users since 1987. In addition to antenatal care, medical help related to birthing, and addiction treatment (including inpatient treatment for newborns with neonatal abstinence syndrome), women are offered referrals to substitution treatment, psychosocial assistance, home visits and welfare services. The Early Intervention for Pregnant Women with Substance Addictions (Fruehintervention fuer suchtmittelabhaengige Schwangere, KIDS) was initiated in Kassel in 2007 with the objective of reaching pregnant women who have substance addictions as early as possible in pregnancy in order to provide referrals to medical and social services. In Portugal, the Integrated Project of Maternal Support provides integrated and global care to pregnant and postpartum addicted woman and their children, following outpatient therapeutic modalities best suited to each situation regarding the treatment, harm-reduction and reintegration needs of these patients.

Policy and legal frameworks concerning pregnant drug users

In terms of legislation applying to pregnant users, or to children before birth, it can be seen that in some Member States pregnancy is one criterion that may trigger eligibility or facilitate an application for opioid substitution treatment ([3]). Treatment is based on the mother's consent; Finland and Sweden reported that it was difficult legally to protect a fetus, for example by compelling the mother to submit to care, as rights started at birth, and the right of the mother to self-determination would be violated, though in both countries there have recently been proposals to change this. In the Netherlands, coercive treatment in the form of a prenatal supervision order is possible once a pregnancy has attained 24 weeks. It is also possible to enforce psychiatric hospital admission for pregnant drug users, but this is seldom applied, as that law was designed to address mental health issues. However, one of the key legal issues with this topic is the clashes of laws and/or perceptions of them: jeopardising the well-being of the child by lifestyle conflicts with the right of a parent to raise children. While a mother may have the right to protection or assistance, and the examples mentioned above show how she may be encouraged to take it, she may also fear applying for it if there is a risk that her child would be taken away, and may even hide or deny her pregnancy because of this; this was reported as a known concern by Germany, Hungary, the Netherlands and Sweden.

While various countries establish obligations to report matters that concern child welfare, it was not clear how many would extend this obligation to concern for the welfare of an unborn child. Sweden reported that the obligation did not apply to unborn children, whereas in Finland, since March 2010, an anticipatory child welfare notification must be submitted when there is reasonable cause to suspect that an unborn child will need child welfare support measures immediately after birth. In Denmark, concerns about the welfare of unborn children must also be reported, and the obligation to report child abuse applies to all citizens regardless of their relationship to the child. In the United Kingdom (England and Wales), there are no mandatory reporting obligations, but professionals and local authorities have a duty to report if an unborn baby or a child is at risk of significant harm. In most countries, obligations to report (or act on) suspicions of a child 'in trouble' are placed mainly on professionals, for example members of the social service system (Slovenia), members of the child risk-warning system (Hungary) and those who work with children (Sweden). Sweden also reported that the Prisons and Probation Service are obliged to report if they suspect that a child is being mistreated. In Germany, such an obligation on professionals to report has been noted to clash with physicians' confidentiality obligations, though a new law – the 'Bundeskinderschutzgesetz', which came into effect on 1 January 2012 – aims to lay down a standard to address this.

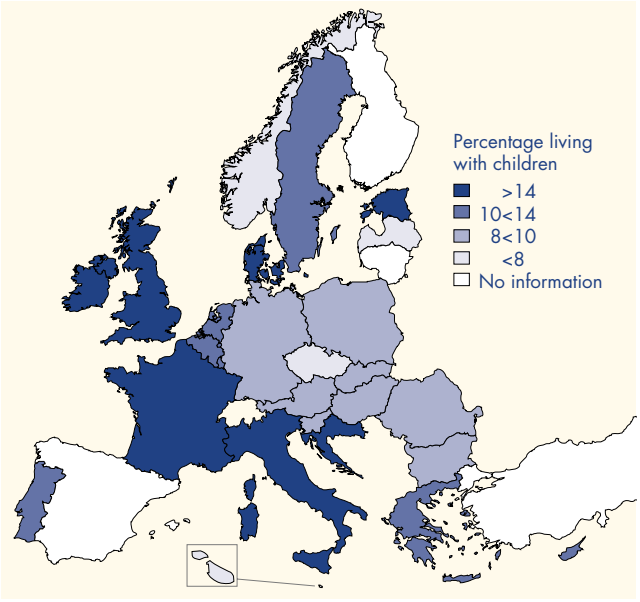
In Poland, if the behaviour of the drug-dependent parent results in harm to the child's health, the child has a right to compensation under the Civil Code, even if the actions occurred during the mother's pregnancy.

([3]) See the EMCDDA website for information on treatment regimes in European countries.

Drug users living with children

No precise information is available on how many drug users live with children in Europe. The only data that are available concern drug users entering treatment. This population, however, is only a partial representation of all drug users who live with children, and not all countries in Europe collect this information. The latest available data on those entering treatment for drug use problems in 26 European countries show that about one in ten clients (ranging between 3% and 17%) entering treatment in 2010 lived with children (alone or with a partner, see Figure 2). Overall, 5% of all treatment entrants (or 40% of those who reported living with children) were single parents; on average, women were four times more likely than men to be single parents.

Figure 2: Percentage of all reported clients entering treatment for drug problems living with children



NB: Data are for 2010 or most recent year available. Data for Poland refer to data from a pilot study; data for the United Kingdom come from its 2011 National report and refer only to England. For more information, see Table TDI-14 in the 2012 statistical bulletin.

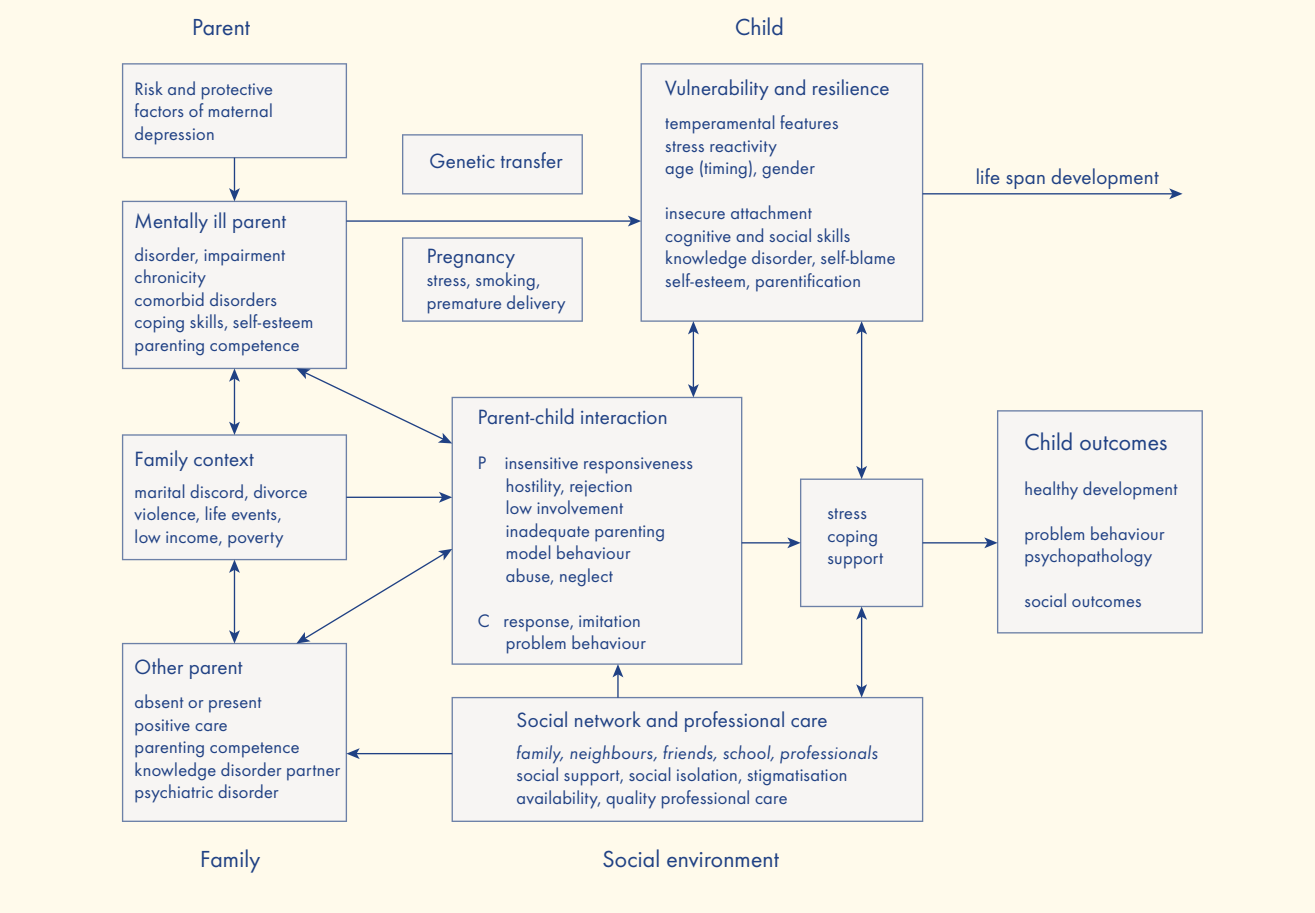
Sources: Reitox national focal points.

Risks related to drug use in the family

Drug use is often a burden not just on the user, but also on other family members, including spouses, parents, siblings and children (Copello et al., 2005). Dependent children are especially affected – albeit differently at different ages – by a parent's drug problem, since parents' ability to rear, protect and care for their children, attend to their health, feed them and financially support them may be greatly diminished by their drug use. Furthermore, being preoccupied about drug supplies can compromise parents' abilities to be consistent with their parenting and emotionally responsive to their children's needs (Barnard and McKeganey, 2004). Drug use problems in families, however, express themselves in a range of ways, varying in intensity and duration, and children will exhibit different degrees of vulnerability and capabilities of tackling the stresses to which they are exposed (Velleman and Templeton, 2007). Below is a summary based on reports by national focal points, which reported an array of studies describing the potential harms that drug use may have on families.

Physical and mental health and other outcomes for the children are the results of a balance between risk and protective factors that operate and interact with each other at the level of the parent, the child and the environment. Risk factors may include genetic and biochemical factors, parenting, family coping styles, and violence within the family and in the surrounding environment. Protective factors, such as high levels of life skills, or attention, care and social support by another parent, family member, or social network, counteract the negative effect of risk factors. Based on the above, a model was developed by Hosman et al. (2009) showing the interconnection of risk and protective factors as they relate to mental health outcomes in general. While this model was not developed for drug use specifically, it can serve as a point of departure for the development and organisation of preventative and treatment interventions of problems in children of parents with a drug use problem, a psychiatric disorder or both.

Figure 3: A developmental model of trans-generational transmission of psychopathology



Source: Adapted from Hosman et al. (2009).

When present in a family setting, addiction problems are often not restricted to one drug-using parent, but may involve both parents or may span generations. Studies reported by the national focal point in Germany have found that, while alcohol dependence usually afflicts only one parent in a family, problem drug users disproportionately often have partners who are also dependent on drugs. Although parents may disapprove of their own drug use and discourage their children from using drugs, an Irish study found that they are usually not successful in transmitting these values to their children. This is demonstrated by statistics in, for example, Norway, where over half of drug users in treatment reported parents with a serious alcohol or drug problem – although this figure may be overstated given the nature of the study population. In addition, a study reported by the Danish national focal point has recently found that about a third of children who grew up with substance-using parents had substance use problems later in life. This study suggested that, in addition to the environment, genetic factors may also play a role.

Parenting problems are among those that affect children the most. Studies described in the German National report found that, compared with non-drug using parents, drug-dependent parents are more prone to neglecting their children, and therefore children in families with addiction problems often need to assume parental responsibilities and tasks, such as running the household and taking care of younger siblings. The interaction between a drug-dependent parent and his or her child is often disturbed: studies from the Netherlands indicate that children are often neglected or abused, or they have low engagement with their parents. One major parenting deficiency reported by the Irish focal point is related to the ability and consistency of setting limits: at times parents use unwarranted discipline, while at other times they are overly permissive. This imbalance in the families places a large amount of stress on the children, especially if the mother is the one affected by the drug problem.

An array of studies in the United Kingdom assessed how drug-using parents function, and found that, in order to

ensure that their family life appears as normal as possible, drug-using parents often resort to 'damage limitation' methods, whereby they try to keep their drug taking secret from their children (Rhodes et al., 2010). They may, for example, try to avoid sleeping during the day, hide from their children when they have withdrawal, or hide their drugs and paraphernalia. Despite all these efforts by the parents, though, children are usually aware of their parents' drug taking, and at earlier ages than the parents may think. The children, however, keep this knowledge to themselves; this points to the potentially high number of children who may be in need of support services that may not be visible to the appropriate service providers.

In Germany, the living circumstances of families affected by drugs have been described in a number of reports. These studies show that, compared with the general population, problem drug users generally have lower levels of education and occupational training, and higher levels of poverty and unemployment. As a result, the socioeconomic circumstances in which they bring up their children are less advantageous than of those who do not use drugs. In addition, children in families with addiction problems may experience emergencies and stays in hospitals, the arrest of parents, suicide attempts and deaths more frequently than other children. The uncertain living circumstances, poor housing conditions, poor nutrition and a socially constrained environment have a negative impact on the physical, psychological and social development of the child.

Conduct disorder and other psychopathological symptoms are some of many ways how children externalise problems in dysfunctional drug-using families. A study in Austria among children aged three to six years old in families with drug-using parents found that a third had signs of developmental disorders, another third showed psychopathological symptoms and 14% exhibited attention deficit disorder. Of all the children, about a third are expected to have problems at school due to their conduct disorders, while another third will have school problems due to their developmental disorders. Academic progress of such children, as reported by an Irish study, may be further hindered by poor attendance and low levels of parental involvement. According to a Danish study, one in ten of the children who live with parents with substance use problems are diagnosed with mental disorders and two in five have physical or mental health problems.

Children of drug-using parents, Ireland further reports, may live under circumstances where their vulnerability is difficult to detect; for example, young carers looking after parents with drug or alcohol addictions. In such cases, families do not want people to know the circumstances within which a child acts as caretaker; they may fear that the child will be taken away by social services. In Austria, for example, a study found that in families affected by drug use a third of the children were moved to foster parents at a very early stage, another third remained with their mothers at first and were transferred to another caregiver within the first few years of infancy, and a third stayed with their mothers. Polydrug-using mothers were more likely to have their children taken away. While living with foster parents may seem to be favourable for the positive development of children, the stabilisation of the biological family through adequate treatment, care and support, and the increase of social network ties with non-drug using friends and extended family are always the best solution for both children and parents.

Resilience

In psychology, *resilience* refers to an individual's tendency to cope with stress and difficulties. Resilience may help a person 'bounce back' to a previous state of normal functioning, or people may use the experience of a stressful situation to function better in the future (Masten, 2001). Resilience can be considered a process rather than a trait of a person. This is an important concept to explain how, in spite of the exposure to many risks, children growing up in families with problems can become well-functioning adults (Velleman and Templeton, 2006). The study of resilience emerged about 40 years ago when some scientists studying high-risk groups found that many children were developing well in spite of their underprivileged environments. Resilience is a natural tendency for some individuals, but it can also be promoted through specific interventions, as many studies have proven. These interventions, for example, connect children with confidants outside their problem families, because positive relationships with competent adults can improve the resilience factors, or involve children in meaningful pastimes. Helping children become aware of their problems increases their desire to overcome those problems. Teachers, social workers and other adults in their environment should create a stimulating environment where children's talents can evolve despite all their difficulties. Such coaching fosters resilience and improves social functioning (Newman, 2002).

Responses targeting drug-using parents

An array of interventions is available for drug-using parents, ranging from addiction treatment and integration of their children in the biological families; through provision of or referral to care services, psychosocial support, prevention

The Exchange on Drug Demand Reduction Action (EDDRA)

The Exchange on Drug Demand Reduction Action (EDDRA) is an online inventory of projects collected by the Reitox national focal points. It provides a broad overview of evaluated interventions in Europe. Some of these projects addressing pregnant women, children and drug-using parents are described in the response sections of the present publication. The EDDRA collection is available at the Best practice portal.

interventions and empowerment; to skills building. These types of interventions are often offered by comprehensive prevention programmes, while smaller programmes may specialise only in one type of response. The examples mentioned below are programmes reported by the national focal points, and may not be an exhaustive list of those that run in various EU countries.

Integration of children in their biological families

Many drug-using parents shy away from seeking treatment or care, because they fear that their children may be taken away from them. While at times these fears may be well founded, in the majority of cases authorities support drug-using parents in their efforts to seek care and treatment in order that children can stay with their biological parents in an improved, healthier environment. However, even when children are taken from their drug-using parents, they are often placed in families of close kin. For example, the wide range of social services provided by the Bulgarian foundation 'For Our Children' includes services promoting the reintegration of babies and children into their biological families, and there is an emphasis on extended families when placement in foster families or care is necessary. One of the founding principles of the Lichtblick project in Frankfurt, Germany, is that it is in the best interest of the children to avoid being removed from the custody of their biological parents. The comprehensive services provided by the project aim to empower drug-using parents to create a healthy physical and mental environment for their children.

In January 2008, a pilot family drug and alcohol court (FDAC) was set up in London to address the specific needs of drug-using parents and thus improve outcomes for their children (Harwin et al., 2011). It was the first court of its kind in England and Wales, and consisted of a rehabilitation programme for drug-using parents whose children are subject to care proceedings, and was led by a judge. In the final evaluation report, it was shown that 39% of children in areas that were served by the FDAC stayed with the family, in comparison with 21% of children in families who were subject to normal care proceedings. There was also a positive difference reported in the proportion of mothers who had stopped substance misuse (48% compared with 39%). A greater reduction in substance use was also reported among fathers in the evaluation (39% of those in the FDAC group compared with one of the 19 fathers in the other group).

The Health Service Executive (HSE) in Ireland has developed a pilot project with a family-oriented approach that is expected to reduce the number of children who need to leave their families to be cared for in alternative forms of care. In addition, the HSE provides a full range of support services to both parents and children, including therapeutic work, parent education programmes, home-based parent and family support programmes, child development and education interventions, youth work and community development. The evaluation of the Families First project in north-east England showed that parents at risk of losing their children can successfully change their lives such that the children can remain safely in the family home. The availability of kinship care, usually provided by grandparents, was an important factor in preventing children from being taken into care (Templeton, 2011).

Family-based residential treatment programmes

Inpatient residential treatment programmes that specifically cater to the needs of families exist in some Member States. For example, the therapeutic community Sananim in the city of Karlov (Czech Republic) has provided treatment to altogether 115 dependent mothers and their 117 children since 2001. The Belgian organisation Trempoline developed the Kangaroo project with the objective of supporting women in their role as mothers. During the daytime, while mothers in this therapeutic programme are engaged in activities (e.g. therapeutic community and social reintegration), their children attend nursery school, kindergarten or school classes, depending on their ages. The inpatient treatment clinic De Lage Kamp in the Netherlands has been serving addicted parents and their children (up to age 12) for more than 15 years. Treatment is offered to up to nine families at a time for the duration of 12 months on average, with detoxification during the first four weeks. Parents participate in group sessions and receive individual counselling, and children are in day care engaged in educational activities and games. A high-threshold programme in Slovenia called Projekt Človek Society houses three families (mothers or fathers and their children) at a time. This inpatient social rehabilitation and

addiction treatment programme teaches parents skills related to parenting and improving the relationship with their children. A nationwide network of inpatient facilities in Finland (the Federation of Mother and Child Homes and Shelters) has been offering treatment and care to drug-using mothers (and, to a lesser extent, fathers) and their children since the late 1990s. Several family inpatient institutions exist in Norway as well: a national study from 2005 showed that 93% of the children were under the age of three years, and 25% of them were born while the mother was already staying at the institution.

The Coolmine Therapeutic Community in Ireland is the only residential service in the country where children of primary school age can live on site with their mother, allowing the mothers to receive the support they need as their children's personal development is strengthened through specialist counselling and child welfare initiatives. The Federation of Mother and Child Homes and Shelters in Finland runs a national specialised treatment system known as Pidä kiinni (Hold tight), consisting of seven mother and child homes around the country. To date, the Pidä kiinni homes and service units have rehabilitated about 1 500 families. The service reaches some 250 families annually, of which about 100 are referred to mother and child shelters and about 150 to outpatient services. In the Lithuanian public institution TC-Laisva valia, up to 10 substance-using women may get long-term psychological care and social rehabilitation services together with their little children. The 'Eltern-Kind-Haus' ('parent–child house') in Boeddiger Berg, Germany, is a special service where drug-using parents live together with their children and receive advice and help regarding child-raising questions and support in organising everyday family life.

The role of the family in treating drug addiction

Evidence shows that involving family members in the treatment of their relatives affected by drug addiction is important for at least two reasons: to alleviate the symptoms of stress and their consequences in family members, and to improve the effectiveness of treatment (Orford et al., 2010). Copello and colleagues (2005) identified three main types of family-based interventions, and presented evidence to support the effectiveness of all three types: those aimed at the involvement of the family to promote the entry of the substance user into treatment; interventions which involve the family in the treatment itself; interventions aimed at supporting the family members. Other reviews have shown that family-oriented interventions also decrease behaviours and situations that facilitate substance use, by modifying the emotional environment linked to substance use. A review study in Germany that assessed services aimed at drug-using parents identified a systematic family-oriented approach as an important conceptual element in work with families with addiction problems. Group services (support groups, individual counselling, case counselling, weekend seminars, crisis intervention and parent training courses), public-relations work (awareness of services), administration (planning of resources) and supporting services (childcare while parents take part in activities or family seminars) are also key elements that contribute to the success of the programmes. Initiating contact with help agencies is often difficult for drug-using parents; feelings of embarrassment and shame, and fear of losing their children were identified as major barriers to seeking care. Outreach and referral by other – often non-drug-related – services may help parents overcome these barriers.

Provision of or referral to care services

Parents with drug problems and their children need ongoing care. This includes follow-up by case managers of those who are involved in prevention programmes with the aim of providing ongoing counselling to prevent drug use and encouraging a healthy lifestyle. Some may require clients to return to the programme that they participated in, while others provide home visits. Specific help offered to clients may include crisis intervention, legal help with issues related to drug use, and childcare while they participate in programme activities. Obviously, not all programmes may be comprehensive enough to offer all services that this target population may need. They often, therefore, provide referrals to other services, or encourage service utilisation.

The Kiddo Project in Belgium helps parents become aware of how their current or past drug problems may affect their children, informs them about other services available and encourages them to make use of those services. In addition to referring mothers to facilities in the area of child and youth welfare services, the 'Liliput – Mutter + Kind' service offers individual counselling to mothers and children, childcare and leisure time activities in Nürnberg, Germany. In Kassel, Germany, KIDS reaches out to expectant drug users and mothers with drug problems and connects them with social and health services. Päiväperho (Butterfly) in Finland links substance-using pregnant women and mothers of small children with child welfare services, substance use services, maternity clinics and family counselling clinics, in addition to providing low-threshold services.

Since 2000, a crisis intervention service called Option 2 has been running in Cardiff and the Vale of Glamorgan, Wales. Staff work intensively with two or three families for up to 30

hours a week over a four-week period, with follow-up visits at one, six and twelve months post intervention. Booster sessions are available to respond to a crisis or to help parents reinforce their coping skills. Parents are asked to develop goals to reduce risks to their children and to identify behavioural changes which will prevent their child from being taken into care by social services. Examples of goals include drug or alcohol abstinence; improved family relations; developing improved routines for children; dealing with domestic violence; and managing children's behaviour. Several similar interventions which target families with substance use problems using the Option 2 model have been developed across the United Kingdom, but provision is not provided on a national basis.

A multidisciplinary social work team, including community care and probation professionals, is available at the Drug Treatment Centre Board in Dublin, Ireland, focusing on family support (including child welfare), advocacy, group work, writing reports and attending inter-agency meetings. A children's playroom provides stimulation and a safe and supportive child-centred setting for children aged between 1 and 14 years, who accompany their parents or guardians to the clinic. They also offer advice and support to parents who may have childcare concerns. The Ballyfermot Advance Project in Ireland subsidises childcare costs in order to facilitate treatment access to drug-using parents.

Social work at police stations is an important element of responses in Finland. It involves responding to situations that emerge in the course of police work involving children, young offenders, people experiencing family and domestic violence, mental health patients, drug users and other people undergoing acute crises.

Psychosocial support

Several activities provide psychosocial support for recovering drug-using parents. Psychotherapy, psychosocial care, and support groups with activities to learn healthy expression of emotions are aimed at minimising the complications related to drug use. Several programmes offer services facilitating social reintegration and rehabilitation.

The Welsh programme Integrated Family Support Services is a multiagency service which provides targeted support to families where there are concerns regarding child welfare and parental substance misuse (drugs, alcohol or both). It is a family-centred approach to services which provides early intervention in addition to crisis management. The aim is to provide intensive support to improve parenting capacity as well as social service intervention and to help bridge the gaps between child and adult services by protecting vulnerable children, while at the same time helping parents to develop new skills. Four 'pioneer' areas in Wales adopted the scheme in late 2010, and it is reported that some early successes in preventing children being taken into care have been observed. These areas were to be evaluated in 2011, and following this it is expected that the programme will be rolled out nationally. The evaluation is due for publication in 2012/13.

An array of services in Germany provides psychosocial support to drug-using parents and their children. Regenbogen, an inpatient aftercare programme in Germany, provides abstinence-based support, counselling and assistance to parents with substance use problems. The HiKiDra project in Kiel offers comprehensive social counselling for parents, and support groups not only for mothers, but also for pregnant women, children and adolescents. The 'Bella Donna' drug-counselling office has been offering services to women and girls in Essen since 1992. Its training programme MUT! helps mothers who use drugs or are in substitution treatment, and their children, by providing support, suggestions and practical help in the everyday chores of raising children. Childcare is available while mothers attend group meetings.

Empowerment and skills building

Parents who are seeking to recover from drug addiction benefit substantially from acquiring and strengthening skills that enable them to forge a strong family. Building parenting skills – including setting limits for their children, planning and organising the household, and planning the children's education – are a main goal of therapeutic programmes. These include being aware of the parent's addiction, learning how to deal with real-life family situations and acquiring everyday practical skills. A key aspect is building family coherence by planning family leisure time and fostering the parent–child relationship. Skills-building activities related to interpersonal skills, communication, coping, problem solving and decision making are also often part of therapeutic work for parents with drug problems.

The Ana Liffey Drug Project in Ireland aims to promote and support high-quality parenting and to enhance the quality of life for children whose parents use drugs. SAOL is a community-based educational and rehabilitation day programme for women in treatment for drug addiction. It provides a full-time childcare facility and early education programme for their children: SAOL Beag (Little SAOL) Children's Centre. Using an individualised curriculum and approach to work with the children, the programme seeks to identify each child's interests, strengths and learning goals

and to plan activities and learning experiences for the child. An integral part of this service is to work in partnership with the parents. Another key element is the relationship the children have with the adults who work with them: the staff are qualified and experienced in dealing with children and aim to form strong, caring relationships with the children.

A special programme in Denmark called 'Dag og Døgncenteret' (the Day Care and Inpatient Centre) is an inpatient programme that places the mother (or parents) and the child together in a foster family under special terms and conditions. In this system, the parents are not allowed to take the child with them if they unexpectedly leave the foster family or experience recurrence of their drug use. In Denmark, other inpatient institutions exist that do not specifically target drug-using parents with children, but are aimed to help families with any psychosocial problem or a risk of neglect. The '1-2-3 Lass!' (1-2-3 Go) project in Luxembourg targets pregnant women and mothers with children under two years of age. It started as a pilot project in 2007 as a collaboration between the 'service parentalité' and the National Drug Addiction Prevention Centre, with the aim to strengthen and improve the parenting skills of participants.

The Polish government sponsored a prevention programme in 2010 entitled 'New Beginning', targeting drug-dependent mothers and pregnant women. The programme featured support groups and parenting classes. The aims were to improve the participants' knowledge and skills regarding conflict solving, coping, positive thinking and leisure time activities; to manage the child's development; to improve the parent–child relationship; and to promote parenting skills. Besides psychological and health matters, some classes were devoted to legal issues.

Internet-based prevention interventions for drug-using parents

Several programmes use alternative means, such as email, phone or the Internet, to reach families affected by drug use. An Internet-based intervention called www.kopopouders.nl ('cheer up, parents'), based in the Netherlands, is the online version of a face-to-face course. The contents are designed to support parents with a psychiatric disorder or addiction problem on issues related to the upbringing of children. Professionals from mental health institutes coach the parents in online group courses, and through chat and email. In 2009, the site reached almost 40 000 parents. A pre–post evaluation showed a significant decrease in parenting problems among participants.

Responses targeting drug users' children

Children in families affected by drug use may have different needs, based on a variety of factors. For example, children who have drug-using parents, but who do not show signs of maladjustment or developmental difficulties, may need different interventions from those children whose behavioural problems are a reaction to the parent's drug problems. On the other hand, the drug use habits of the parents may be hidden from outsiders, with the result that the potential maladjustment of the child may not be responded to appropriately. Despite the potential difficulties concerning identifying children who are raised in families affected by drug use, an array of interventions is available for them, ranging from integration of children in their biological families, through provision of care services, psychosocial support and prevention interventions, to skills building.

Care services

In some European countries, services targeting children of drug users are historically part of the welfare services. For example, in Prague, the Centre for Children, Young People, and the Family has been serving families affected by alcohol and drug use since 1967. Their programmes for children include special counselling and child welfare services with the aim of providing children with a safe space where they can strengthen their personal development. The centre has also provided research data for studies assessing the effects of parents' alcohol use on children.

In Portugal, the Centre of Integrated Responses performs the assessment and screening of children in families with addiction- or alcohol-related problems, youth at risk or young people with alcohol or drug problems. In 2010, 3 920 adolescents were attended to, and 20 referrals and 750 appointments of family support were made. Appointments, often through partnerships with other entities, are also available to parents, teachers and members of the educational community.

Often care services for children are not specialised in drug use, but cater to the needs of families with a range of mental health problems. The 'Squeak Says the Mouse' project in the Netherlands, for example, offers support in low-economic-status neighbourhoods for children between the ages of four and eight who have a parent with a psychosocial, mental health or substance use problem. The aim is to counterbalance the combination of parental factors and the high-risk environment and keep the children from developing problems similar to those of their parents. A pre–post evaluation showed a significant decrease in emotional problems and a significant increase in positive social

behaviours among participating children. Two projects in Austria (the Jojo project in Salzburg and KIPKE in St Pölten) target children of parents with psychiatric illnesses. Children participate in individual and group sessions where they learn skills that help them cope with their parents' illness.

Psychosocial support

In Belgium, the project 'La Brique' implemented by the AVAT institution is a place where children aged 12–17 who have drug-using parents can receive psychosocial support and express their feelings in a creative way. In Germany, the national model project 'Trampolin' focuses on children in families with addiction problems and seeks to strengthen their self-image and ability to solve problems. For example, specific group activities aim to inform participants about drugs and alcohol, remove taboos on the subject of addiction and teach strategies that help them cope with stress. The project is supported by the German Centre for Addiction Problems of Children and Youth (Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters) and the German Institute for Research on Addiction and Prevention (Deutsches Institut fuer Sucht- und Praeventionsforschung), and is carried out at sites in all 16 German Laender. The KiSEL project in Loerrach focuses mainly on children and adolescents from families with addiction problems, but it also provides parenting support counselling services for parents. In the Netherlands, face-to-face support groups for children of parents with a psychiatric disorder and children of addicted parents aim to increase the social well-being of the children by increasing their resilience, thereby diminishing their likelihood of developing psychopathology. An effectiveness study is currently ongoing in the age group 8–12 years. A large number of municipalities in Sweden have support groups for children whose parents have substance use problems. During these group activities, children share their experiences with others who live under similar circumstances. No evaluations, however, have assessed the effectiveness of these support groups in Sweden.

Empowerment and skills building

'Strengthening families' is a family-based intervention, developed in the United States two decades ago, that targets parents with a drug or alcohol problem and their children. The intervention aims to increase the social capacities, communication skills and self-confidence of participating children, and addresses several problems, not only those related to drug use. Adapted versions of Strengthening families have been implemented in at least 11 European countries ([4]). A German project called 'Jonathan' has been available for children and youth from families with addiction problems in Erfurt since 2006. Services include informing different age groups about specific topics relating

Internet-based interventions for children of drug-using parents

Several European countries reported on Internet-based responses for children with drug-using parents, taking advantage of the computer literacy of younger generations to reach the target group. The *'Kidkit'* project in Germany is a low-threshold, Internet-based service available since 2002 for children and adolescents who live in families with addiction problems and/or experience domestic violence, providing information about topics such as 'addiction and family' and 'violence and family'. The project also offers free and anonymous online counselling.

The Netherlands-based *Kopstoring* is an interactive website for adolescents and young adults aged 16–25 who live with drug-using parents. The site, which receives about 10 000 unique visitors each month, includes information pages, a panel discussion, email services and a chat box, and aims to strengthen the coping skills of adolescents and young adults in order to prevent and alleviate behavioural and psychological problems. A process evaluation showed significant decreases in parentification – whereby a child is obliged to act as parent to their own parent – and in negative feelings towards the home situation. The website is currently ongoing a randomised controlled evaluation and a cost-effectiveness assessment. Another Dutch site, *Survivalkid* is a members-only site for youngsters aged 12–24 who have parents or siblings with a psychiatric disorder or substance use problem. The site provides information on psychiatric disorders and addiction, has a chat function with peers, and includes a chat and email facility with a 'survival coach'.

The *DrugLijn* project in Belgium provides general information on addiction, including suggestions to answer the question 'What to do if your parent(s) use drugs?' (*). In Sweden, the Swedish Council for Information on Alcohol and Other Drugs has developed a web-based self-help programme, *Drugsmart*, for children of substance-using parents. The programme will be evaluated by researchers at the organisation STAD (Stockholm Prevents Alcohol and Drugs).

(*) Websites dealing with the issue of drug-using parents may exist in other countries as well.

([4]) Germany, Greece, Ireland, the Netherlands, Poland, Portugal, Slovenia, Sweden, the United Kingdom, Norway.

to addiction problems, leisure time activities, pedagogical assistance and social skills development. Other services have also been available since 2011, including consultation days for parents, children and institutions. At times, help is provided not only to families affected by drug use, but also to families with a range of other mental health problems.

Policy and legal frameworks concerning drug-using parents and their children

Legal framework at international level

The main international laws governing illicit drugs are the UN Conventions of 1961, 1971 and 1988. The first two make no mention of young people. The preamble of the 1988 Convention Against Illicit Traffic in Drugs expresses deep concern for the fact that children are used as a consumer market and for drug distribution, and in Article 3(5) it mentions the victimisation of minors or distribution near schoolchildren, for example, as aggravating supply offences. Nevertheless, there is no express mention of children of drug users.

However, the following year (in November 1989) the *UN Convention on the Rights of the Child* was signed. Article 33 states:

> States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

The preamble states that the child 'needs special safeguards and care, including appropriate legal protection before as well as after birth'. As there is no mention of from whose illicit drug use the child should be protected, this has been interpreted as meaning that states should protect children from drug use within the family (Barrett and Veerman, 2012). It may be read together with Article 24, which gives the right to antenatal and postnatal care, and therefore may include substitution treatment for opioid-dependent people, and may also be considered as supporting parenting skills.

Legal framework at European level

At the European level, there is again no specific law applying to the children of drug users. Nevertheless, the issue of removing children from families may be governed by the right to family life. Article 8 of the European Convention on Human Rights states:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

In interpreting this, states are allowed some discretion, known as the margin of appreciation. This will differ according to context but is particularly wide in the area of child protection (Kilkelly, 2003). Nevertheless, it has been established by the court that a family life will always include the relationship between a mother and child, even when there is no marriage, no cohabitation, or only potential family life even if it has not been established (for example, if a child was removed from a parent at birth) (Kilkelly, 2003). As the well-being of the child is paramount, the return of the child to the parents should always be considered; without measures to prepare for the child's return to his or her parents, the implementation of a custody order may be damaging to the child (Conrod et al., 2010). This was reported as a basic principle in Belgium, Latvia, Slovenia and Slovakia. In the Czech Republic, one of the objectives of the national action plan on caring for vulnerable children is to reduce the number of children in institutional care, while the Irish Child Care Act, 1991, aims to avoid the use of care. If disagreements between parents or authorities occur, the child has a right to be informed of proceedings and to express its opinion, according to the European Convention on the Exercise of Children's Rights 1996.

Legal framework at national level

Given the very specific focus of the Convention on the Rights of the Child on illicit drug use, as it was drafted 20 years ago, it is perhaps a sign of development of the public health paradigm in the field of substance use that most countries appear to address the problem in a more general frame of harm to the child that may be caused by addiction to any substance, including alcohol, or by belonging to a certain 'risk group'. No country in Europe reported that drug use in itself was a reason to remove the child from the parent. Perhaps comparably, few countries reported that the children of drug-using parents were a specific target group in the national drug strategy or action plan. In Portugal, there are several mentions in the 1999 National Strategy and the 2005–12 National Plan. The 1999 document identifies the difficulty of finding places in therapeutic

communities and specialist treatment programmes for pregnant women and those with children, and requests attention to prevention activities for the children of addicts. These are developed in the 2005 plan, and have resulted in guidelines for children of drug users (2010), while guidelines for monitoring pregnant women are being drafted. The Luxembourg National Drug Action Plan refers to the 'parental service', which follows judicial measures under the Child Protection Act, as a priority 1 project that should be further developed. In Austria, which has drug or addiction policy papers in each of the nine provinces rather than one national document, the children of addicted parents are explicitly mentioned in the policy papers in four provinces as target groups for prevention and/or treatment services (in fact the 1999 Drug Policy Programme of Vienna points to good results from a hospital project, indicating that this was a focus early on). In Ireland, the National Drugs Strategy of 2001 considered childcare facilities in treatment centres, and the new strategy of 2009–16 identified the children of drug users as a 'group at risk' and called for considering ways to address the needs of the children of problem drug users. The current UK Drug Strategy of 2010 focuses on early intervention for vulnerable young people, in which it includes children of drug users; in Northern Ireland, the rate of children on the child protection register due to parental drug use is a key indicator in the Children Services Plan 2008–11, rather than the drug strategy. Within the wider substance use framework, the 2011 Swedish strategy for alcohol, narcotic drugs, doping and tobacco policy contains an interim target for its second objective that fewer children should be born with damage caused by those substances. However, most countries reported that the children or parents would be covered by more general terms in the national drug or addiction strategy documents without specific mention.

Besides treatment, childcare facilities may also be an issue for drug-using parents, though there was little focus reported on this. In 2001, the Irish National Drugs Strategy called for consideration of how to integrate childcare facilities with treatment and rehabilitation centres, and provision in residential treatment settings. Four years later, it was considered that full-time childcare facilities within an addiction setting may lead to further stigmatisation of the children of drug users, and that more appropriate services should be provided.

Given the potential for conflicts between laws and strategies, it is interesting to note calls and efforts made in coordination in this area. In Germany, from January 2012, the law to strengthen protection of children aims to provide a legal foundation for binding network structures for child protection, where conflicts have occurred in the past. The Irish National Drugs Strategy 2009–16 called for facilitating closer engagement between child, outreach and drug services at a local level. The Ministry of Family in Luxembourg set up a 'national office of childhood' in December 2008. Youth care in the Netherlands is being revised, after the multiplicity financing structures was identified as a major barrier; there will be one financing structure and central coordination of financing at the level of the municipalities, committing collaboration between all professionals. Austria reported good results in care and support for pregnant drug users and their children, from a service providing interdisciplinary cooperation between hospitals. The 1999 Portuguese drug strategy declares the importance of coordination of programmes for pregnant addicts with maternity departments and obstetrics services. In Sweden, the 2011 alcohol, narcotic drugs, doping and tobacco strategy has set targets for a clearer division of responsibilities between the principals for substance use and dependence care. In the United Kingdom, statutory Local Safeguarding Children Boards (Child Protection Committees in Scotland) are made up of representatives from across key children's services and should ensure regular sharing of information and local multiagency working.

Conclusions

Drug users who aim to stabilise their lives face several challenges, including access to treatment, stabilisation of their drug use, social reintegration and referral for health problems other than drug use. Drug users who have children, however, constitute a special subgroup, because in addition to their concerns related to drug use in general, they also have additional needs, such as childcare while they are in treatment and assistance with issues related to parenting. Furthermore, the legal protection and the right of their children to grow up in their own family may be threatened with the possibility that the children can be removed if child protection services consider their environment dangerous to their well-being. This Selected issue gives a broad overview, based on reports by EU Member States and Norway, on the extent of and available responses – interventions, laws and policies – to the problems of pregnant drug users and families that are affected by problem drug use.

National reports indicate that legislation in Europe strives to keep the family united rather than take away the children. No country reported that drug use was a reason per se to remove the child from the parent. Legislation applying to pregnant drug users or to children before birth facilitates eligibility to treatment in many countries. In addition to legislation, a variety of interventions – many of them evidence-based – have been developed in European countries to help pregnant drug users and addicted parents and their children. For example, the majority of treatment interventions for pregnant women follow the evidence of providing substitution treatment to those dependent on opioids. Furthermore, to ensure that pregnant drug users receive proper and timely care, some countries organise outreach services and referral systems, and offer multidisciplinary comprehensive programmes during and after pregnancy, and therapeutic communities where recovering parents and their children can remain together. Interventions responding to the needs of drug-using parents and their children include measures enabling the children to stay with their biological families, family-based interventions, provision of or referral to care services, psychosocial support, empowerment and skills building. Internet-based prevention programmes are also available, especially for adolescents and young adults with drug-using parents, a target group that often still lacks appropriate interventions.

Data on the prevalence of drug use among pregnant women is not available for most European countries, so programmes aimed at helping pregnant drug users may not be aware of the size of the target group. In addition, it is unknown to what extent families affected by drug use are reached by existing programmes. National reports, however, indicate that coverage may be small or vary substantially by country, and that the viability of some of these programmes may be questionable. There are several factors that may contribute to this situation. First, a shortage of appropriate and available interventions at organisations that may cater for the needs of problem drug users and their families is often combined with a lack of policy support. Second, reaching the target group may be difficult. For example, several countries reported that a number of problem drug-using parents are not in treatment, and their children therefore may not be reached by addiction care. When in treatment, some clients may not disclose that they are parents. It has also been reported that children of clients in addiction care may not be targeted systematically, and that problem drug users may shy away from contacting such services because of their fear of stigmatisation surrounding drug addiction and mental disorders, and their fear of losing their children.

Those treatment services that exist may have several impediments that prevent them from increasing their coverage. For example, a potentially general issue reported by Finland relates to public funding: as drug treatment services are often dependent on funding from local or government authorities, budget cuts resulting from financial crisis may have negatively affected, among other things, the functioning of interventions and services targeting drug users with children. Diminished funding may have led to a loss of treatment places, an insufficiency of medications, a decrease in the variety and diversity of services, and the eventual closure of such services – to name just a few. As recovering from substance use and problems related to it may be lifelong processes, securing long-term government or other funding is an essential attribute of prevention efforts.

In light of the above, continuous monitoring, especially identifying the size of the target population, might be helpful to better understand the issues, needs and potential solutions related to drug-using pregnant women, and drug users and their children. Identification and promotion of exchange of best practices will support countries in setting their goals and planning their responses. Where needed, accessibility and coverage of treatment should be increased, especially for pregnant drug users. Removing barriers to seeking treatment, including lack of childcare and fear of legal consequences, might further help this target population. Evidence-based family interventions should be further promoted. Appropriate interventions that strengthen the resilience of children can also help prevent children of drug users from becoming drug users themselves. The variety and coverage of appropriate preventative interventions based on such approaches still have room for improvement, as has the evidence base for interventions for pregnant drug users, drug-using parents and the children of drug-using parents.

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