AGREEMENT REFERENCE NUMBER: S12. 324695 (2001 CVG2-212)

TECHNICAL FINAL REPORT

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IREFREA NATIONAL NETWORKS

IREFREA AUSTRIA
Dr. BOHRN KARL
Institut für Sozial und Gesundheitspsychologie (ISG)
Linke Wienzeile, 112/4
A-1060 Wien - AUSTRIA
E-mail address irefrea@chello.at

IREFREA FRANCE
Dr. BROYER GERARD
Universite Lumiere Lyon 2 – Institut de Psychologie
5, Avenue Pierre Mendès France
CP 11. 69676 Bron Cedex - FRANCE
E-mail address broyer@univ-lyon2.fr

IREFREA GERMANY
Dr. BRÖMER HORST
Lepsiusstraße 76
D-12163 Berlin - GERMANY
E-mail address irefrea.d@gmx.de

IREFREA GREECE
Dr. KOKKEVI ANNA
Averof 21
104-33 Athens - GREEK
E-MAIL ADDRESS akokke@mail.ariadne-t.gr

IREFREA ITALY
Dr. STOCCO PAOLO
Via Orsera 4
30126 Lido di Venezia - ITALY
E-MAIL ADDRESS irefrea@villarenata.org

IREFREA NETHERLAND
Dr. VAN DE WIJNGAART GOOF
Utrecht University, Oudegracht 325
3511 Utrecht
E-mail address addict@fsw.ruu.nl

IREFREA PORTUGAL
Dr. MENDES FERNANDO JOACHIM
Av. Joao de Deus Ramos, 130 –A, 1°dto
3030 Coimbra – PORTUGAL
E-mail address irefrea@esoterica.pt

IREFREA SPAIN
Dr. CALAFAT FAR AMADOR
Rambla 15, 2°, 3°
07003 Palma de Mallorca – SPAIN
E-mail address irefrea@irefrea.org

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FINAL REPORT

Survey N° 1
Study on the perspectives regarding the improvement of assistance for female drug addicts with children in Europe

INDEX

INTRODUCTION

Since 1996, IREFREA has been carrying out a series of research projects with the purpose of examining the various facets of the relationship between Drug Addiction and Gender Identity. Through these European studies, we are able to evaluate the evolution of drug addiction amongst women. From the results obtained to present, we have found that the Area referring to motherhood, and above all the relationship between the addicted mother and her children, is particularly important and appears to be equally essential for both parties. The framework of relations and the various dysfunctions which arise when the maternal role is taken on have led us to consider the need to develop a line of research specifically aimed at the relationship between the Addicted Mother and her children. This line of research is particularly concerned with the problems of guardianship and legal custody which the drug addicted mother might find herself facing.

The research Irefrea has conducted in recent years on the subject of drug addiction and gender identity has enabled us to observe a series of circumstances which have a direct influence on the course of addiction.

The scant representation of women on treatment programmes seems to be the outcome of several factors reviewed in our recent European study entitled *"Barreras al Tratamiento en Drogodependencias e Identidad de Género" (Gender Identity and Barriers to treatment of Drug-Dependencies).* One of the factors that appear to have a significant impact on accessing and remaining on treatment programmes is motherhood. This is a factor which, as we have indicated on a number of occasions, plays a double role: on the one hand, it can act as a determining factor in the decision to give up drug use and/or start treatment, but on the other, it can turn into an obstacle to the drug-user's remaining on the programme and achieving rehabilitation. Motherhood, and in particular the link between the drug-using mother and the child, is a determining factor in the drug-addict's progress, and is a factor which requires closer study.

In Irefrea's view, the importance of the specificities of gender and particular requirements of women joining therapeutic programmes in order to give them prospects of success are today sufficiently well established.
Taking this premise as a starting point, this study aims to analyse the situation of drug-using mothers as regards their drug addiction and the mother-child relationship. The study has examined in particular aspects such as the quality of this relationship during addiction and the impact of the maintenance or loss of the mother-child relationships during treatment, whether in a positive sense, with the programme acting as a stimulus, or in a negative sense, where it acts as an obstacle, whether for legal reasons such as the child's being taken into care, or the male-centric design of the therapeutic programme, which therefore, does not envisage this possibility, along with other general aspects.

During treatment the mother-child relationship appears to be crucial both to the future of the mother and the psychological and social maturation of the child.

Separation and the breaking of this bond can be a determining factor in the mother's giving up rehabilitation treatment. By contrast, fostering the continuation of the mother-child bonds has shown itself to be a determining factor in a successful outcome. And this view has been taken up by numerous residential care centres and therapeutic communities, which in recent years have been modifying their programmes to envisage residential care of mothers accompanied by children aged 1 to 7 years, and even from the time of pregnancy.

OBJECTIVES

- To ascertain the extent to which the mother-child relationship suffers addiction-related distortions in the case of drug-dependent women.
- To study the differential characteristics of the progression of the addition in women receiving treatment.
- To assess the extent to which health-care resources are able to embrace mother-child relationships.
- To analyse the existence of differences between outpatient therapeutic intervention and residential care in the case of drug-using mothers.
- To ascertain the circumstances in which child protection services intervene in the case of drug-dependent mothers.
- To formulate alternatives and models of action, which permit an improvement in the effectiveness of care, delivered to drug-dependent mothers.

REPORT OF THE ACTIVITIES

Project Head. Paolo Stocco, Juanjo Llopis.

Participating countries. Germany, Austria, France, Italy, Portugal, Spain.

Programme phases. Four phases are foreseen for this project and are to be carried out from: 2001.11.02 – 2002.11.02.

First phase (1 month)

- In accordance with the foreseen, the first phase of the study was dedicated to the formulation of a methodology common to the various countries and the identification of the key informers.

With these aims, from 2002.28.2002 to 03.03.2002 an initial meeting of the members of the "Gender Identity group" took place in Alicante (Spain).

- Bibliographic research

With the aim of verifying what is already known and what has already been done regarding the subject of female drug addiction and motherhood, research was carried out on international bibliographic material.

Included in the most important works are: Council of Europe (1995), *Women and drugs.* Netherlands. Council of Europe (1997), *Special needs of children of drug misusers.* Germany. Council of Europe (1997) *Women and drugs. Focus on prevention.* Germany. Council of Europe (2000) *Pregnancy and drug misuse*

update 2000. Germany. Dagmar Hedrich (2000) *Problem drug use by women.* Focus on community-based interventions, Pompidou Group, Strasbourg. Klee H. Jackson M. Lewis S. (2002) *Drug misuse and motherhood.* Routledge, London.

Second phase (2 month)

- Semi-structured interviews were carried out with open and closed questions targeted on expert informants such as professional drug-dependency experts, social services and child-protection agencies.

The objective was to ascertain the opinions of professionals involved in the various aspects of the problem and use this information to design a questionnaire for the third phase.

Third phase (6 months)

- In accordance with the foreseen, this phase of the study was dedicated to the sample group selection.

Survey of a sample made up, firstly, of a group of drug-dependent mothers who either live with their children, who have either retained or lost custody of their children, and have received or currently receive care under any of the various agonist maintenance treatment programmes. And a second group of drug-dependent mothers who either live with their children or have lost custody over them and who are undergoing treatment at a residential centre.

The objective was to conduct a transversal comparative epidemiological study of two samples of drug-dependent women with children, selected randomly and paired depending on the type of treatment requested, whether voluntary or imposed by the legal system.

- Drug-addicted women, including both women who retain the guardianship or custody of their children and those who do not, and who are receiving treatment in maintenance programmes using opiate agonists, versus drug-dependent mothers who, independently from whether they have lost custody over their children or not, receive specific treatment for their addiction at residential centres.
- The questionnaire used in this phase of the investigation was prepared following analysis of the interviews with the expert informants.

Fourth phase (3 months)

- In accordance with the foreseen, the last phase of the study was dedicated to the elaboration of the data and the release of the results.
- Data gathering form the two samples of women was conducted via this semi-structured questionnaire, made up of open and closed questions, in which subsequent coding and computer processing was envisaged.

The statistical procedures used are based on non-parametric tests when the dependent variable is not nominal (given that the sample does not have a normal distribution) and the χ^2 statistic when comparing the measurements from the two groups with nominal variables.

- One of IREFREA's main objectives is to achieve a constant discussion and release of the results of the studies that have been carried out.

Accordingly, there has always been frequent contact within the team, between the different partners and the outside, the institutions or those interested in the work being carried out, either by means of telephone or by e-mail.

INTERPRETATION OF THE RESULTS FROM THE QUESTIONNAIRES COMPLETED BY PROFESSIONALS

Introduction

These results are one part of this research whose aim is to provide a broad insight into the area to be investigated through interviews with key informants. Our objective was to find out the opinions and beliefs of various European professionals whose work is directly linked with the areas to be investigated: addiction, social services, child protection services etc., with sufficient knowledge of the situation facing the addicted mother to become Key Informants.

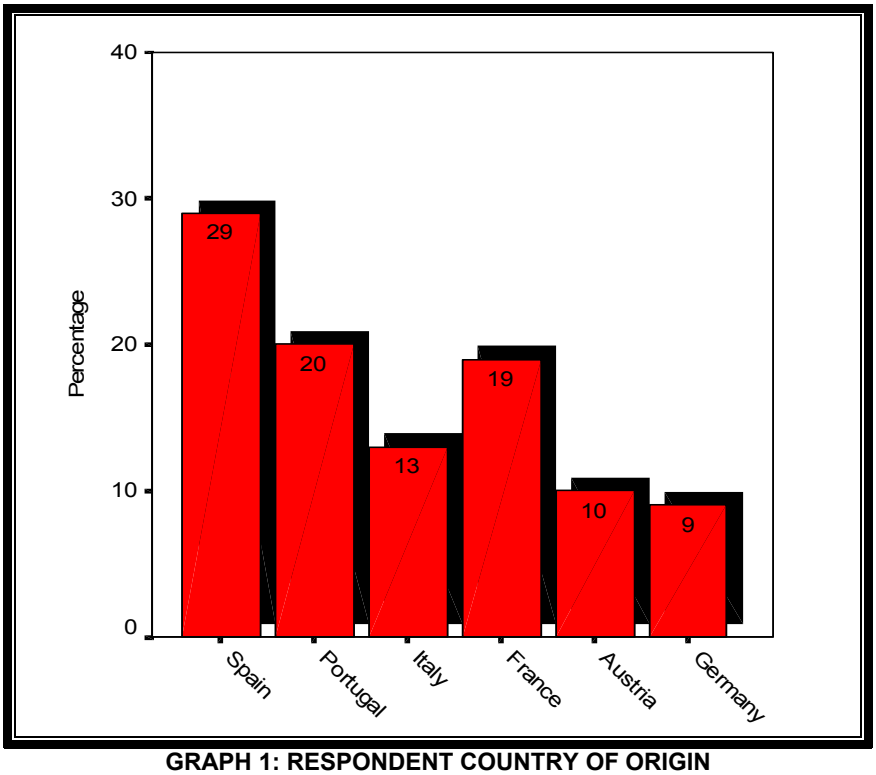
Through the in-depth analysis of the surveys carried out on the key informants, we are able to find out what the most significant aspects are, and in this way, devise a standardised interview tool with which to carry out the second part of our research: to find out the attitudes, beliefs and needs of the drug addicted woman with children.

We would like to point out that the sample used in the first part of the study covered in this report was chosen at random by requesting the help of the professionals surveyed, and in no way does it claim to be representative of the various European professionals involved in this field. We also want to make it clear that this is only a preparative report to enable us to develop the second part of the present research which aims to provide in-depth knowledge into the characteristics of Identity and Gender and their relation to drug addiction.

Description of the sample

The sample was made up of 103 professionals working in the field of drug addiction, with academic backgrounds in Psychology (36%), Medicine (21.4%) and Social Work (19.5%). Most of the respondents work in drug addiction centres (58.3%) and management of drug addiction plans (10.7), with a smaller representation (lower than 5% in each area) from general health centres, social services and drug addiction related health centres.

The gender composition of the sample was very balanced (49.5% women and 50.5% men). However, representation by country was less so, the greatest number of respondents coming from Spain, followed by Portugal, France, Italy, Austria and Germany.



GRAPH 1: RESPONDENT COUNTRY OF ORIGIN

Drug addiction in women

According to the professionals, percentages show that fewer women addicts seek intervention than men, with women falling below 40% of the total, as is reflected in the accumulated percentage. The opinion of the professionals is slightly higher than, but coincides fairly well with the figures for the notification of treatment initiation (where women account for less than 30%), but lower than results of surveys into drug consumption in the population as a whole, in which women and men are equally represented and, in the case of certain drugs, the proportion is even higher for women.

This disagreement of results takes us to two hypothesis: the first one in which the condition of feminine gender would act since as protection factor for the dependence development differences would not be observed in the general population's consumptions in relation to the sex, or the second hypothesis in which such a protection factor would not exist, but rather the addicted women and they transform into a numerous hidden population that doesn't end up requesting help in the treatment centers for diverse reasons.

	Percentage	Accumulated Percentage
Below 20%	43.7	43.7
20 - 40%	39.8	83.5
40 - 60%	10.7	94.2
60 - 80%	1.9	96.1
Above 80%	1.9	98.1
Do not know/ Do not respond	1.9	100.0
Total	100.0	

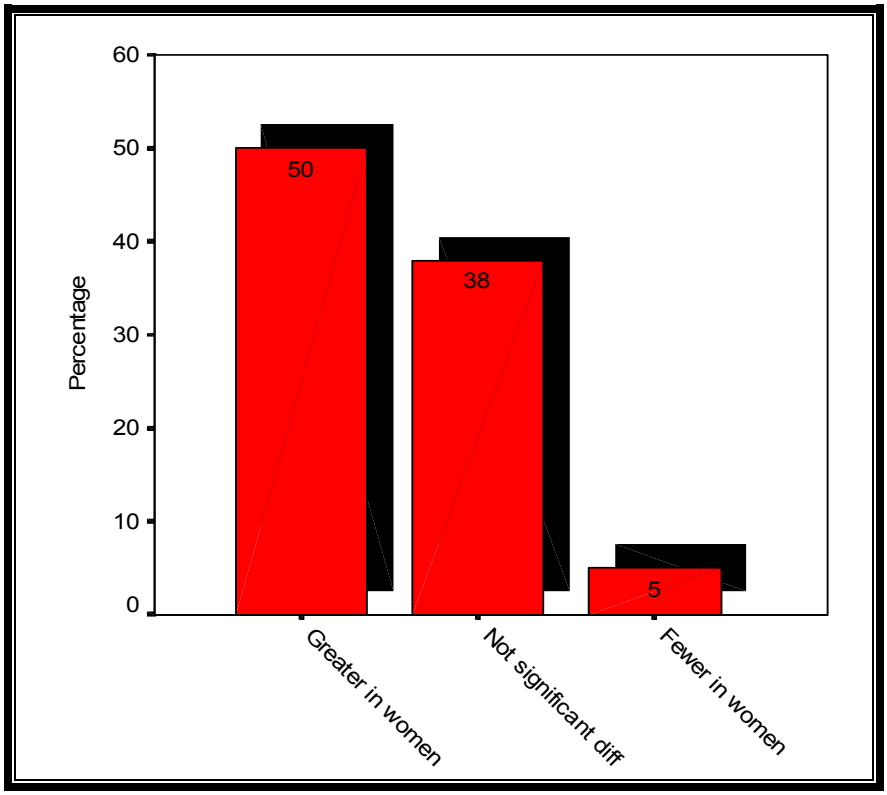
There is little agreement amongst respondents on the question of the proportion of mothers included in the group of women addicts seeking intervention, and because of this disparity, data on this point has not been interpreted.

	Percentage	Accumulated Percentage
Majority	25.2	25.2
Approximately half	32.0	57.3
Minority	41.7	99.0
Do not know/ Do not respond	1.0	100.0
Total	100.0	

In response to the question of whether addiction in women presents specific characteristics of its own, 83.5% of the professionals considered this to be the case. In all likelihood, the presence of specific characteristics in female addiction implies that women addicts also have specific needs which should be taken into account in the initial evaluation stage, and included in the objectives of therapy programmes.

	Percentage	Accumulated Percentage
Completely agree	25.2	25.2
Agree	58.3	83.5
Disagree	12.6	96.1
Completely disagree	2.9	99.0
Do not know/ Do not respond	1.0	100.0
Total	100.0	

When questioned on the seriousness of the addiction, more than half the sample (56%) consider that the seriousness and consequences of the addiction in women are greater in comparison with male addicts, 37.9% do not believe that there are significant differences, and only 4.9% are of the opinion that addiction has fewer consequences for women than for men.



GRAPH 2: SERIOUSNESS AND CONSEQUENCES OF THE ADDICTION IN WOMEN VS MEN

Pregnancy and addiction

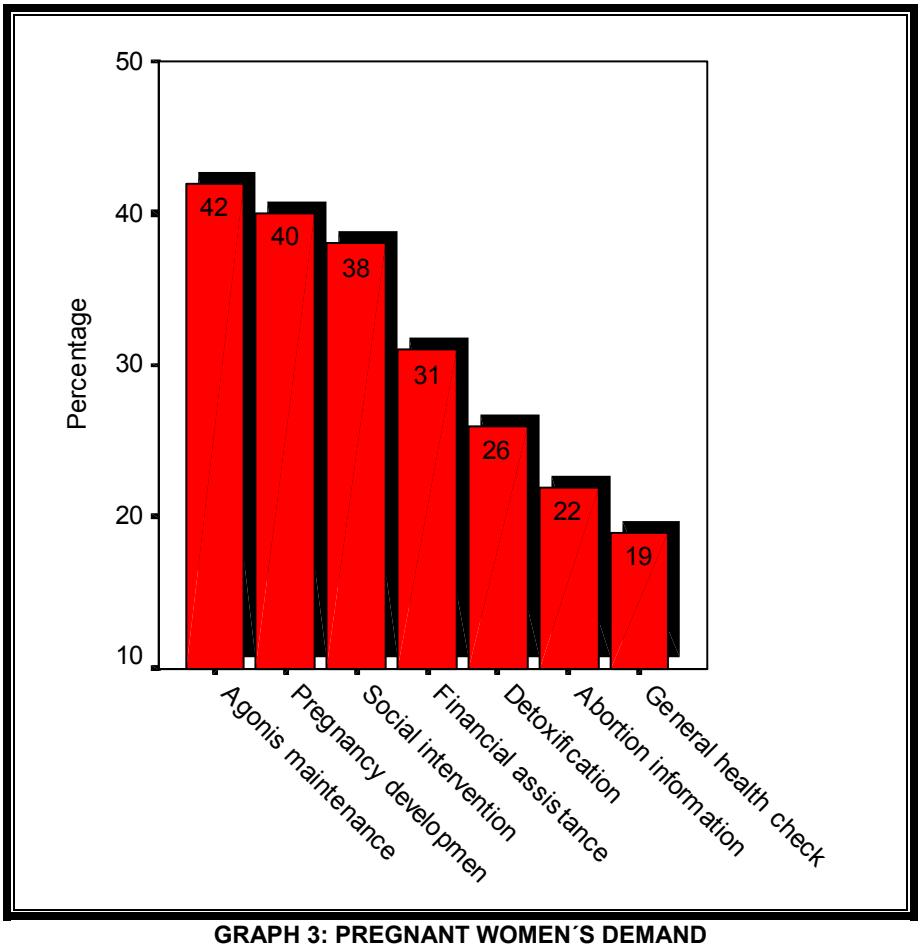
This section included a question to evaluate whether the possibility that the woman might be pregnant was taken into account a priori in women addicts seeking treatment, and whether systematic pregnancy tests were carried out prior to establishing a pharmacological treatment programme. This factor was considered due to the aggressive nature that the various addiction treatments can have on the development of the foetus.

Results reveal that systematic pregnancy testing is only carried out in 13% of cases, although this percentage increases to 68% when a possibility of pregnancy is suspected. On this point, we must bear in mind what can be considered clear indications of pregnancy in the case of the active female drug user as, for instance, many women addicts do not usually consider recurrent missed periods they experience to be an indication of pregnancy. This is particularly the case amongst opiate addicts, whose periods practically disappear on a permanent basis.

A specific protocol is required for pregnancy detection in women drug addicts, and likewise, an equally specific protocol for their treatment.

	Percentage	Accumulated percentage
Yes	13.6	13.6
Only if pregnancy is suspected	55.3	68.9
No	29.1	98.1
Do not know/ Do not respond	1.9	100.0
Total	100.0	

Results on the most frequent demands made by addicted mothers are surprising: there is no homogenous demand amongst pregnant addicts. Over 43% of the professionals consulted do not consider any one demand to be “most frequent”. Leaving this data to one side, the analysis of priorities shows that the most frequently expressed demands are for agonist maintenance therapy, health care checks during the development of the pregnancy and social intervention, all of which show percentages of around 40% (43%, 40% and 38% respectively). Application for financial help is made by almost a third of pregnant patients (30%). Detoxification treatment is also requested, but to a lesser extent, as is information on abortion and finally, the patient’s own health care. In light of the results obtained, there seems to be a priority amongst this type of patient for non-aggressive treatment for their addiction, (42% request substitution therapy compared to 26% who want to carry out detoxification treatment), health care check ups during the development of the pregnancy, and social intervention in the situation they are facing when they come to ask for treatment. The demand for financial assistance is also “high” (given the percentages obtained from the items making up the questionnaire). Lower percentages are observed for items related to giving up drug use, information on abortion and concern for the patient’s own health, which indicate a preference for dealing with the most immediate circumstances.



GRAPH 3: PREGNANT WOMEN´S DEMAND

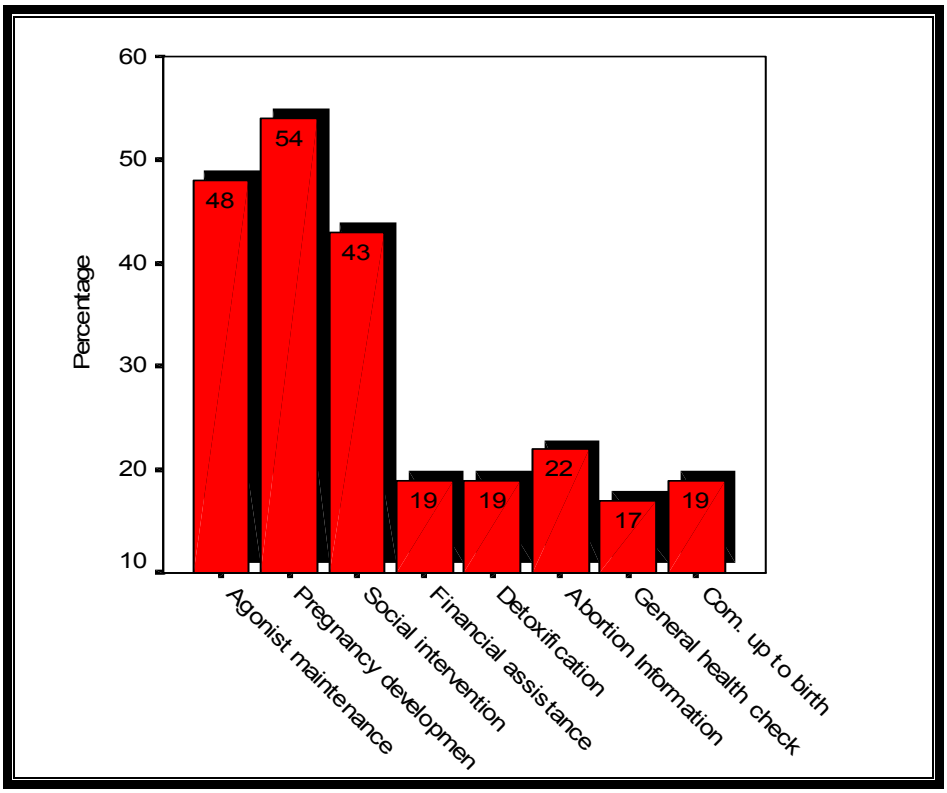
The intervention patterns followed for pregnant patients are interesting in that the percentages are greater than those referring to the rate of demand in all but two categories (it should be remembered that we are dealing with a multiple choice style questionnaire).

At first glance, this might suggest that there are more resources than those requested, but a closer reading of these percentages reveals that this may not be the most logical deduction. We are more likely to be facing a problem of low correlation between the supply and demand responses. The reasons that have led us to this explanation are set out below.

The professionals seem to be more concerned with the control of the pregnancy's development and the health of their patients than do the pregnant women themselves.

The percentage obtained shows that social intervention takes place in a higher number of cases than those it is requested for, although we still need to know whether this intervention pursues the same objectives as those the patient requests. This "reasonable doubt" arises from the interpretation of other items, such as that referring to financial assistance, the concession of which is reflected in a much lower percentage than that representing the demand for financial aid (19% against 31 %), even though in many cases social intervention undoubtedly calls for an economic contribution to such basic areas a housing.

Detoxification is carried out at a much lower rate than the demand reflected in the figures, which shows that detoxification treatment is only feasible in the second term of pregnancy, and not in every case. In categories referring to abortion and information on abortion, the figures are the same for demands and interventions. Admission to Therapy Communities up to the moment of the birth seems to be the pattern followed in 19% of pregnancy cases, which is a rather surprising figure given the scarce availability of this type of resource, and furthermore, it is not one of the demands usually made by pregnant addicts, possibly because it is not a widely known alternative.



GRAPH 4: PATTERNS FOLLOWED IN ATTENDING PREGNANT WOMEN

Motherhood and addiction

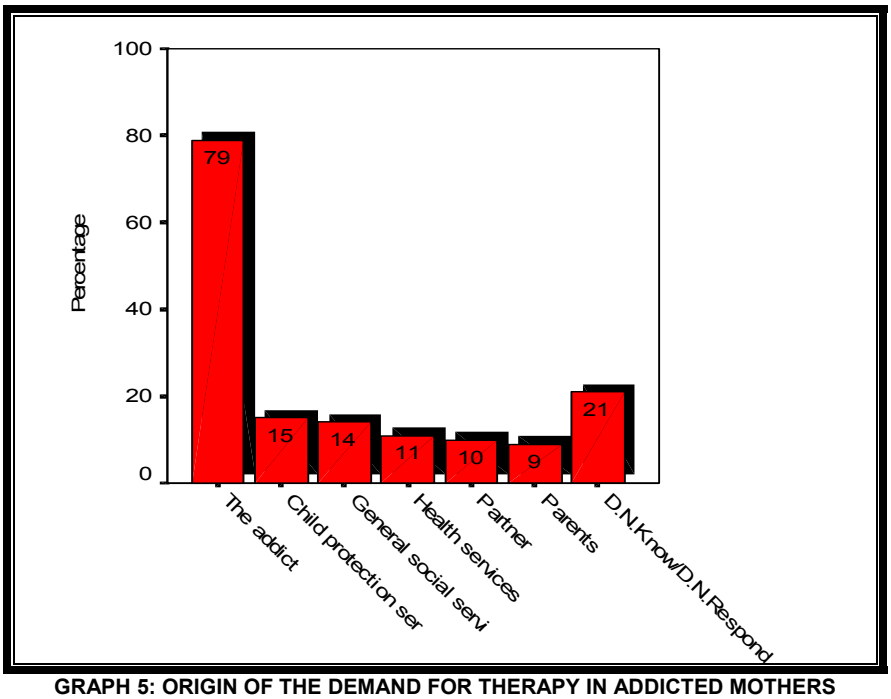
Certain discrepancies exist as far as the repercussions of pregnancy and motherhood are concerned. Pregnancy and motherhood appear to be obstacles to the women's requesting treatment. This becomes obvious when professionals are asked whether they consider that women hide their addiction and request less treatment for fear of losing custody of their children, a position which 79.6% of the professionals in the survey agreed to be the case.

	Percentage	Accumulated percentage
Completely agree	25.2	25.2
Agree	54.4	79.6
Disagree	17.5	97.1
Completely disagree	2.9	100.0

The discrepancy to which we refer above occurs when they are asked about the repercussions of motherhood on the addiction. Most consider that motherhood has a positive effect on addiction (68% of the sample professionals agree that this is the case), which seems to support the supposed "therapeutic effect" that is attributed to pregnancy in the prognosis for the development of certain illnesses, while at the same time, it is considered an obstacle to gaining access to the specific resources for the treatment of their addiction.

	Percentage	Accumulated percentage
Very positive	6.8	6.8
Positive	61.2	68.0
Negative	20.4	88.3
Very negative	1.0	89.3
Do not know/ do not respond	10.7	100.0
Total	100.0	

Data from the variable in which we look at the origin of the demand from women addicts seem to indicate that we are dealing with a social group with little support from its immediate environment (family and partner). This does not appear to be the case to the same extent with male addicts, whose parents and partner are usually the ones who take on the role of mediator when treatment is sought. Thus, all other institutions obtain higher scores than the family and partner when identifying the source or origin of the demand for therapy. In any event, the addict herself usually seeks intervention in most cases, with a percentage of 78%, a figure which reveals the lonely and isolated situation in which the woman finds herself on facing up to treatment for her addiction (it should be remembered that the external support figure and family backing in the treatment of opiate addiction are of vital importance in determining a favourable prognosis for the treatment of the addiction).



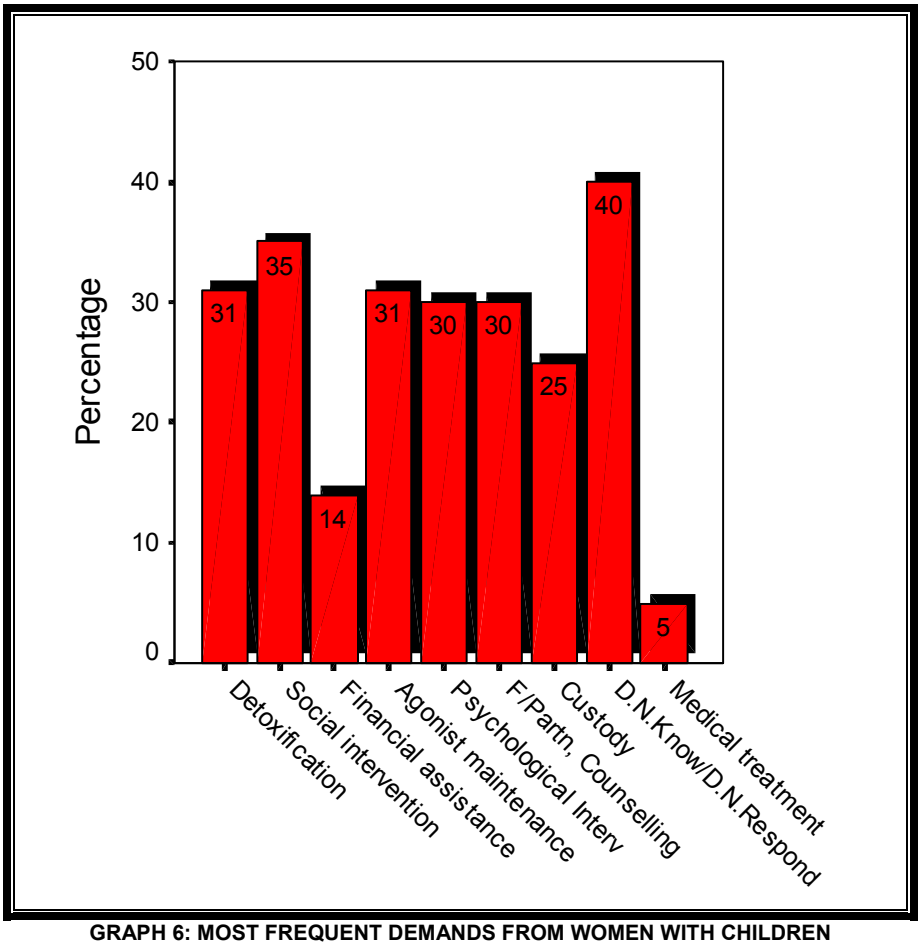
GRAPH 5: ORIGIN OF THE DEMAND FOR THERAPY IN ADDICTED MOTHERS

The most frequent demands from addicted women with children show very low percentages, an effect we have seen above with reference to pregnant addicts seeking social or health intervention. This question did not require the woman to have children in her care (we referred to pregnant women in general, whether or not they were already mothers).

The fact that 21% of the sample did not respond to this question is significant. This might indicate a serious lack of knowledge about the needs of this social group, or once again, that there is no specific demand from this group.

Of the demands actually made, it can be seen that social intervention is requested most frequently, followed by treatment for the addiction. We should point out that in this case, detoxification is sought more than agonist maintenance therapy. (31% compared with 12%), in direct contrast to what was seen amongst pregnant addicts.

In “low” percentages (bearing in mind the scores obtained for the rest of the items included in the question) we find that financial assistance is also sought, together with help in resolving family and partner relationship conflicts, intervention in matters of custody, and finally with the lowest score, medical health treatment.



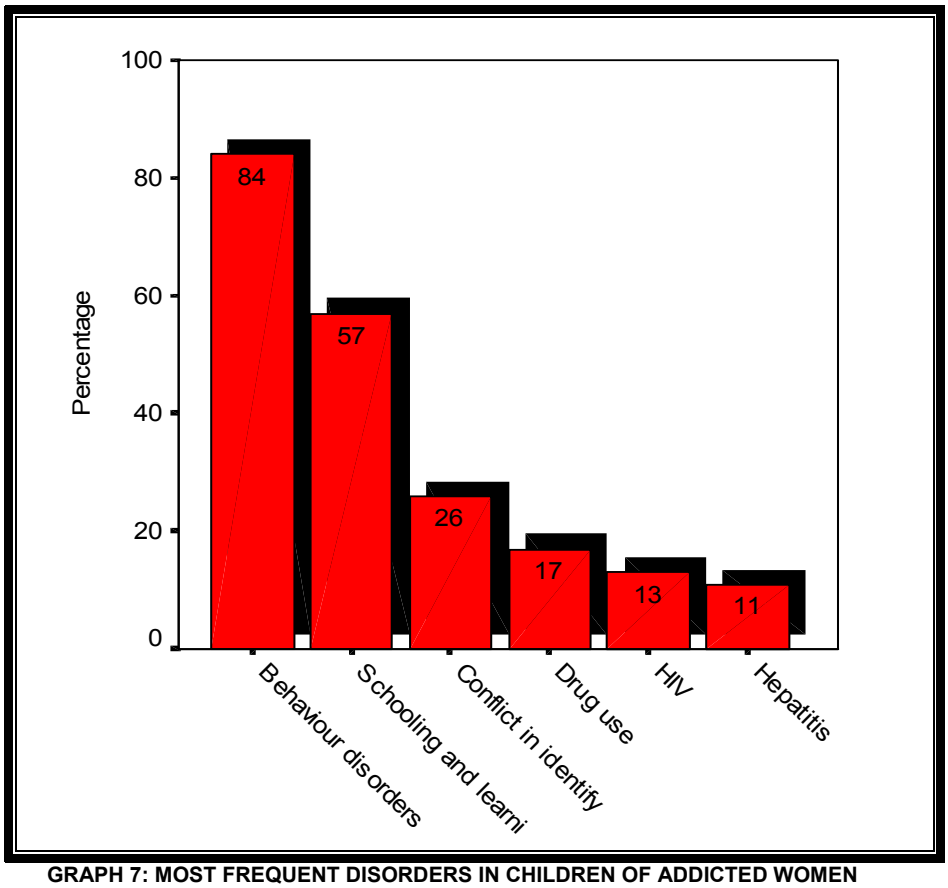
GRAPH 6: MOST FREQUENT DEMANDS FROM WOMEN WITH CHILDREN

Children of addicted women

The variable related to the consequences of the addiction on the children of addicted mothers has a higher response rate from the professionals consulted than most of the other questions in the survey, with high percentages observed in items related to behaviour disorders and schooling and learning disorders (84%, 57% respectively). A further consequence noted in an appreciably high percentage (26%) is the conflict in the identification of the mother figure.

The percentage related to drug use (17.5%), while not amongst the highest, is certainly alarming given the average age of the social group we are dealing with, and we would go as far as to say that it should be borne firmly in mind with a view to taking preventative focused action when working with this social group.

Neither must the incidence of chronic illnesses with grave prognoses (HIV 13%, hepatitis 11%) be disregarded, due to the repercussion it has on the development of the child.



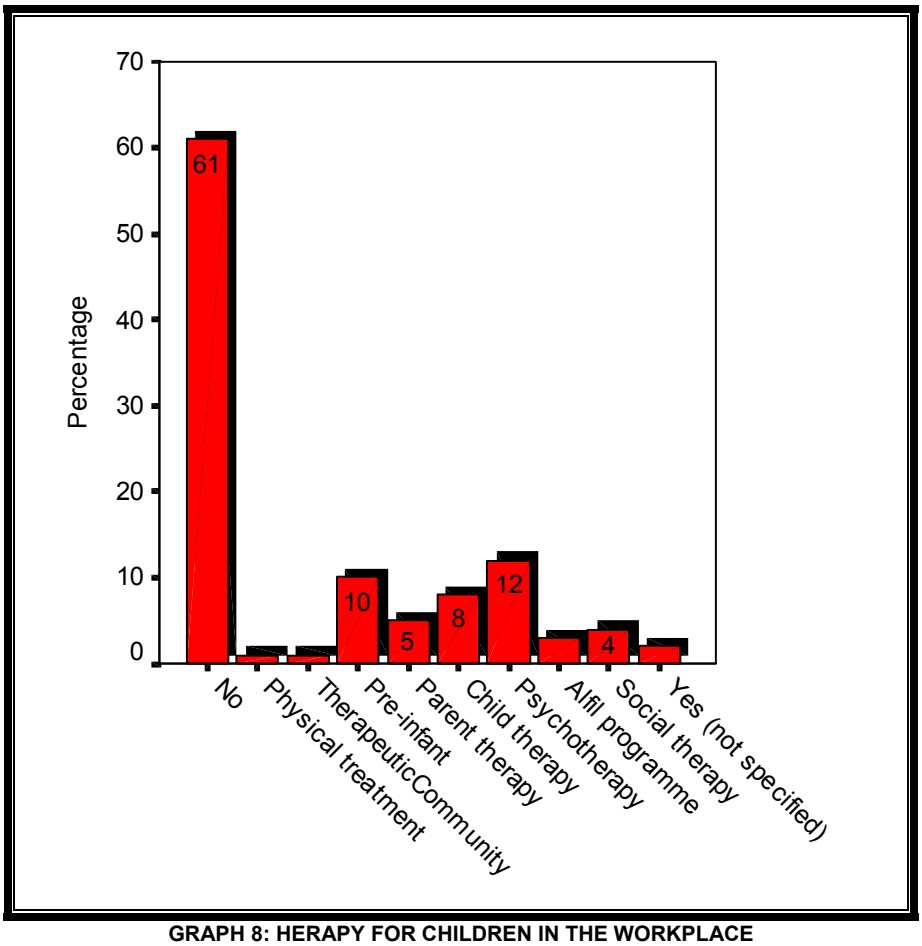
GRAPH 7: MOST FREQUENT DISORDERS IN CHILDREN OF ADDICTED WOMEN

A look at the figures referring to the above data bears out the motives for which most of the professionals consulted consider there to be a clear need for intervention in the attention to children with addicted mothers from the moment of birth. Only 7.8% of the sample express their disagreement with this statement.

	Percentage	Accumulated percentage
Completely agree	51.5	51.5
Agree	39.8	91.3
Disagree	4.9	96.1
Completely disagree	2.9	99.0
Do not know/do not respond	1.0	100.0
Total	100.0	

Responses to the question on the availability of specific intervention for children in the workplace of the professionals surveyed are included in the following figure. In 61% of the workplaces covered by the questionnaire, no specific intervention was offered, which leads us to reflect on the gap between the needs detected by the professionals and the means available in the centres where they work: 61% of these centres have no intervention programme. Moreover, we should note that the interventions which do exist are disparate, which seems to indicate that there is no

general intervention criterion, but rather, any action which does take place depends on the resources available in each unit.



GRAPH 8: HERAPY FOR CHILDREN IN THE WORKPLACE

The woman addict and the family

When questioned about the source of family support for addicted mothers, the results show that it chiefly comes from the woman's parents. This is followed by support provided by various institutions, and to a far lesser extent, with scarcely noticeable percentages, partner and siblings. Once again, we can compare the woman's situation with that of her male counterpart, who, a priori, and on the basis of our clinical experience, receive a much higher level of support from their parents, and above all, from their partners.

	Percentage	Accumulated percentage
Parents	57.3	57.3
Siblings	3.9	61.2
Partner	5.8	67.0
Institutions	17.5	84.5
Do not know/do not respond	10.7	95.1
Partner and institutions	2.9	98.1
Partner and siblings	1.0	99.0
Siblings and institutions	1.0	100.0
Total	100.0	

The professionals consulted do not appear to observe any significant differences between men and women addicts as far as family history of drug use is concerned.

	Percentage	Accumulated percentage
More important than in the case of men	14.6	14.6
Less important than in the case of men	6.8	21.4
No significant differences	72.8	94.2
Do not know/do not respond	5.8	100.0
Total	100.0	

The woman addict and the partner

When questioned on their opinion as to whether the partners of women addicts were habitually also addicts, 90% agreed that this was the case.

	Percentage	Accumulated percentage
Completely agree	31.1	31.1
Agree	59.2	90.3
Disagree	9.7	100.0
Completely disagree	0.0	100.0
Total	100.0	

The information reflected in the table above becomes even more important if we consider the professionals' opinion on the incidence of the problems faced by the children of addicted mothers when her partner is also a drug addict. On this aspect, the question evaluates whether, in these cases, there is a greater incidence of problems, to which 96% of the sample responded that this was the case. This is an essential factor in the evolution of addiction amongst women. The risk factor brought in by the addicted male partner manifests itself in a worsening evolution of the woman's adjustment to her addiction, with more serious consequences of both a physical and social nature. Previous studies carried out by this research group have demonstrated this aspect, to which we must now add the seriousness of the repercussions of both parents' addiction on their children's development. According to the opinion of this sample of professionals, these repercussions take the form of

a high incidence of behaviour, schooling and drug use problems amongst the children of addicted mothers. We firmly consider the addiction of both parents to be determinant in the appearance of all types of disorders in their children.

	Percentage	Accumulated percentage
Completely agree	50.5	50.5
Agree	45.6	96.1
Disagree	3.9	100.0
Completely disagree	0.0	100.0
Total	100.0	

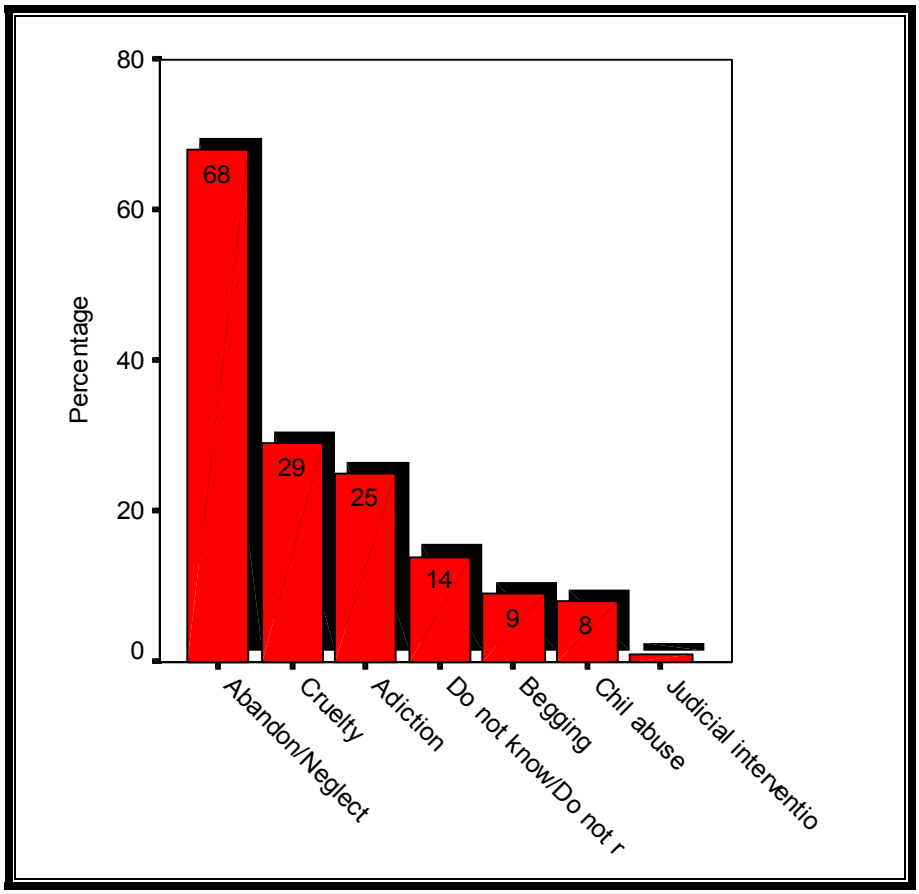
The woman and custody

When questioned on the reasons for the withdrawal of custody, we find that the chief motive is when the child is abandoned (68%), in all likelihood arising from the mother's living conditions as a result of her addiction. This abandon can take two forms, active or passive, through active behaviour or through neglect. In response to an open question, the professionals consulted consider that the children's basic needs are not covered, neither timetables nor school obligations are respected, decent housing is not provided etc., which they consider to be an abandoning or neglect of the child's basic needs.

The second most cited reason is cruelty, although clarification is needed as to whether this cruelty is perpetrated by the mother herself or from those around her, given that on this point, the answers were very brief.

The third reason given for loss of custody is the addiction itself. Once again we are faced with a statement "the addiction" which is open to interpretation, since the term in itself does not clarify exactly what the respondents want to convey through this answer.

The fact that the mother is begging or is completing a prison sentence accounts for 8.7% of the cases in which custody is withdrawn. Child sexual abuse is reported as representing 7.8% (although once again we do not know who the perpetrator of this abuse is) and finally, judicial intervention accounts for just 1%**.** 13.6% of the professionals do not answer this question, which could mean that in their particular area of work, they have not come across such cases, and are not aware of the circumstances which could give rise to loss of custody. Once again, the results lead us to consider that the mother's addiction is not the only cause of intervention in the custody/guardianship of her children. The results of the previous variables must be borne in mind in that partner addiction and lack of family support are essential factors in the achievement of an effective maternal relationship.



GRAPH 9: REASONS FOR LOSS OF CUSTODY BY ADDICTED MOTHERS

Requests for intervention in matters relating to the custody of children of addicts come in the majority of cases from Social Services, according to 58% of the sample consulted. This is followed by a notably high percentage of respondents, 28.2%, who either do not know where the request for intervention comes from, or do not respond, possibly for the same reason. The maternal family makes the request for intervention in guardianship in 20.4% of the cases. Much further below are the cases of requests made by schools (2.9%) and hospitals (2.%). Finally, the father and the paternal family (with values of 1% in each case), a fact we consider worth highlighting as it shows the scarce presence of a father figure and his family origins. The very low participation on the part of the school community also strikes us as remarkable, given that in principle, this should be the first institution to detect problems in the child, such as behaviour or learning disorders, dietary or hygiene deficiencies, and even cases of cruelty. This information should enable the institution to seek early intervention, thereby leading to improved prevention of problems for the child caused by his or her parents' drug addiction. However, our results indicate that school participation is minimum (2.9%).

	Percentage
Social Services	58.3
Maternal family	20.4
School	2.9
Paternal family	1.0
Father	1.0
Do not know/ do not respond	28.2
Hospital	2.9

We consider the improvement of the methods and means for the detection of warning signs of cruelty in the home, abandon/neglect or behaviour disorders amongst school age children to be an urgent need in the early intervention in the repercussions of the parents' addiction on their children's development. It must be remembered that if coordination between the school environment and social services is not tight, any warning signs detected at school could remain simply as a comment of the type "something is going on, but… there's nothing we can do about it". Coordination in the detection of cases of this type, and the follow up of the child's education between social services, child protection services and the school is not just necessary, but in these cases, vital.

Once custody has been withdrawn from the mother, we need to know who takes on responsibility for the child. The results obtained from the professionals surveyed are set out in the following table.

	Percentage	Accumulated percentage
Father	7.8	7.8
Maternal grandparents	50.5	58.3
Paternal grandparents	1.0	59.2
Foster home	14.6	73.8
Institution	8.7	82.5
Do not know/do not respond	17.5	100.0
Total	100.0	

It can be observed that in half the cases, custody of the addicted woman's children is granted to the maternal grandparents, which generally involves a change in the child's legal situation. However, no real change in the actual situation takes place, as the maternal grandparents do not in effect exercise custody, although they appear as legal guardians for all official purposes. In our previous publications on this matter, we have seen how finally, the children in many cases lived with their mother under the guardianship of the maternal grandparents and how this gave rise to conflicts in the relationship and the loss of the maternal role as a reference in the children's upbringing.
In 14.6% of cases, guardianship is given to a foster family, 8.7% to an institution, while in only 7.8% of cases is it passed to the father. On this point, we must take

into consideration the 1% of cases where custody goes to the paternal grandparents. 17.5% of the professionals surveyed did not know who was granted custody, a very significant figure which speaks for itself.
Once custody has been withdrawn, it is restored if the woman comes off drugs in 23% of cases, while in 70%, other factors are also taken into consideration.

	Percentage	Accumulated percentage
Yes	23.3	23.3
No	6.8	30.1
Also depends on other circumstances	69.9	100.0
Total	100.0	

When questioned on whether any specific intervention programme for addicted mothers is run in the centre where the professionals consulted work, the answer is in the main negative, as can be seen in the table below. This coincides with the results of the previous variables on the gap between the need for specific intervention for addicted mothers and the minimal introduction of specific programmes within therapy resources.

	Percentage	Accumulated percentage
No	65.0	65.0
Yes	35.0	100.0
Total	100.0	

When questioned on whether professionals need specific training to be able to work with drug addicted mothers, 82.5% agreed that this was the case. On this point, the opinion of 83.5% of the professionals consulted that addiction in women manifests specific characteristics of its own is worth reiterating.

	Percentage	Accumulated percentage
Completely agree	29.1	29.1
Agree	53.4	82.5
Disagree	15.5	98.1
Completely disagree	1.9	100.0
Total	100.0	

When both parents are addicted, the professionals did not wholly agree on the circumstances under which the woman should undergo treatment with respect to her partner. No clear opinion is revealed in the results, possibly due to the lack of experience all of us reveal when dealing with specific attention to women.

	Percentage	Accumulated percentage
Together with her partner	25.2	25.2
On condition of partner's abstinence	11.7	36.9
Separately in the same centre	23.3	60.2
Separately in different centres/programmes	25.2	85.4
Do not know/ do not respond	14.6	100.0
Total	100.0	

Conclusions

Below, we synthesize the above data and highlight certain points based on the responses of the key European informants interviewed.

1. Of the total number of addicts, there are slightly fewer women than men, and amongst these women, the number of mothers is significant.
2. Drug addiction amongst women has its own characteristics and is differentiated from male addiction, since it is more serious and has greater consequences in women.
3. The fact that an initial protocol for the evaluation of the addiction in women, including systematic pregnancy detection is practically non-existent is of major importance.
4. Both pregnant addicts and addicted mothers are ignorant of (according to the opinion of the respondents) the services and benefits for the improvement of their social and health situation to which they are entitled.
5. Results from the interviews show that, to a great extent, it is the professionals from the various help agencies and services who decide on, or at least suggest, the intervention to be followed in the case of pregnant addicts.
6. Motherhood is shown to be an obstacle to accessing treatment initiation on the one hand, while on the other, opinion holds that pregnancy has a positive effect in possibly protecting against the evolution of the addiction, showing an obvious discrepancy.
7. The addicted mother experiences a significant lack of family support, both in facing up to the addiction and in carrying out her role as a mother.
8. Once again, the most obvious data on evaluating the demands made by the addicted mother to the various aid services is the lack of knowledge of what is on offer, which ends up being interpreted as "everyone else" decides what is best for the woman.
9. The consequences of maternal addiction have serious far-reaching implications for her children, particularly concerning behaviour disorders and schooling. The significant percentage of drug use amongst children and adolescents with addicted mothers should be emphasized.
10. The unanimous opinion amongst professionals on the clear need for specific intervention in the case of children of addicted mothers once

again contrasts with the practical non-existence of prevention or specific attention programmes for children of addicted mothers. The few programmes that are run follow disparate criteria with no defined line of objectives and methodology, which seems to reveal a lack of knowledge on the problematic and needs of these children.

11. As in our previous studies, the figure of the male addicted partner is determinant throughout the whole process of the woman's addiction, and has a negative effect on the educational, social and health development of her children.
12. The main reasons for intervention in the guardianship and custody of the addicted woman's children is abandon/neglect and cruelty. These results once again highlight the need for the implementation of prevention programmes in the first years of these children's lives.
13. Requests for intervention in matters of child custody come in the main from Social Services. Two points are of particular significance on this issue. Firstly, the high percentage of professionals surveyed who are unaware of both the origins of this intervention in custody matters, and of what happens to the children once custody has been withdrawn. Secondly, the low participation of educational institutions in these circumstances is outstanding, given that it is the institution in closest contact with these children and as such, is in a position to easily detect any type of disorder which might arise in its earliest stages.

We finally want to emphasize that specific training for professionals working with addicted mothers, the introduction of specific intervention programmes for mothers and children and the introduction of early detection and prevention programmes for children of addicted mothers must become a priority if therapy work in drug addiction is to be improved.

INTERPRETATION OF THE RESULTS FROM THE QUESTIONNAIRES COMPLETED BY MOTHERS

Description of the sample

The study presented here was conducted on a group of 284 women from 6 countries of the European Union who were receiving treatment for drug addiction. The breakdown is shown in the table below:

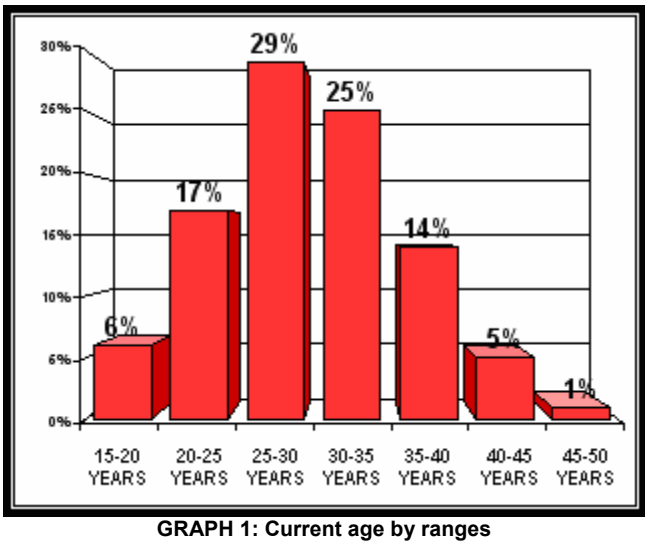
Country of origin of questionnaire respondents and treatment currently being followed

		Total	
Country of origin of questionnaire respondent	SPAIN	50	
	Portugal	50	
	France	49	
	ITALY	50	
	AUSTRIA	48	
	GERMANY	37	
Total		284	
		TREATMENT AT RESIDENTIAL CENTRE	OUT-PATIENT TREATMENT WITH AGONIST
		141	143

The results of the survey are presented here according to the treatment currently received, in accordance with the study's objectives, such that we can assess the differences between the group of mothers receiving outpatient treatment and those in residential centres.

The statistical procedures used are based on non-parametric tests when the dependent variable is not nominal (given that the sample does not have a normal distribution) and the χ^2 statistic when comparing the measurements from the two groups with nominal variables.

The sample description shows the **mean age** of the mothers taking part to be 30.7 years, with a median of 30 and standard deviation of 6.8 years. In order to facilitate comprehension of the data we have grouped the results by age ranges, as shown in the following graph:

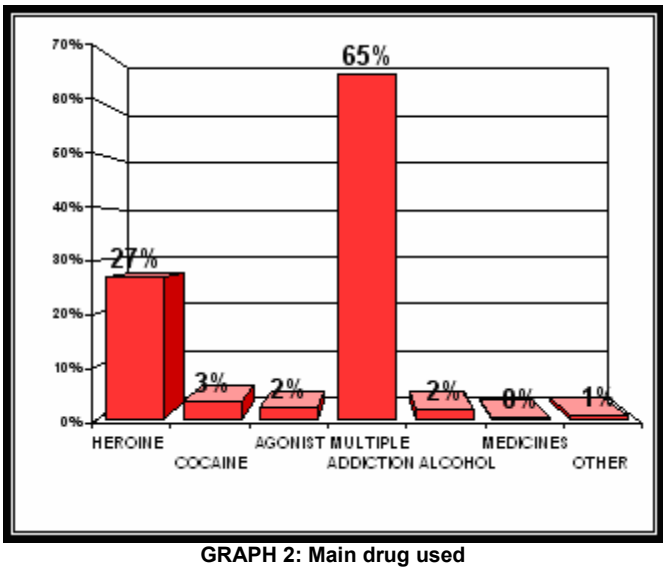


GRAPH 1: Current age by ranges

It is worth highlighting that 86.7% of the sample falls in the 20 to 40-age range. There is no statistically significant difference between ages in terms of the type of treatment currently received.

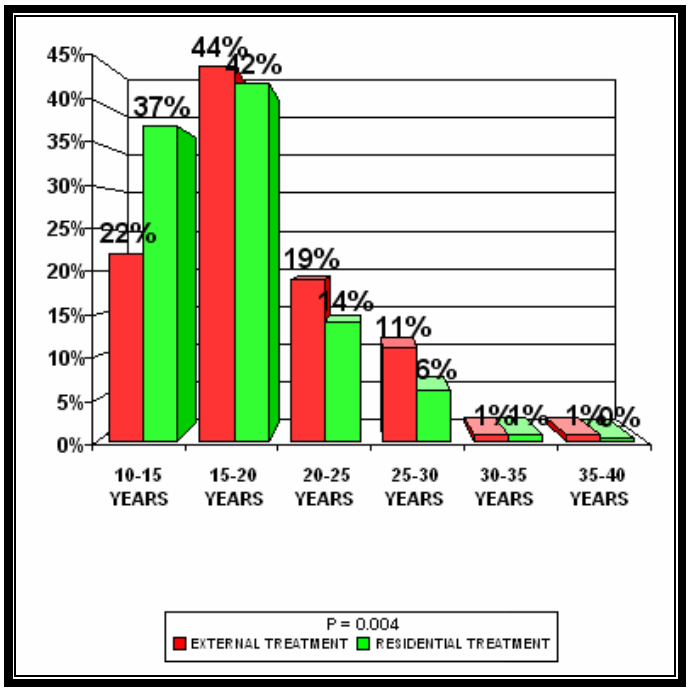
As regards the **drug used or main drug used**, we observed that, except in the case of heroin, only in rare instances we could talk of their being a single substance determining treatment, if we are to judge from the responses given by the women included in the survey. Thus, in 65% of cases there is a multiple drug addiction and in 27% of cases respondents stated that heroin plays the key role in addiction. These results may be skewed by the fact that half the sample comes from opiate agonist programmes whose main diagnosis would therefore necessarily be opiate addiction.

Given the uniformity of the responses no significant differences were observed based on treatment type.



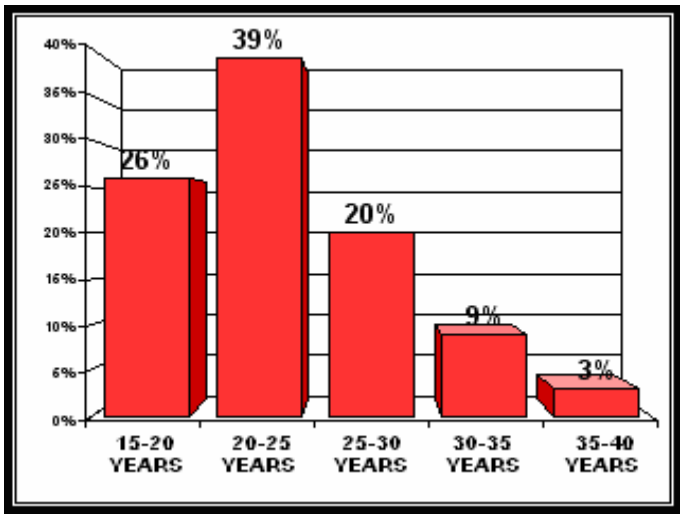
GRAPH 2: Main drug used

Significant differences were seen between the two groups regarding **age of starting problematic use** (P = 0.007).
The graph reveals that women receiving residential treatment admit having commenced problematic substance abuse at an earlier age than those receiving outpatient treatment. Thus, 22% of the latter group situate the age of starting problematic drug use at between 15 and 20, whereas 37% of the group receiving residential care started problematic drug use between these ages. This is a very early age in both groups, as 66% of those receiving outpatient treatment and 79% of those receiving residential care began problematic drug use before the age of 20. The age at which drug abuse began is later in the case of outpatient agonist treatment (32% began drug misuse when aged over 20).



GRAPH 3: Age at which problematic drug use began

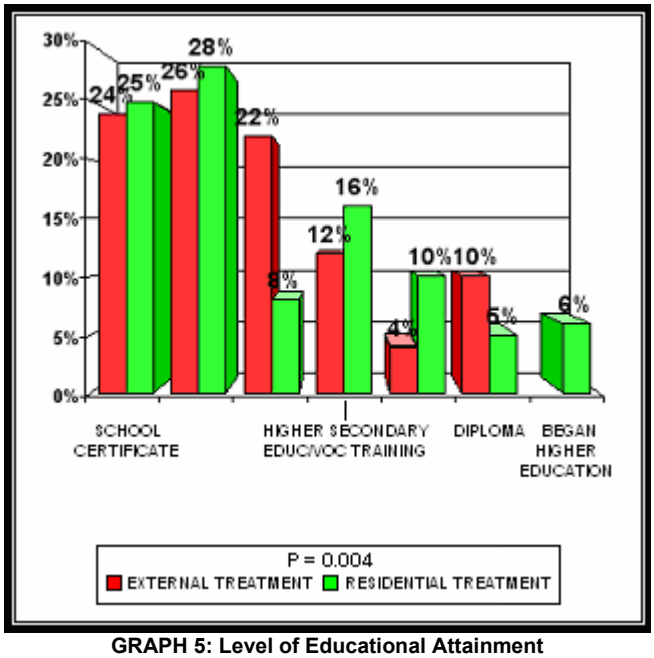
Surprisingly, the early-observed ages at which problematic drug use began do not translate into earlier treatment of the addiction, as when the two groups are compared no statistically significant differences are found. The data show signs of a longer progression of the addictive behaviour over time in the case of women receiving residential treatment, with greater delay in their application for treatment for addiction, which possibly translates into a worse prognosis in terms of solving their drug problem.



GRAPH 4: Age when first treated

Significant differences may be observed between the two groups as regards **levels of schooling**.

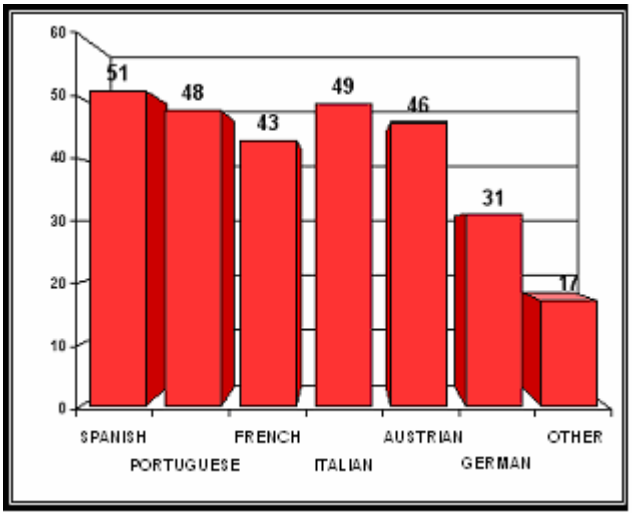
More women in residential treatment than those receiving out-patient treatment have attained school leaving or high-school/secondary education certificates, but surprisingly, a larger number women receiving residential care started higher secondary education (22% compared with 8%) or completed a diploma.



GRAPH 5: Level of Educational Attainment

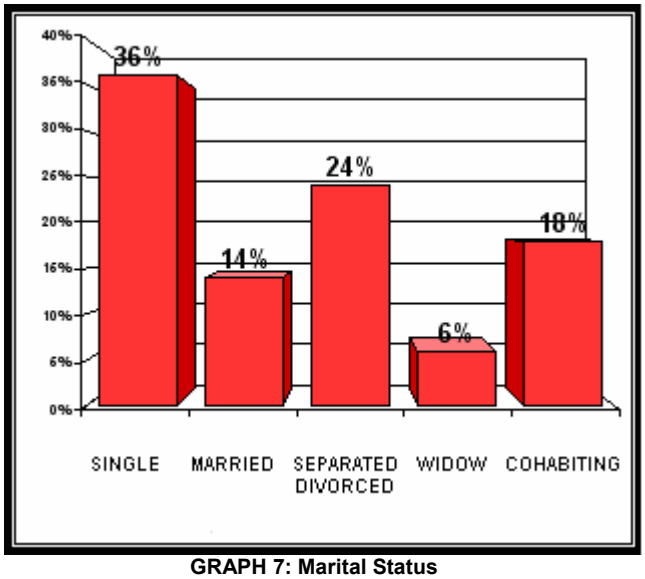
Significant differences appear in the data regarding **nationality** as a result of the differing proportions of the various nationalities in the sample. Thus the *n* obtained for each item is practically the same as the proportion of the sample coming from each of the countries. These data indicate that almost all the women included in

the study originated in the country in which they were receiving treatment, with only a minimal percentage of immigrants.



GRAPH 6: Nationality

The **marital status** of the sample does not reveal significant differences in terms of treatment, but it is worth highlighting that only 32% of the sample lives with their partners, while 66% are single mothers, widows or separated/divorced.

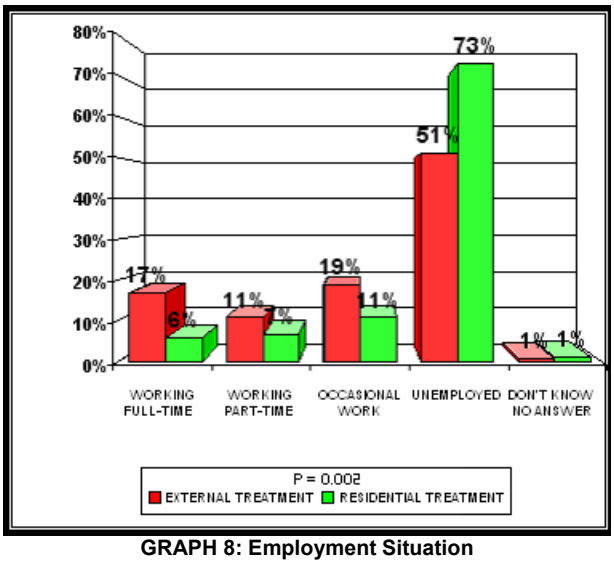


GRAPH 7: Marital Status

Statistical analysis of **employment status** reveals significant differences between the two groups. Women in the therapeutic community are affected by higher rates of unemployment and a smaller percentage of those in work have jobs in which they are given any kind of security (whether in temporary, part-time or full-time work).

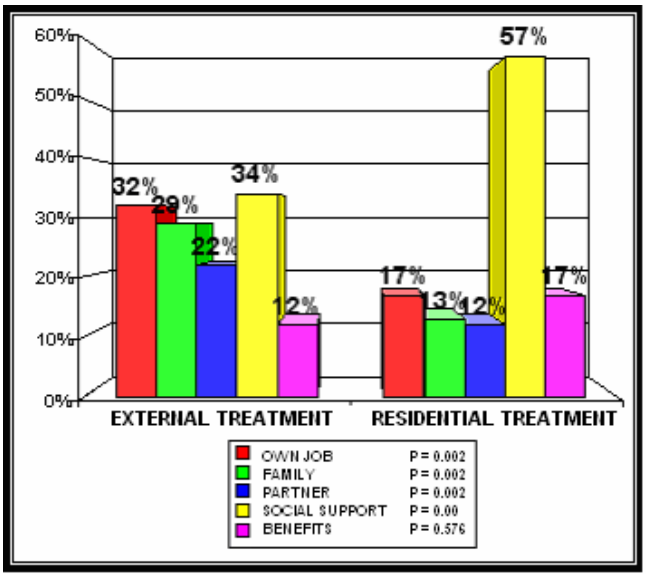
The results here must be interpreted with a certain amount of caution, given the different circumstances in each of the samples. The questionnaire covers the employment situation at the time it was taken, so one should take into account the

fact that in the case of residential treatment it is usually not possible for patients to leave on a daily basis to work outside the centre. Thus we may conclude that the percentages of unemployment in this group are consistent with the therapeutic option.
In the case of women receiving outpatient treatment, and therefore, who are able to continue with a steady job, the extremely high level of unemployment deserves highlighting (51%) as it implies their extremely limited economic independence, as we shall examine below.



GRAPH 8: Employment Situation

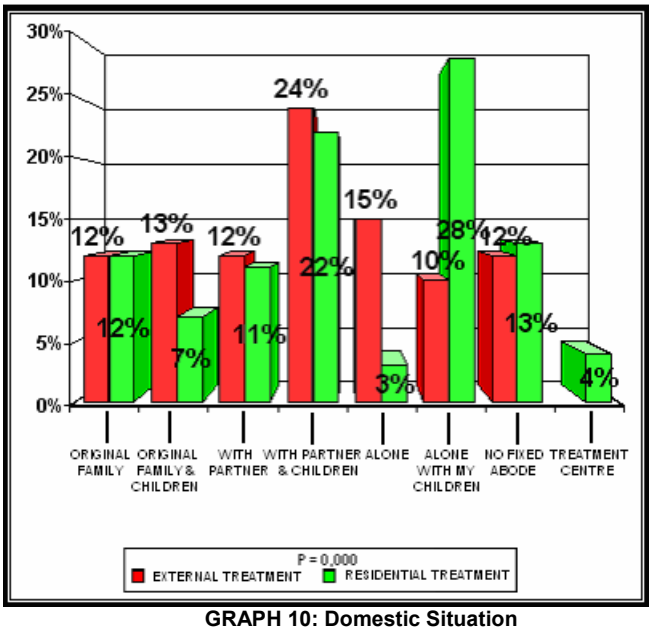
When the variable relating to the **main source of financial income** is analysed, statistically significant differences are observed in all the categories, except in the case of unemployment benefits, in which both groups have similar percentages. We have envisaged the selection of multiple options on the questionnaire, as the women included in the sample may rely upon a variety of economic sources. Looking at the results obtained, we see that this is borne out by the fact that the sum of the percentages does indeed exceed 100%, indicating that the women in the study rely upon more than one source of income. The significant differences observed when the samples are compared are shown below.



GRAPH 9: Main Source of Income

The data show that women receiving residential treatment mainly obtain their income from social support and unemployment benefits, whereas those receiving outpatient treatment obtain income from their own job or in the form of economic support from their family or partner. In this group the contribution of social support is also significant, although it is considerably less than that received by the women in the therapeutic community (34% vs. 57%).
These data are consistent with the results shown in the section on the women's employment status. First of all, these data show the important role of the social benefits that are available in some countries in order allow drug users to opt for residential care, where the patients' ability to obtain regular income of their own is clearly limited. Against this reality there is the need to have a number of sources of income when taking treatment, including work (it can be an important negative distorting factor due to the incompatibility of working hours with the times treatment centres are open, or alternatively, a positive factor in developing a degree of economic independence and supporting the addict's decision).

In terms of the **domestic situation** variable there were also significant differences between the two groups of addicted mothers.

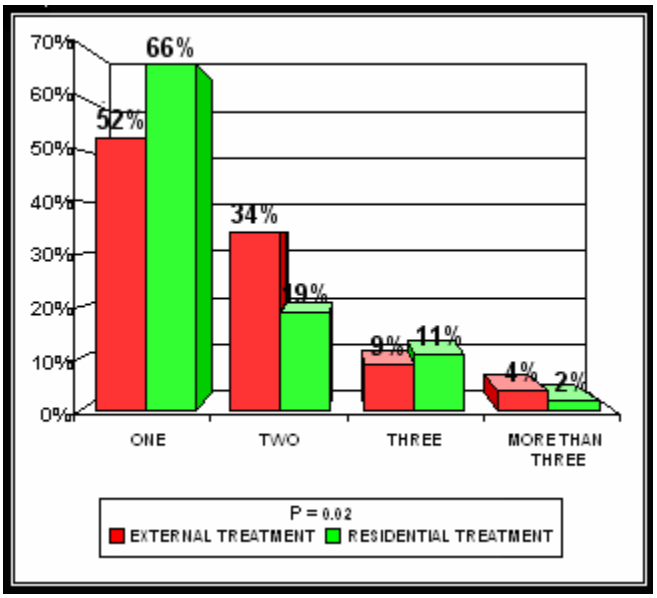


GRAPH 10: Domestic Situation

The data show the most noteworthy differences relate to the “live alone” option and that of living alone with children. Thus, almost a third of women receiving residential treatment live alone with their children as compared with a tenth of those receiving outpatient treatment. The percentage of women on outpatient treatment programmes who live alone is 15% compared with 3% of those receiving residential care.

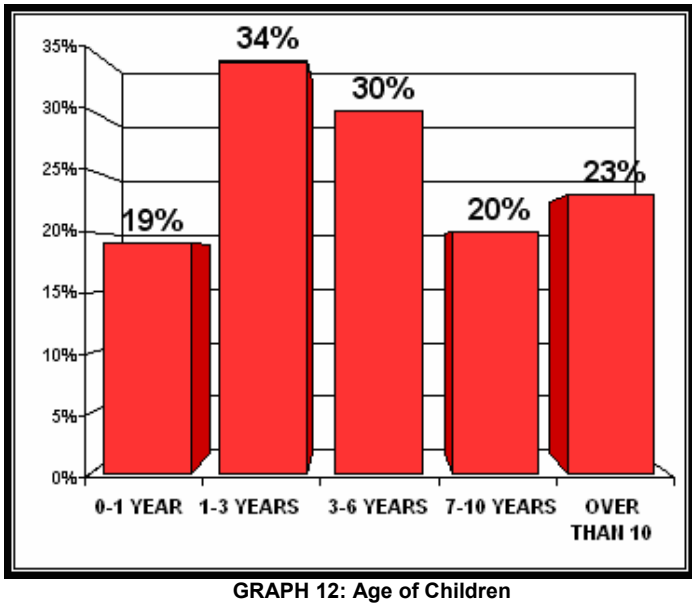
13% of mothers in residential care and 12% of mothers receiving outpatient treatment state that they have no fixed abode. This result needs to be taken into account as a possible factor in social marginalization and causing greater difficulty in achieving the family and social support essential for the optimal outcome of the treatment.

The two groups also have significant differences in terms of the **number of children**. Women receiving residential treatment tend to have more children than those receiving care external.



GRAPH 11: Number of Children

No significant differences exist between the groups regarding **age of children.** In all cases the majority of children are in the 1 to 6-age range (this is a multiple response item). Most of the women included in the study had children under the age of 6. This is the period of the child's development during which the mother's role has greatest importance.

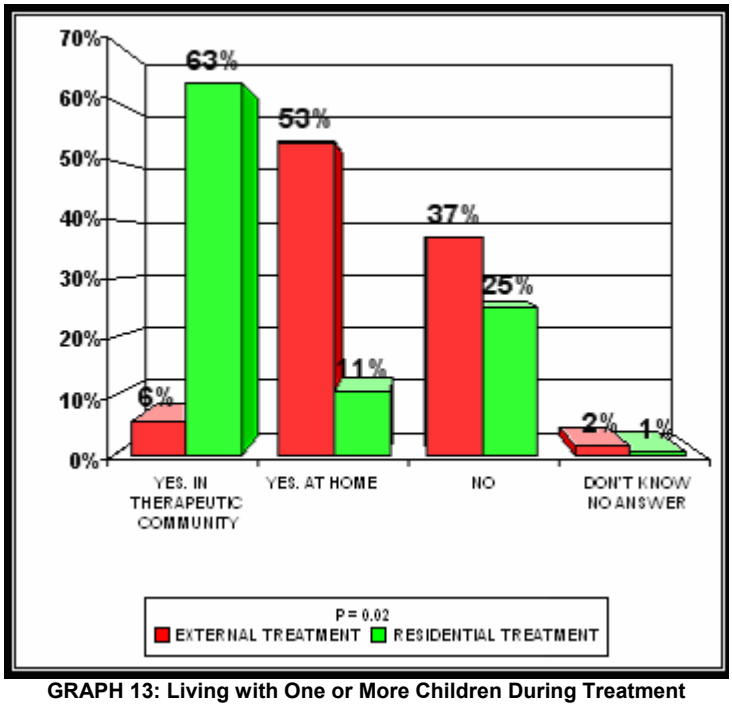


GRAPH 12: Age of Children

When the women were asked whether they had any **of their children living with them during treatment**, significant differences arose in addition to those, which are obviously inherent in the treatment itself.

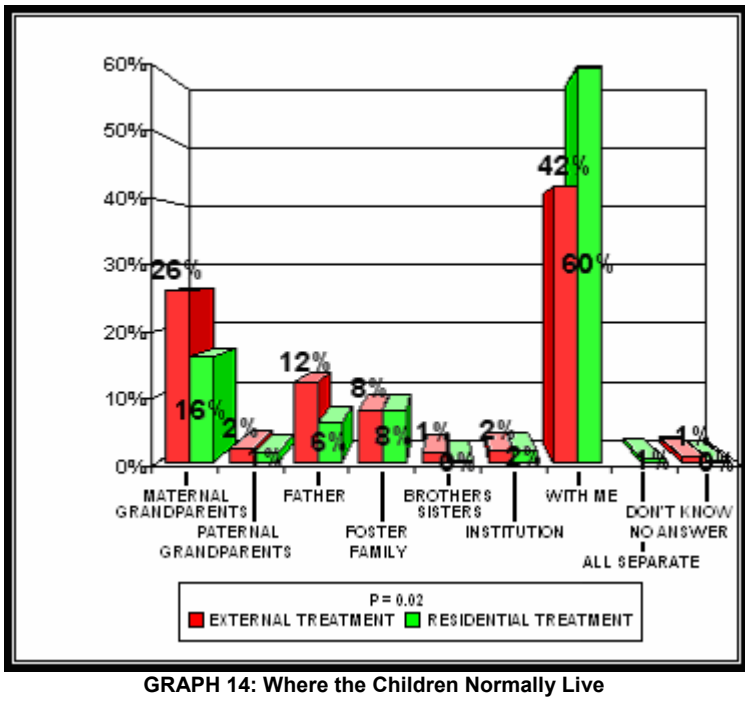
In general women in therapeutic communities live with a larger number of children than those receiving out-patient treatment. One significant fact is that 63% of mothers living in therapeutic communities can continue their treatment without

losing contact with their children, thus being able to take an active part in their education, maturation and personal development while undergoing rehabilitation. Additionally, this has a positive impact on their sense of self-sufficiency as a person and as a mother. Moreover, it allows the mother-child relationship to be developed with a view to preventing future disorders in the children.



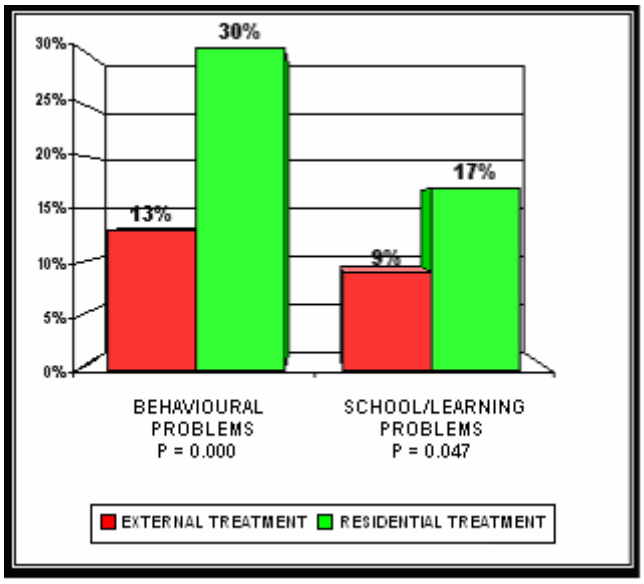
GRAPH 13: Living with One or More Children During Treatment

Comparing the results of the **normally living with children** variable we also see significant differences between the groups. 60% of mothers in therapeutic communities habitually live with their children, compared with 40% of those receiving out-patient treatment. The next most common options are for the children to live with their maternal grandparents or their father. Both of these cases are more common in the group of mothers receiving out-patient treatment than in the residential sample. Institutional intervention (foster family or institution) intended to ensure a "protected" family nucleus also needs to be taken into account (10% of both the sample receiving out-patient treatment and that in residential care) due to its impact on the mother-child bond.



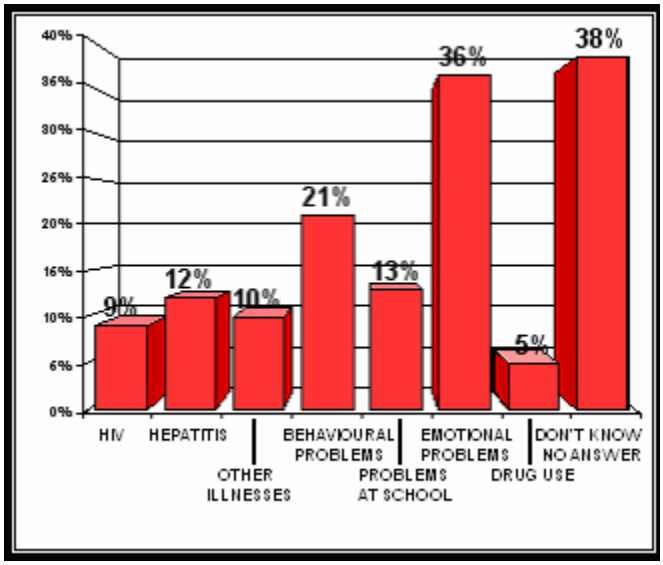
GRAPH 14: Where the Children Normally Live

As regards the **impact of addiction on children** no major differences were observed between the groups. The exceptions are the educational attainment, learning difficulties and emotional disturbances categories, where children of mothers receiving out-patient treatment show, significantly, a lower incidence. We may deduce from this that this is the reality of the situation, or alternatively, if we take into account the data reviewed so far, together with the fact that this is a subjective variable, we may interpret this as meaning that mothers receiving treatment in therapeutic communities live closer to their children and so have a more accurate perception of the problems affecting them. This greater awareness therefore translates into reported higher percentages of behavioural problems and educational and learning difficulties.



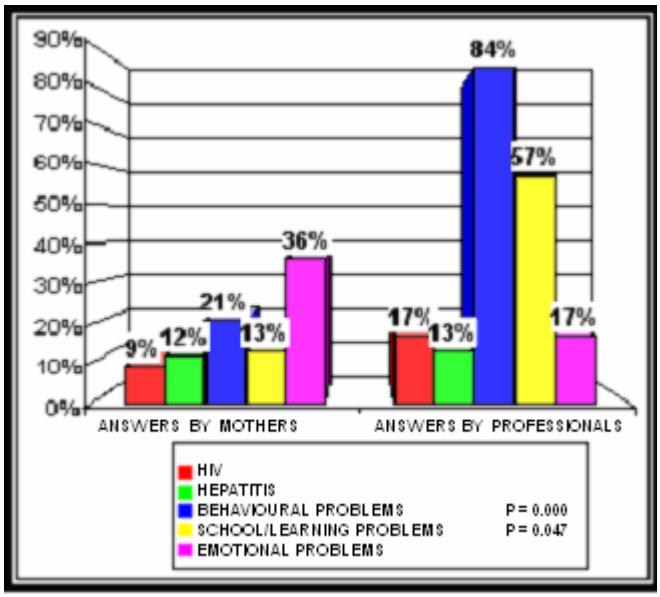
GRAPH 15: Impact of Addiction on Children

Analysing the results of the sample as a whole, we see that the percentages obtained are extremely low, in particular 38% of mothers do not observe any problems. As regards problems arising directly out of addiction, the most important are emotional and behavioural in nature, followed by those relating to schooling and health effects such as hepatitis and HIV.



GRAPH 16: Impact of Addiction on Children. Overall Sample

Comparing these results with those obtained in the survey of the opinions of professionals we can observe the differences in percentages of the incidence of the problems. Clearly, professionals view these problems as being more serious.



GRAPH 17: Impact of Addiction on Children.
Mothers' and Professionals' responses

In our view, among the consequences for the children there is one item which should be looked at in more detail, despite its not offering significant differences between the samples, namely the fact that 5% of mothers stated that their children take drugs whereas professionals put this figure at 17%. Bearing in mind that only 23% of the children covered by the study are aged over 10, and even though we do not have specific data correlating children's age and drug taking, this apparently modest 5% could, in our opinion, be much more important than the percentages obtained for other responses such as physical illness or schooling difficulties, which are more easily detected at an early age.

In order to determine the extent to which the composition of the sample is influencing the results obtained, we have crossed the data shown in the table below. 55 mothers have children aged over 10 and nine of them admit that their children have drug usage problems. Making a simple mathematical calculation we find that 16.36% of children aged over 10 take drugs. One unexpected finding is that according to their mothers' own perceptions 8% of the addicts' children aged between 7 and 10 have drug usage problems (independent of substance).

Age of children: over 10 * DRUG USE

		DRUG USE		Total
		No	YES	
Age of children: over 10	No	207	4	211
	Yes	55	9	64
Total		262	13	275

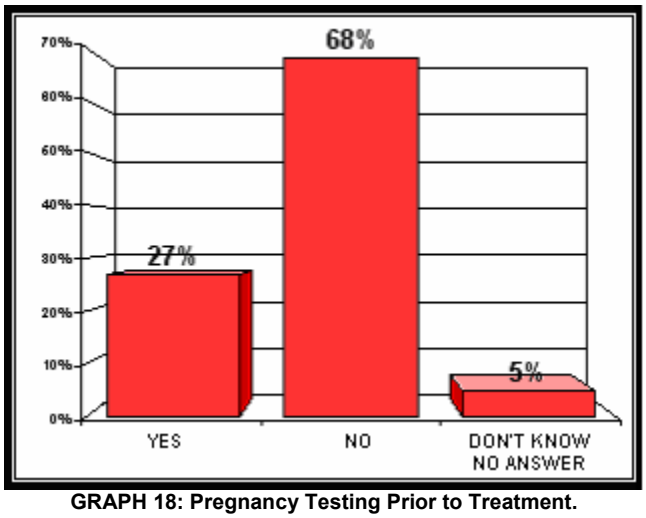
Age of children: 7-10 years * DRUG USE

		DRUG USE		Total
		NO	YES	
Age of children: 7-10 years	No	212	9	221
	Yes	50	4	54
Total		262	13	275

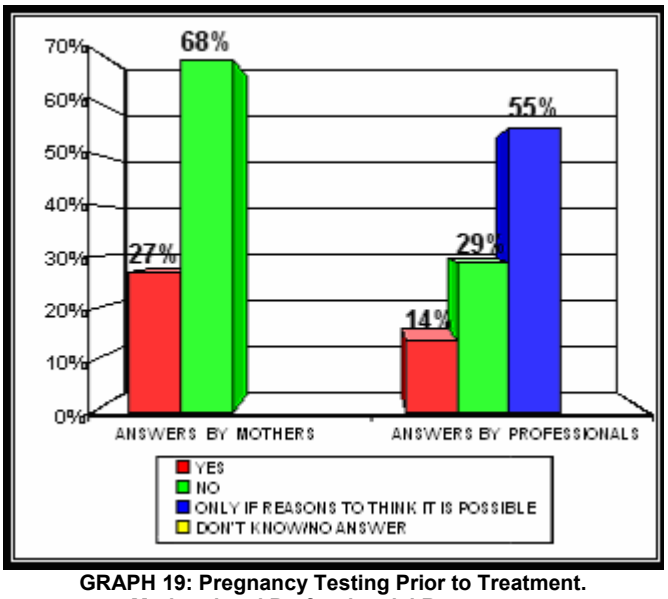
Addiction and pregnancy

68% of the sample were not administered a pregnancy test before starting treatment (there was no significant difference between groups). Only a third of the sample stated that they had taken a test.

Again, comparing the results offered by the survey of professionals, we find substantially different percentages and an observation that may explain these differences: 55% of professionals only performed a pregnancy test when they considered there were grounds to suspect pregnancy.

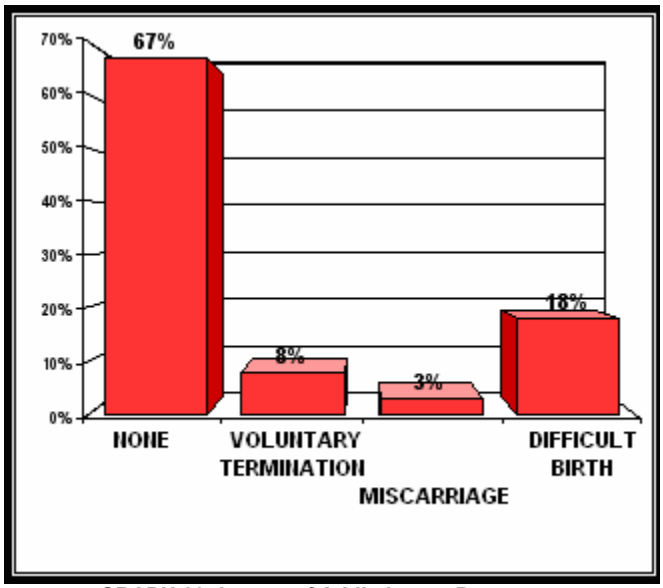


GRAPH 18: Pregnancy Testing Prior to Treatment. Responses of Mothers



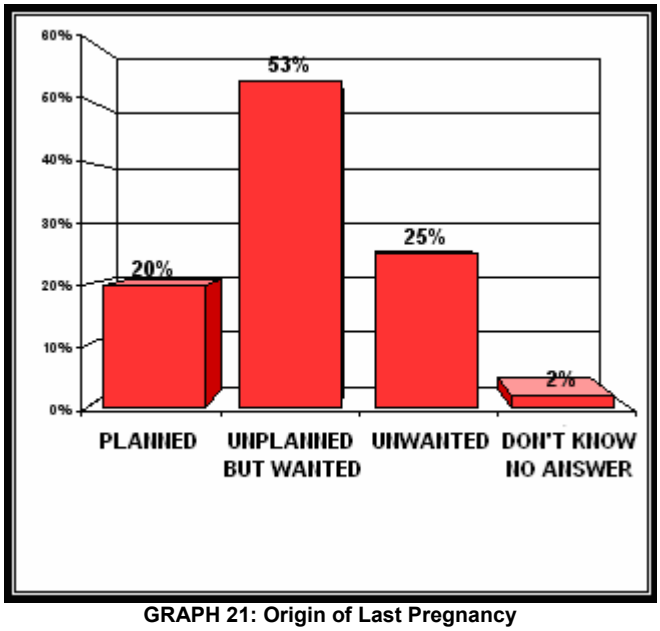
GRAPH 19: Pregnancy Testing Prior to Treatment. Mothers' and Professionals' Responses

As regards the **impact of addiction on pregnancy**, no major differences were observed between the groups. The most frequent consequence is a difficult birth and voluntary interruption of pregnancy. There were only a minimal percentage of miscarriages. However, in relation to this latter finding, it should be borne in mind that addicts are often unaware that they are pregnant and may mistake a spontaneous abortion for the return of the menstrual cycle.



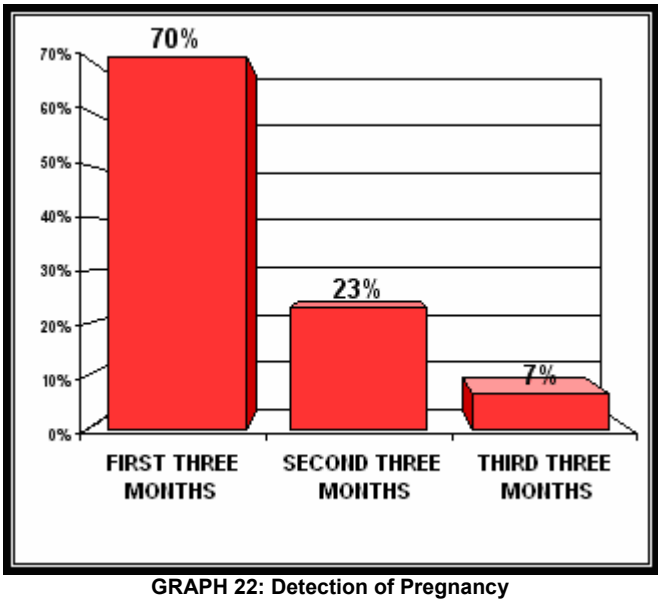
GRAPH 20: Impact of Addiction on Pregnancy

The **origin of last pregnancy** was "accidental" in 78% of cases, with no significant difference between groups. 53% of the women stated that the pregnancy was "unplanned but wanted", although 25% of the sample stated it to be "unwanted", a fact which may have a considerable impact on the future of the mother-child relationship.



GRAPH 21: Origin of Last Pregnancy

As regards **detection of pregnancy**, we find that 70% of the sample discovered they were pregnant during the first three months, 23% in the second three months, and 7% in the last three months.



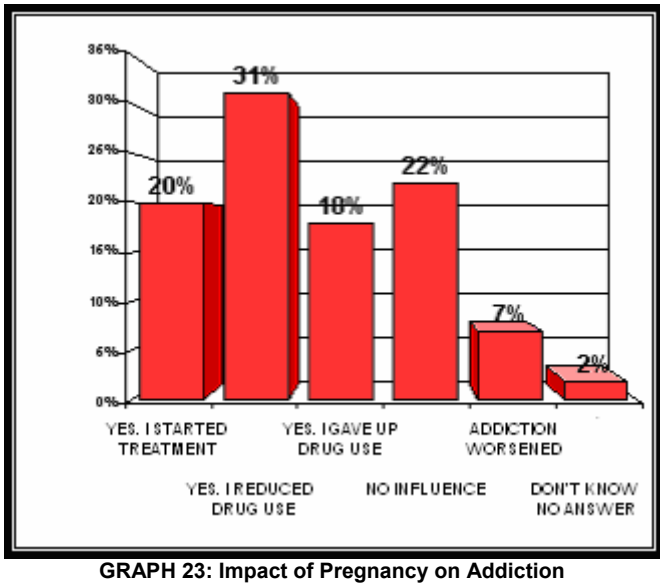
GRAPH 22: Detection of Pregnancy

Given the high incidence of unwanted pregnancies we have crossed the data, observing that over half of these reach term because they are detected in the second three months, a point at which legislation in most countries does not allow abortion. The differences found when the “Situation in which last pregnancy originated”/”TIME AT WHICH PREGNANCY DISCOVERED” variables were cross checked are statistically significant (P = 0.000).

Situation in which last pregnancy originated * TIME AT WHICH PREGNANCY DISCOVERED

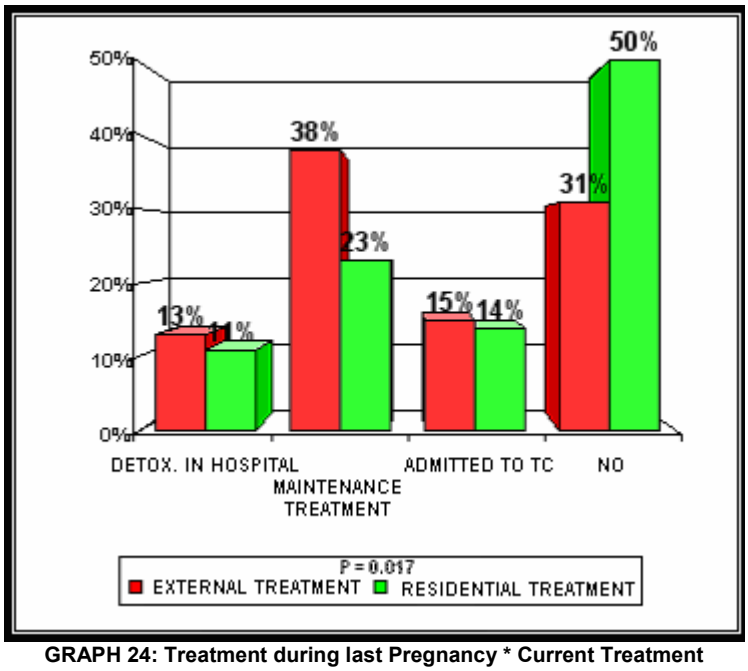
		TIME AT WHICH PREGNANCY DISCOVERED				Total
		FIRST THREE MONTHS	SECOND THREE MONTHS	LAST THREE MONTHS	DK/NA	
Situation in which last pregnancy originated	PLANNED	44	7	4	1	56
	UNPLANNED BUT WANTED	118	25	4	1	148
	UNWANTED	33	33	3		69

As no significant difference was found between the groups in terms of the **impact of pregnancy on addiction** (P = 0.062) we proceeded to analyse the sample as a whole. The results suggest that pregnancy has a positive influence on addicts' behaviour, given that only 7% of mothers state that their addiction worsened, whereas 69% stated that pregnancy brought an improvement (including 18% of them giving up drugs). 22% stated that there they made no changes to their pattern of addiction following discovery that they were pregnant.



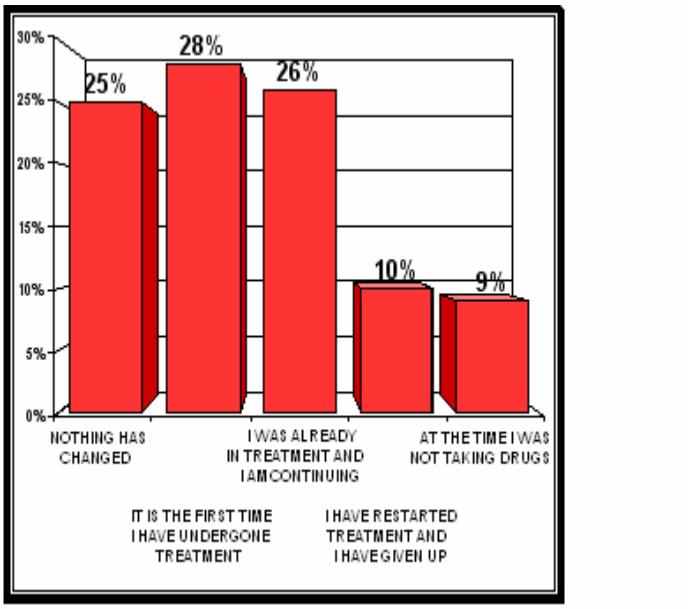
GRAPH 23: Impact of Pregnancy on Addiction

The variable assessing whether the addicts studied underwent specific treatment or not at the time of their last pregnancy, we find significant differences when both groups are compared.



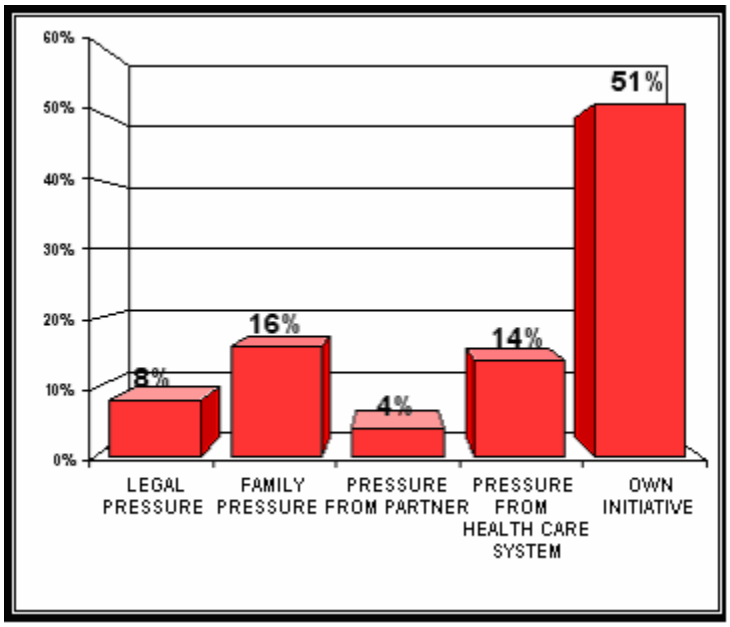
GRAPH 24: Treatment during last Pregnancy * Current Treatment

As the graph highlights, a larger percentage of women on out-patient treatment programmes are receiving treatment than those in therapeutic communities.
In terms of types of treatment, we observed larger differences in the maintenance therapy category (38% compared with 23%), which may be due to the fact that this kind of programme tends to last longer. In the case of mothers in out-patient treatment, 13% have undergone hospital detoxification and been admitted to a therapeutic community. 11% of mothers in residential treatment had received hospital detoxification and almost a quarter of the sample had been on a maintenance programme. One third of the mothers receiving out-patient treatment and half of those receiving residential care were not undergoing any treatment at the time of their last pregnancy. The data showed that most of the women in the sample had changed their treatment since their last pregnancy.
As regards the impact of motherhood on treatment undergone at the time of giving birth, no significant difference between the groups was seen. The general trend is for there to be no changes in treatment as a result of having a child. Thus we observe that 9% of subjects did not take drugs at the time of giving birth, 26% said nothing had changed, and a further 26% stated that they were “already in treatment and continuing it”. The impact was positive for 36% of subjects, motivating the start of treatment in 27% of cases or previously abandoned renewing treatment in 10% of cases.



GRAPH 25: Impact of Motherhood (birth of last child) on Treatment

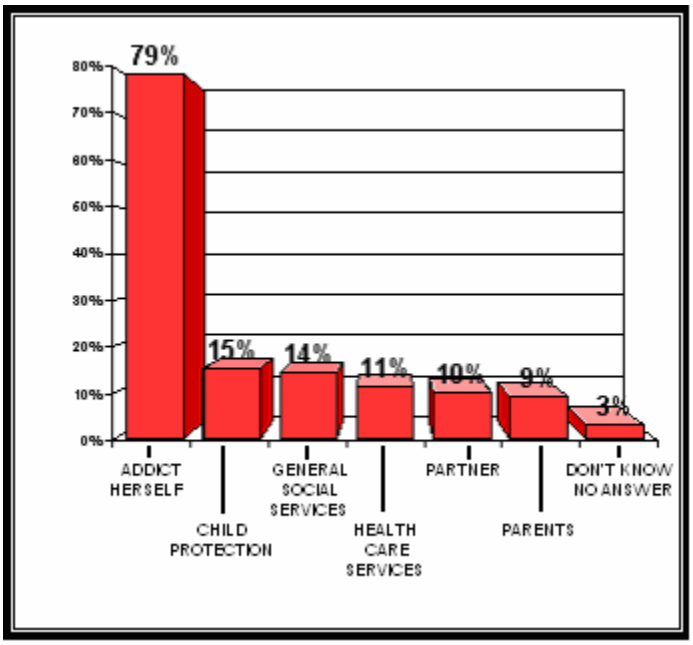
No significant differences were observed between the two groups regarding the **reasons for starting current treatment programme**. In general, the addict herself sought treatment in more than half of the cases (52%). Pressure from the family, the health-care system, the legal system, or partners was also an influence (in descending order of importance).



GRAPH 26: Reasons for Starting Current Treatment Programme

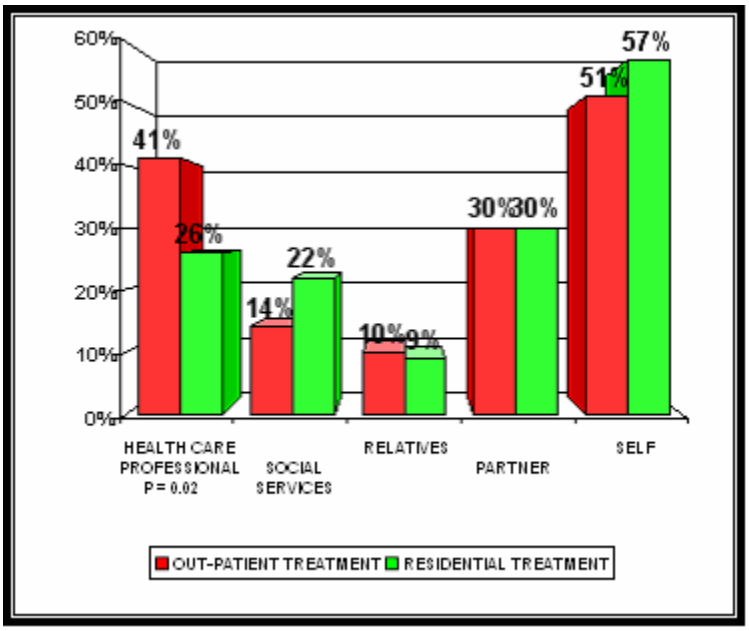
Looking again at the example of the results obtained in the survey of professionals, on this point we observe a certain degree of similarity between the distribution of the results obtained, although a new category –child protection services– also appears.

Possibly, the percentage difference observed in decision making by the patient herself (79% and 52%) is due to the fact that professionals are unaware of the pressures that the addict's milieu is exerting and which shape the patient's decision whether to start treatment or not. The drug-using mothers acknowledge the weight of external factors producing an increase in the percentage weight of the remaining items.



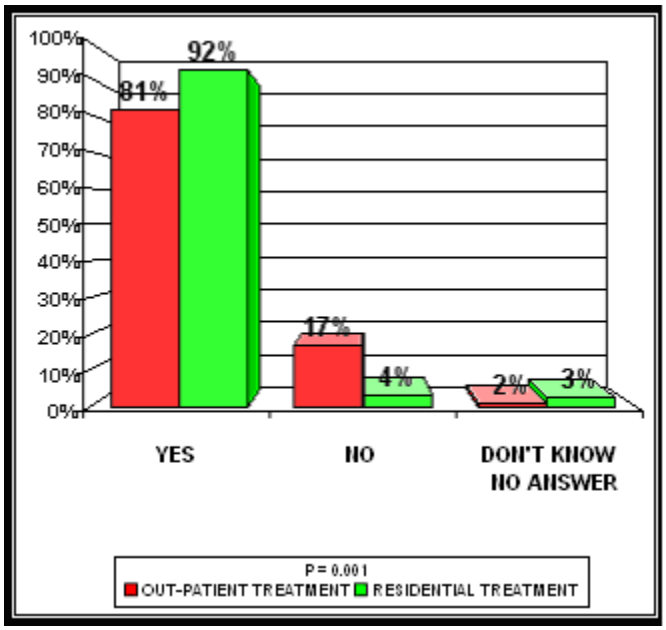
GRAPH 27: Origin of Demand for Treatment among Drug-using mothers. Responses given by Professionals (Different answers were possible)

Having examined the origin of the request for treatment it is worth looking at who was responsible for the decision regarding the type of treatment undergone at the time of the study. Significant differences were found between the two samples.
Although for the two groups the decision regarding the type of treatment was in most cases made by the patients themselves (51% of women on maintenance programmes and 57% of women in residential treatment programmes) differences were observed in the influence of health-care and social services professionals.
In the case of women receiving out-patient treatment, health-care professionals decide the type of treatment received in almost three times as many cases as social services, while in the case of women in residential treatment, the influence of the health-care and social services systems is much more balanced.
This is possibly a reflection of the resources available for each of the services. Health-care professionals have greater access to out-patient treatment as there is no limit to the number of patients they can treat under an agonist dispensing programme, whereas health-care professionals cannot recommend therapeutic communities as widely given the limitations as to available places and frequent delays in patients' being admitted to treatment centres.



GRAPH 28: Who Decided the Current Treatment?

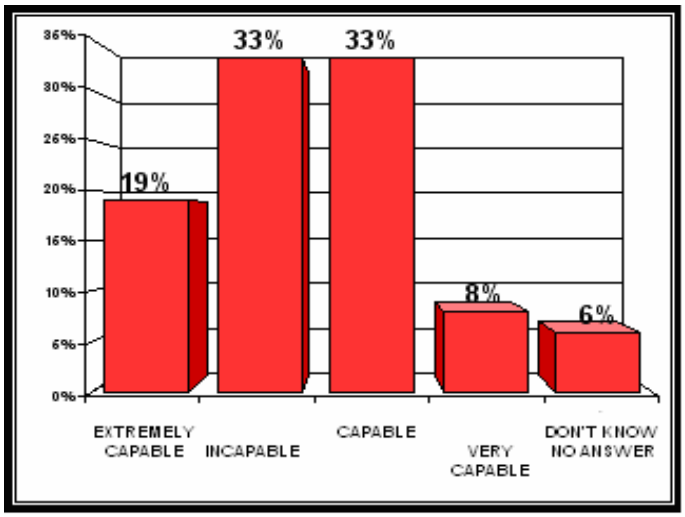
The results of the two variables we have just examined raise the question of the extent to which the drug-using mothers have agreed to the type of treatment they are receiving. We have observed that women on residential treatment programmes are more satisfied, which is consistent if we consider that they are there as a result of their own decision, to a greater extent than women receiving out-patient treatment. The differences are statistically significant.



GRAPH 29: Agreement to Treatment Received * Current Treatment

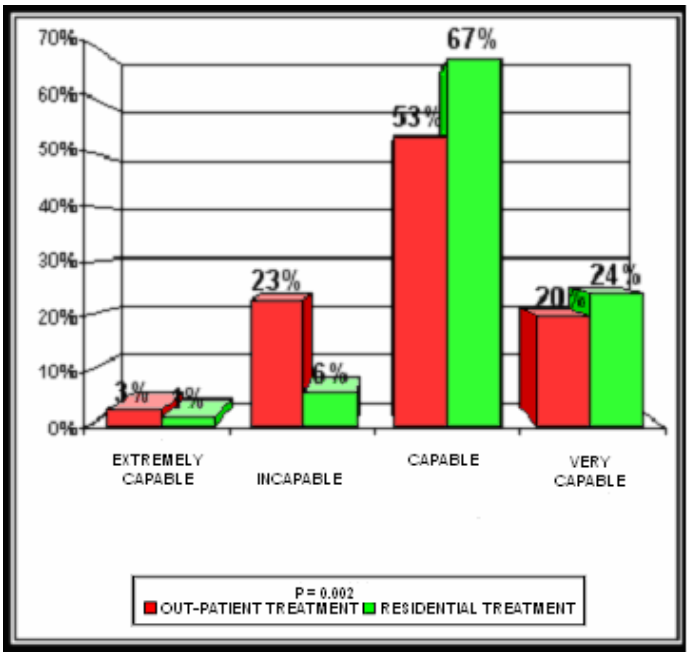
In terms of the subjects' assessment of themselves as mothers before starting treatment, no statistical difference was found between the groups. In general, they

did not have a very positive view of their capabilities as mothers, given that 52% felt themselves incapable or very incapable, compared with 41% who felt they were either capable or very capable and 6% who had not considered the question.



GRAPH 30: Self-evaluation as Mothers before Starting Treatment

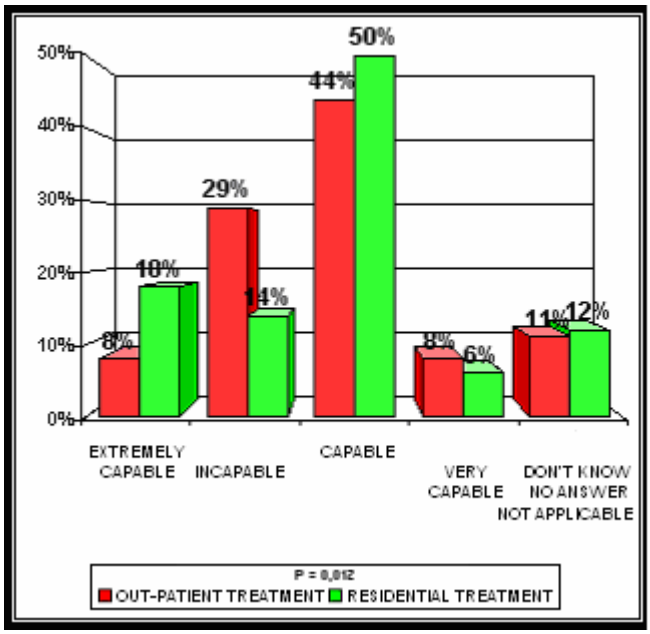
After starting the therapeutic programme the groups differed in terms of their perceptions of themselves as mothers, with the differences between the two groups being statistically significant. We observed that although in both groups the view patients had of themselves as mothers improved significantly (P = 0.000), mothers in residential treatment centres tend to feel much more capable than those receiving out-patient treatment. This implies that although both modes of treatment improve patients' views of themselves as mothers, residential treatment is more effective in achieving this. Although we cannot say so without reservations, we think that these results can be attributed to the higher percentage of addicts who undergo residential treatment accompanied by their children, which no doubt reduces their perceived effectiveness in the maternal role.



GRAPH 31: Self-Evaluation as Mothers during treatment

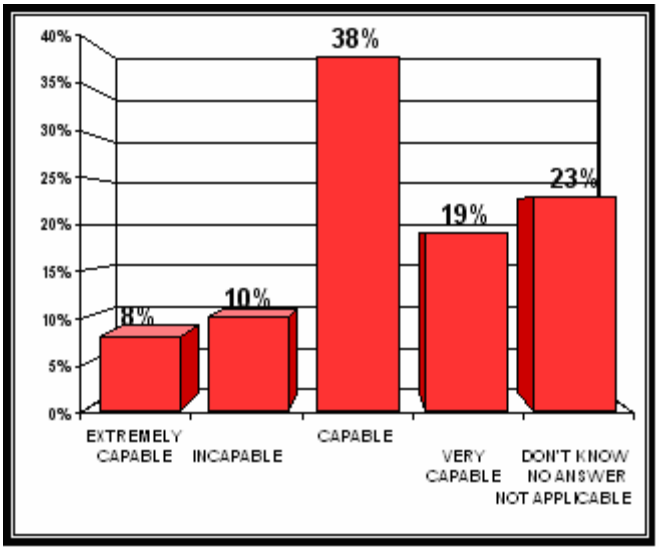
Additionally, statistically significant differences were observed between the groups in relation to the perception addicts have of their partner and family environment concerning their capability or incapability at playing a maternal role.

In the case of the family, although more than half of all cases in both groups state that their family makes them feel capable as mothers, a third faces disapproval of their maternal role as they are considered by their families of origin to be either incapable or very incapable in this regard. This fact must considerably undermine their self-esteem. Over 10% of both groups state that they do not know what their family of origin thinks or have no contact with them. The differences between the groups translate into more negative consideration by the family in the case of mothers receiving out-patient treatment.



GRAPH 32: How my Family Make me Feel about my Role as a Mother

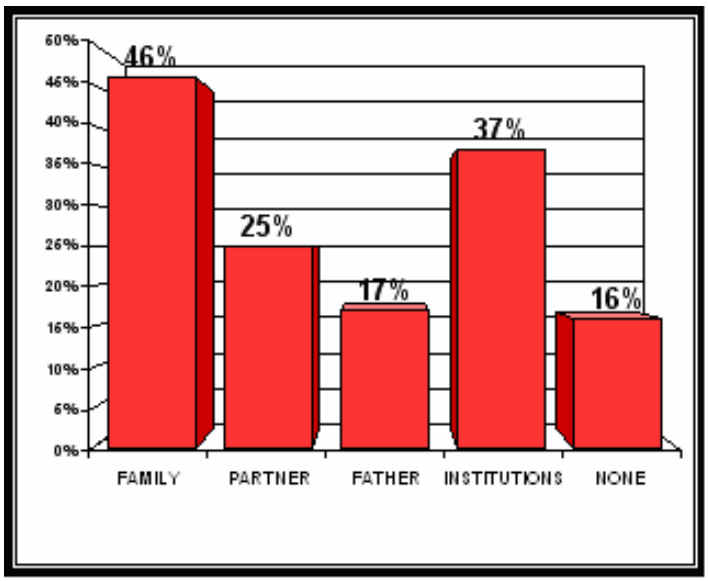
The view transmitted by the addict's partner regarding her performance as a mother initially gives more grounds for optimism, although we need to take into account the fact the drop in the more negative "incapable and very incapable" categories are offset by an increase in the "Don't knows" and not in those who have a positive view of their abilities as mothers.



GRAPH 33: Consideration as Mother by Partner

When assessing the origin of support and/or difficulties that drug-using mothers may have in performing their maternal role, we do not find any significant differences between the groups. The two questions concerned here allowed multiple responses. The results show how the support basically comes from the family and institutions (46% and 37%, respectively) and, to a lesser extent, from

the partner. The father of the child comes fourth (with a modest 17%) whereas 16% of the sample states that they have not received any support. We can conclude that on the basis of the results of this question, males do not appear to represent a solid support for the raising children of in the sample, a role played fundamentally by the family of origin and institutions.

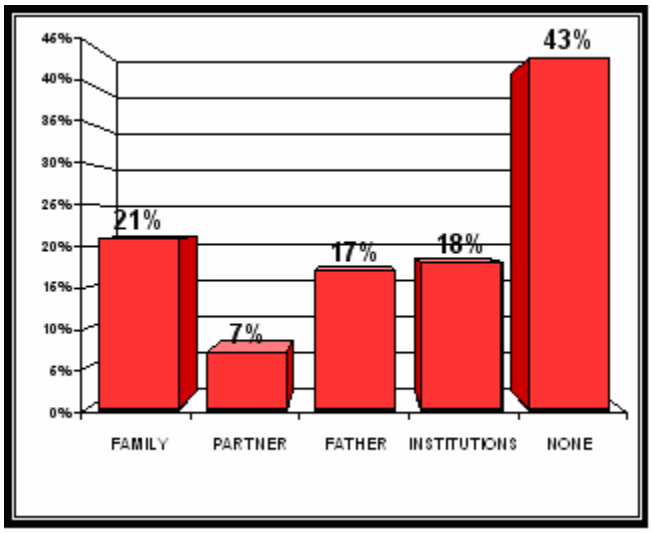


GRAPH 34: Support Received in Performing the Maternal Role

We will now look at the opinions of mothers on the issues that they consider to be the greatest obstacles to their performing their maternal role. 41% of the sample states that they have not found any obstacles to their performing their maternal role. In the case of those stating that they have met obstacles, the main obstacle has been the family, institutions and the father of the child, and to a lesser extent their partner (7%).

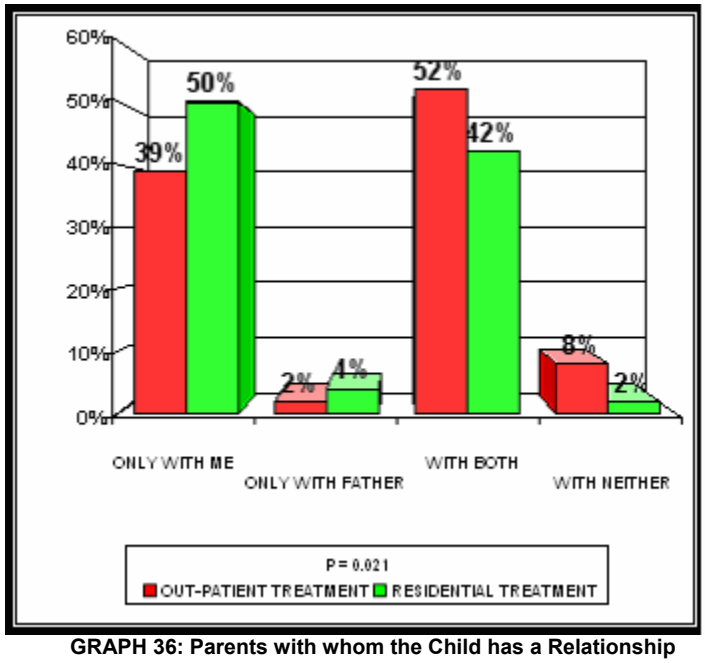
Comparing the percentages obtained in the two questions we see that in general the balance is positive, and there are no circumstances in which a greater degree of difficulty of support in the performance of the maternal role is attributed. The category that comes out worse is that of “father of the child”, who is mentioned as a source of support and as an obstacle in an equal number of cases.

As regards the **source of difficulties for performing the maternal role**, the family of origin is revealed to be of considerable importance in either a positive or negative sense. These results are consistent with the family’s perception of the addict’s ability to perform the role of mother. Many families opt to support the addict as they do not consider her sufficiently capable, or alternatively, they try to sideline her for precisely the same reason (the percentages found were 37% for the out-patient treatment group and 32% for those receiving residential treatment).



GRAPH 35: Origin of Difficulties for Performing Maternal Role

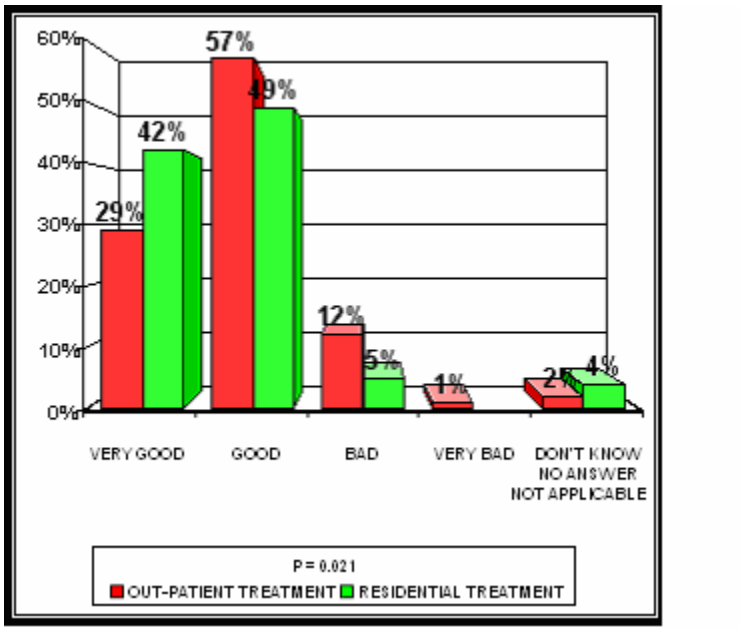
As regards the relationship between the children of drug addicts in the sample and their parents, we observed significant differences between the two groups. A large percentage of drug-using mothers in residential treatment programmes stated that their children only have a relationship with their mothers, with their mothers and families, and only with their fathers. In the case of drug-using mothers in out-patient treatment programmes, the largest number stated that their children have a relationship with both parents, to a lesser extent only with the mother, and in 8% of cases with neither parent.



GRAPH 36: Parents with whom the Child has a Relationship

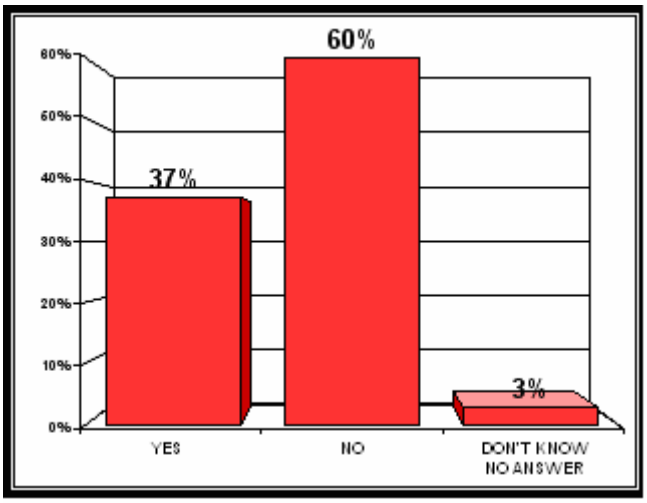
As regards the type of relationship most of the mothers have with their children, 88% consider the relationship to be good, and only 9% rate it as bad. Comparing both groups we find significant differences, in particular in the better perception of

the relationship by mothers who are receiving residential treatment. Again we should stress that their children, who could have a positive influence on the mother-child relationship, accompany a larger proportion of the addicts in this group.



GRAPH 37: Mothers' Rating of their Relationship with their Child

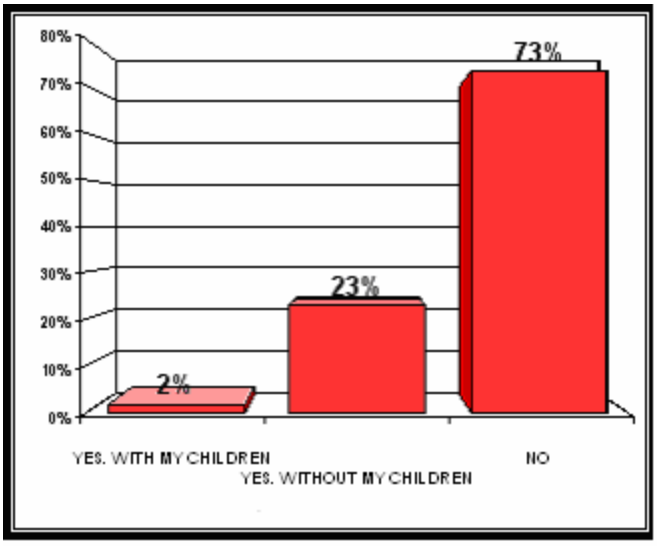
As regards criminal background and prison sentences among the addicts studied, we have not found significant differences based on treatment. Slightly more than a third of the sample (37%) had a criminal record and 60% had not been arrested or convicted.



GRAPH 38: Criminal Records

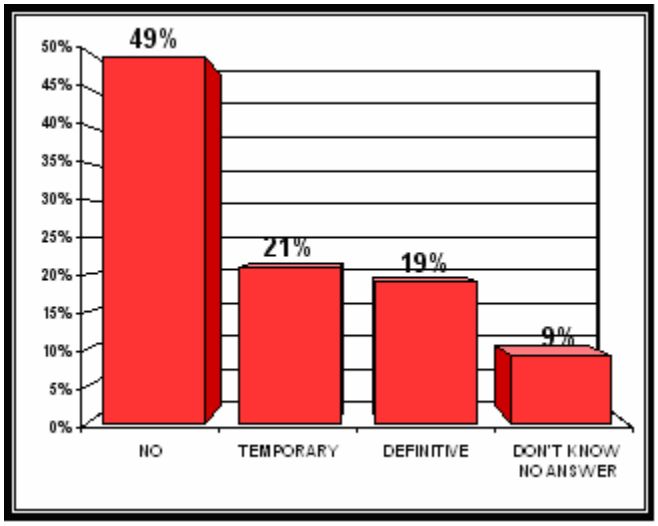
Of the sample, 23% have served a prison sentence without their children, 2% have spent time in prison accompanied by their children and 73% have never been to prison. Given that in response to the foregoing question 37% of mothers stated that

they had a criminal record, it may be noted that 12% of these offences were not punished with a prison sentence.



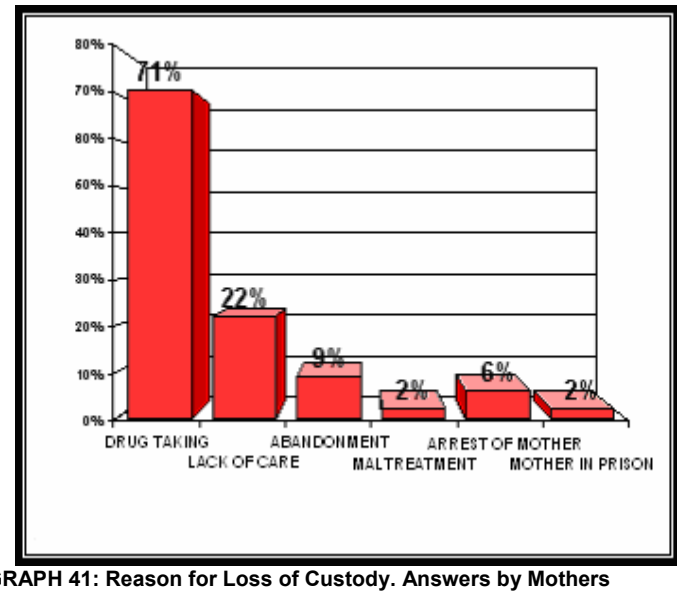
GRAPH 39: Previously in Prison

There are no significant differences between the two groups of mothers in relation to **prior loss of custody of a child**. In half the cases there was no previous withdrawal of custody over a child. In the 49% of cases where there was loss of custody, in 21% loss of custody was temporary and in 21% it was permanent.



GRAPH 40: Previous Loss of Custody over a Child

The main reason given for loss of custody was substance abuse (72%). 41% of addicts also acknowledged that other factors may have played a role: 22% admitted lack of care over their children, 9% abandonment, 6% arrest, and 2% maltreatment or imprisonment.



GRAPH 41: Reason for Loss of Custody. Answers by Mothers

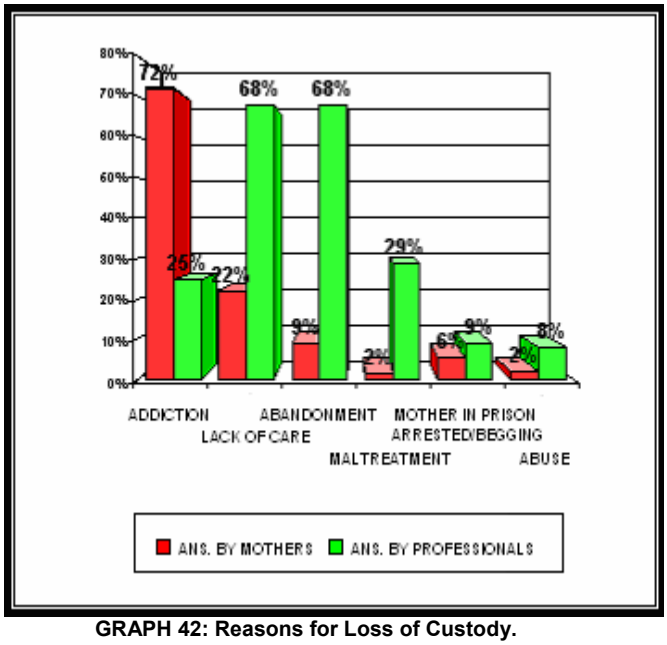
On this point we felt it to be of interest to obtain the results of the survey of European professionals and compare their replies with those given by the subjects involved in the study. As can be seen in the comparative graph, the professionals' view differs entirely from those of the drug-using mothers. Thus, the mothers attribute the loss of custody to drug addiction in 72% of cases, whereas professionals opt for this response in only a quarter of cases. In the remainder of the categories the opposite effect occurs. Thus the factors the subjects consider secondary to the pattern of addiction are cited by professionals as principal causes of the loss of custody, namely the lack of care and abandonment of the children (both categories obtain a score of 68%), maltreatment (30%), arrest and imprisonment of the mother (9% and 8%, respectively).

This could either be due to denial by the mothers of the circumstances that have motivated the withdrawal of custody or a lack of awareness on the part of professionals of the procedures involved. However, even if this were the case the differences are too great. The key could lie in the differences in the way the mothers and professionals view the concept of drug dependence. It is possible that for the addicts themselves the abandonment and lack of care for their children is a direct result of substance abuse and their replies point to their interpretation that this behaviour would not have occurred without drugs being taken.

Female drug addicts predominantly view addiction as a root cause and do not seem to be aware of its ramifications. By contrast, professionals see the most important factors to be the circumstances surrounding drug dependence, and as the consequences of addiction as being the reason for the children's being taken into care.

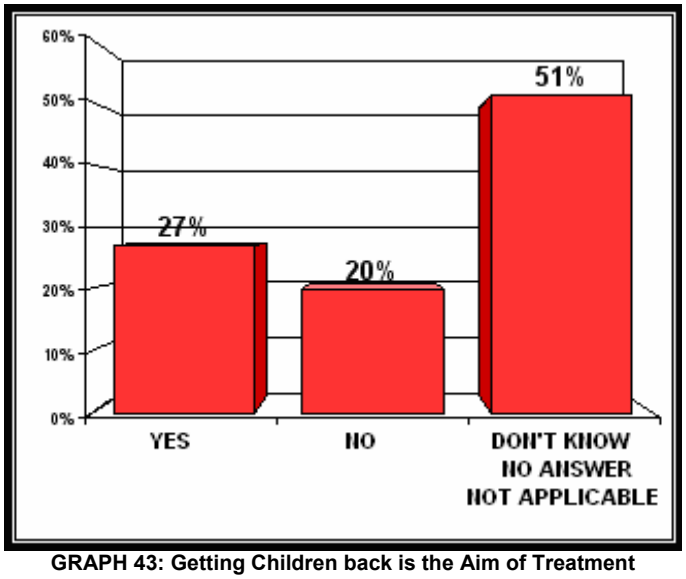
To some extent, the approach taken by the experts would suggest that addiction, provided that it does not have a direct effect on behaviour or social and family relationships, need not invariably be a cause of custody of the children being taken away. This therefore lends support to some extent to both agonist maintenance programmes and residential programmes, provided in the case of the latter that the

children are able to accompany the mother during rehabilitation or detoxification treatment.



GRAPH 42: Reasons for Loss of Custody. Responses Mothers' and Professionals'

In 27% of cases recovering custody over their children is the main reason for starting drug-dependency treatment. This represents more than half of all the women who had lost custody of their children (49% of the overall sample).



GRAPH 43: Getting Children back is the Aim of Treatment

Concerns about the future

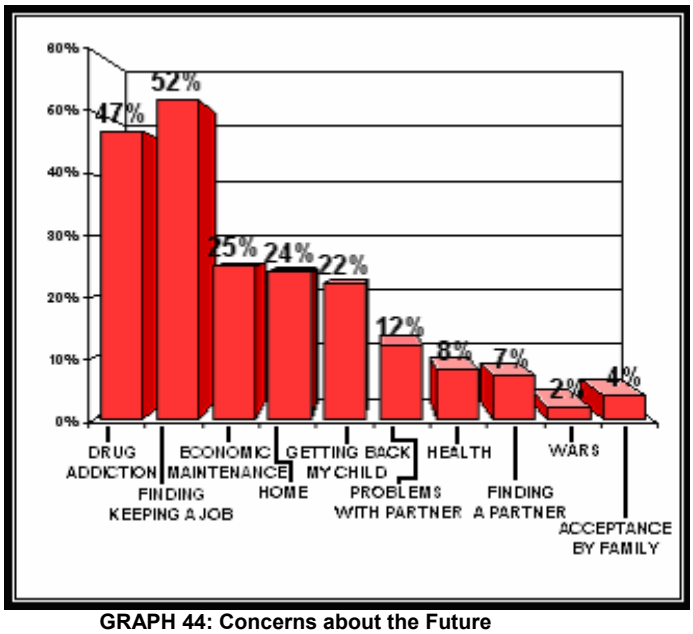
We have made an evaluation about which were the restlessness of the addict mothers related about their future and their children's future. So we include two questions of open answer that the interviewed could express freely their opinion.

The dispersion of the answers provoke that we don't found significant statistical differences comparing the two groups that receive different type of treatment (graphics 44 and 45).

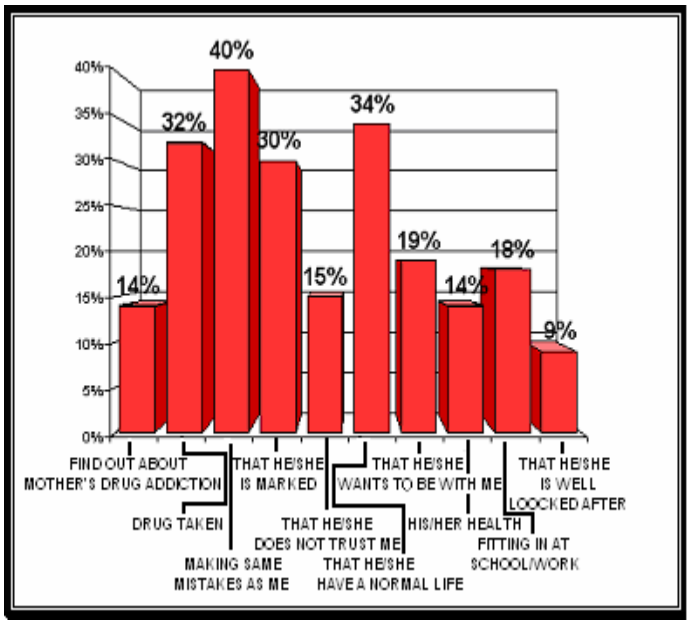
First of all we observe that seem big differences among the concerns of the mothers respect their future compared with the concerns about the future of their descent. In the first case the concerns are directed in one block that we could qualify as a "desire for normalize their life" and need the abandon of their addiction, obtain a job, economic independence and to have an appropriate home. Is significant that those are the conditions that usually demand the Services of Children Protection to avoid the intervention about tutelage of them or to retrieve the tutelage of them, it is probably that we are in front off a different reality: the main mother's preoccupation are directly related with the mother-children relationships.

In spite of the differences before marked for these two variables of opinion exists continuity between those concerns about the future of their children. Newly we are in front off the fear and also the hope to can normalize their life, and the most significant desire of their children don't repeat their mistake history that their have left. The preoccupation of the addict mothers of the two samples are directed to avoid the drug use of their children and not suffer the repercussions of the mother's addiction, as much as health level as social repulse. Also we want to remark this 34 % of mothers that their concerns is transformed in the hoped desire of their children have a normal and happy life.

In resume, the answers of the two variables of opinion returns to confront with the reality of the addict women. The intense maternal concerns to maintain or restore the maternal-filial link in the best possible conditions, that the normality.



GRAPH 44: Concerns about the Future



GRAPH 45: Concerns about their Children's Future

CONCLUSIONS

While we cannot expect to reach any final conclusions on such a complex subject, the work we have carried out has highlighted some very important questions for the understanding of the phenomena substance addicted women and maternity and an improvement of treatment policies.

1. The study revealed that the treatment structures foreseen for substitutive pharmacological treatment, whether as an outpatient or residential, should adapt more to specifically female characteristics and the condition of maternity from the very beginning of pregnancy.

2. The actual condition of pregnancy is something that has been considerably underestimated, by both the operators in the field and the women themselves who do not seem to recognise how important it is to know as soon as possible if they are actually pregnant so that they can immediately adopt suitable behavioural measures and make conscious decisions.
This is also true of the treating team, who should have intervention protocols of both a medical and psychosocial nature that are more suitable for the condition of pregnancy. On the other hand, a belated knowledge of an existing pregnancy by both the operators and the mother herself can lead to serious risks for the foetus' health and the mother, as well as influencing any decision to undergo an abortion.

3. Operators in the sector have to realise that a pregnancy has important repercussions on the evolution of substance-addiction by the woman in relation to the motivation to undergo treatment and her relationship with drugs. The study shows that a pregnant woman is more disposed to undergo treatment, whether as an outpatient or residential, and this improves the possibility of beginning a therapeutic project and also improves its chances of success.

4. The results of the study highlight that there is an increase in the number of undesired births due to the sporadic use of pregnancy tests at the beginning of treatment (outpatient or residential) and the lack of constant monitoring, as well as due to the women's relative ignorance regarding their state of fertility, even in the case of amenorrhoea caused by drug assumption.

5. According to the mothers themselves and operators in the sector, the fate of the undesired children of substance addicted women leads to serious risks for the psychological well-being of the minor due to frequent separations and precocious institutionalisation, a higher risk of premature drug abuse, scholastic failure and emotive and behavioural problems.

6. An important factor that restricts the possibility of social emancipation of the substance-addicted woman is the lack of financial independence thus limiting the possibilities of social reintegration.

7. Female substance addicts who maintain a constant relationship with their child show a greater awareness of the educational needs and care of the child.

8. The majority of substance addicted mothers either lives alone or without the support of a partner or the child's father. This results in a series of unfulfilled needs for both the mother (for example in undergoing treatment) and the child who consequently has no father as a role model.

9. The family can have a positive influence on the success of treatment and, vice versa, can also hinder the evolution of or decision to undergo treatment.

10. Substance addicted mothers have a negative auto-perception of their own maternal abilities. Participation in treatment programmes can result in a more realistic and less downgrading auto-perception, especially in residential treatment programmes.

RECOMMENDATIONS

1. Operators working in the field of substance addiction treatment should collaborate with operators in the field of minors, thus leading to the enhancement of reciprocal knowledge and methodology of their work, aimed at favouring any possible premature preventive measures for the children of substance addicted mothers and consequently avoiding any form of stigmatisation.

2. Treatment services should improve the network activity with the medical services in charge of the woman's health or offer gynaecological services aimed at avoiding an undesired pregnancy and supplying information regarding sexually responsible behaviour and infective illnesses.

3. As far as possible, treatment structures should promote a constant mother-child relationship.

4. Treatment services in charge of the mother-child couple should make sure there are both male and female reference figures, thus highlighting both genders as identification models.

5. Treatment services should pay close attention to the importance of the substance addicted mother's immediate family, thus resulting in a better understanding of dysfunctional dynamics and allowing the creation of affective bonds that can lead to support of treatment as well as helping the treatment team to promote a positive social reintegration and an efficient prevention of relapses.

6. The immediate family should be supported by the service operators, promoting true affective, social and financial autonomy and therefore improving the conditions of emancipation and reacquiring responsibility for maternal competence and avoiding a repetition of inter-generational problems.

7. Treatment services should take into consideration the importance of encouraging improvement of one's auto-effectiveness regarding the ability to carry out the maternal role.

8. Particular attention must be paid to the children who are the most exposed to risk factors in prevention and their possible consumption of drugs before they are even adolescents as a result of their premature contact with and initiation of drug consumption (legal/illegal).

ANNEX 1

THE PROBLEM OF THE PROTECTION AND FATE OF MINORS OF SUBSTANCE ADDICTED MOTHERS

By Laura De Fazio, Università di Modena e Reggio Emilia - Italia

The problem of the protection and fate of minors with mothers that are likely to be at risk involves diverse problems and is characterised by a remarkable complexity when in reference to women with problems of substance addiction. As far as the situation in Italy is concerned, this complexity is underlined by the fact that the literature available gives no indications for either possible tendencies or for legal behaviour.

Indeed, it is often the case that the interventions of judges for minors concerning minors considered to be at risk, the children of substance addicted mothers, are relatively sporadic and impromptu and are certainly not classified or classifiable on the basis of official statistics. Very often it only comes to the intervention of legal authority after parental unsuitability has already been noted.

As far as the activities of the judges that strive for the preparation of alternative instruments of protection are concerned, the number of cases in which prescriptive-type interventions are part of a wider project of rehabilitation and support for the nuclear family is modest. Unfortunately, these interventions often end with a decree of adaptability when these rules are ignored.

It must be recognised that in relation to such situations there is a series of deep-rooted stereotypes that influence the judges' decisions to a certain extent. This leads to the risk that the prescription of certain interventions takes place under the influence of quite tenacious social prejudice, to the detriment of solutions that might often be more problematic but certainly more rehabilitative.

Indeed, despite the changes that have taken place in the field of substance addiction in general, and in particular regarding women, the stereotype of the substance addicted mother as completely and automatically unsuitable to take care of a minor once the child has been born and it has been confirmed that the woman is still taking drugs, is still prevalent in Italian society. Such a definition would appear to characterise the majority of all interventions on behalf of both judges and social workers, despite greater attention being paid to the specialised literature on the phenomena of the progressive "normalisation" of the substance-addicted population.

This statement refers to a new and diverse mode of placing oneself in the position of substance addiction that increasingly seems to exclude forms of total escape from social reality in favour of a greater compatibility of substance addicts with a normal working, social and family life.

Therefore, if the phenomenon is considered from such a point of view, it might be useful to evaluate the hypothesis of modifying the evaluation criteria for suitability or unsuitability of substance-addicted parents.

On the other hand, recent legislative modifications in Italy appear to be moving in such a direction. Two new laws have been issued in the last three years,

profoundly changing the system and field of national and international adoption and foster care in Italy.
Law n. 476 of 31 December 1998 *"Ratification and execution of the Convention for the protection of minors and the cooperation in the field of international adoption completed in Aja on May 1993. Modifications of law 4 May 1983 n. 184 regarding foreign minors"* only took effect on 16 November 2000, and regulates the subject of international adoption, establishing the Italian central authority for adoption (Commission for international adoption) and the obligation to resort to authorized institutions. It also deals with entrusting the social-welfare and health services new tasks, stating shorter periods of time for the procedure, abolishing pre-adoptive foster care and making it easier for couples wanting to adopt.

Law n. 149 of 28 March 2001 *"Modifications to the law of 4 May 1983, n. 184,states "Control of the adoption and foster care of minors", as well as title VII of the first book of the civil code",* leading precisely to the modification of the previous Italian law of 1983 on adoption and foster care. The main novelties being introduced concern an increase in age of those wanting to adopt to 45, recognition of years of living together as part of the three years of marriage necessary for adoption, the possibility for the adopted child to know his or her true origins with the agreement of the judge for minors, once over 25 or 18 if there are psycho-physical problems, or even earlier for the adoptive parents should there be serious and proven motives.
However, above all the new system calls for a sort of Copernican revolution: it even speaks of “a minor’s right to have a family” and no longer of the “control of adoption and foster care of minors".
Taking this recognition of the minor as a subject with rights – one of the great novelties recently on the subject of international principles and rights – the law underlines what is perhaps the greatest right of all: the right of every minor to have a family that takes care of him, and that above all, should be “his” original family since, as stated in the law, “the minor has the right to grow up and be educated in the surroundings of his own family.”
As far as institutes for foster care and adoption are concerned, it is of interest to comment on the experiences in other European countries such as France and the United Kingdom that were based on the initiatives of foster care and have recently been experimented in Italy.
As part of the Institute of the *placement familial* the figure of the “maternal assistant” was inserted in France in 1977 and is thus used to make the distinction between the normal foster care family of a traditional nature and the professional foster care family.
The reference point for the English is to be found in the wording of the 1989 Children Act, in which the contract for foster care is signed by the maternal assistant, her husband, any children of age, the social-service’s director, the social assistant who is in charge of the foster care and it is then brought to the attention of all those living in the same house, as is the case in France.
There are certain Italian initiatives that follow the same lines and have created educational courses for professional foster care families.

In Europe one can observe a considerable increase in proposals that fall into the category of the aforementioned tendency. This includes the English approach of “non-permanent foster care” as a formula that would appear useful, especially in the case of substance addicted parents, and foster care is offered together with a therapeutic programme. This is also being carried out in other cases, such as, for example, that of handicapped minors, thus granting the parents a much-needed rest.

The French make the distinction between day foster care (only 8 hours a day) and permanent foster care, day and night.
In certain Italian structures day foster care is also relatively common, representing a contribution to carrying out the consensual family foster care requested by the natural family and approved by the tutelary judge, or for a short defined period or for intervals, with the child’s daily return to his family.
In France they also speak of *familles logeuses*, that is host families that represent an intermediary stepping stone for the boy between his childhood and the end of adolescence, characterised by financial, emotive and housing independence.
The model of the host family has also been adopted in the Italian programme called Bed and Breakfast, which is soon to be tried out. Here, the foster parents do not intervene directly on the minor, but it is possible to ask them to be present, to pay attention to the child’s problems, and to communicate with him at moments such as meal times.
On the basis of the indications derived from the European normative context regarding the protection of minors, and in particular the problems of the children of substance addicted mothers, it is clear that there is an opportunity to undertake the redefinition of the level at which the substance addicted mother can be certified as suitable or unsuitable to carry out her function in the face of the Italian environment that still reveals a particular persistence regarding the stereotype of the substance addicted mother.
This obviously does not mean that there are no substance addicted mothers who show absolutely no interest in their children, thus being so unsuitable that a family must be found for the child through the channels of foster care or adoption institutes, but such situations do not appear to be a daily occurrence.
Indeed, it should e underlined how important it is to remember that, as is the case with other mothers, those with problems of substance addiction may also have an affective capacity and should therefore be helped to extend it, rather than being penalised with the loss of the affective relationship with a much desired child.
Indeed, psychological literature shows that very often the child was much desired and wanted by the mother precisely as a sort of redemption, motivation and gratification.

Furthermore, it is the affective elements themselves that move such women and motivate them to become pregnant or continue a pregnancy, something that is sometimes experienced as an opportunity to escape from a certain type of reality.
It is well known that such a motivation is certainly not sufficient but the general picture should lead to the reject the assumption that a substance addicted parent should believe themselves to be incapable of a valid affective relationship.

Moreover, the latest statistics regarding the panorama of female substance addiction show that there can be situations in which some women are able to maintain an affective relationship and even to develop an educational ability towards a minor, despite the presence of substance addiction.

ANNEX 2

Measures to protect at risk children of female drug addicts in Spain

By Rosa Varela Garay, Graduate in Social Work.

Pregnancy, birth and motherhood generally constitute crisis situations for women. If serious drug addition is added to the picture, it is difficult for the mother to find the personal resources needed to perform her maternal role.

Spanish national legislation on this subject is wide-ranging and comprehensive. In the seventies major changes were made, situating Spain among the world's most advanced countries in terms of childcare legislation.

In particular, the situation of at-risk and "abandoned" or "unprotected" children of drug-addicted mothers is covered by the following law:
Organic Law 1/1996, 15 January 1996, on the Legal Protection of Children, partially modifying the Civil Code and Law of Civil Proceedings (*Ley orgánica 1/1996, de 15 de Enero, de Protección jurídica del Menor y de modificación parcial del Código Civil y de la Ley de Enjuiciamiento Civil*).
This law constitutes a fundamental text on the protection of children and is based on the full recognition of their rights and their progressive capacity to exercise them.

The specific measures envisaged include:
- Establishing the obligation upon all persons who become aware of a possible risk situation or of the abandonment of a child to give immediate help and to notify the authorities or their nearest officers.
- Establishing an obligation upon the relevant public authorities to investigate the facts of which it becomes aware and, in the event of a situation deemed to constitute abandonment, to automatically take on the guardianship of the child by direct application of the law.
- Introduction of a series of concepts to facilitate action by the public authorities:

Risk situation. Situation in which the potential for harm to the child is not sufficient to justify taking the child out of his[1] family. In this case, the protection of the child by the authorities consists of preventing and rectifying risk situations, with the establishment of adequate social resource for this purpose.
Once a risk situation has been identified, the competent authorities with responsibility for child protection must set in motion the relevant actions to reduce the risk and monitor the progress of the child within the family.

[1] The masculine pronoun should be understood as referring to both sexes [Trans.]

Situation of "abandonment"[2]. In some localities it is rapidly seen that the resources available to meet demand are inadequate, in which case this situation is quickly reached. In this case the seriousness of the circumstances makes it advisable to take the child out of his family environment and for the authorities to take effective guardianship while the causes giving rise to the assessment of abandonment persist.

The public body concerned may take custody of the child under the terms laid down in Article 172 of the Spanish Civil code when the parents or guardians are unable look after the child or when a court order is issued to this effect under the applicable legislation.

The authorities may take automatic guardianship of the child without the need for a prior court order, thus enabling them to act in an emergency when circumstances require. They are, however, subsequently required to inform the Attorney General's Office.

Custody of a child implies the obligation upon the person exercising custody to care for the child, keep him in his company, feed and educate him, and ensure he receives a proper upbringing and education.

The public authorities are to take custody of a child in three specific cases.

- When it becomes aware that a child is in a situation of abandonment, in which case the authorities shall take custody and guardianship over the child. This custody may be entrusted, under their supervision, to the director of a centre or a person or persons able to take the child into their care.
- When the persons with parental authority so require, having duly shown that as a result of illness or other serious circumstances they are unable to take care of the child themselves.
- When, pursuant to the applicable legislation, a court order is given, i.e. when a judge, during separation, divorce or annulment proceedings, a criminal trial, or a period prior to the constitution of definitive ordinary guardianship, decides, as a temporary measure, that it is in the child's best interests for him to be entrusted to the custody of the authorities.

All measures taken to protect the child must have the cooperation of the child and his family and must not interfere with the child's schooling, social or working life. To this end, care may be arranged in any of the following manners:

* Residential care (foster homes, care centres, etc…).
* Formalize or promote fostering either within the extended family with other relatives in order to encourage the child's re-integration in his social and family context, or in an alternative family.

Fostering, as a child-protection service, came into existence in Spain with Law 21/1987, 11 November 1987, partially modifying the Civil Code and Law of Civil

[2] The Spanish term "*desamparo*" means abandonment in the sense of a dereliction of parental duty while the child remains with his family, as well as in the strict sense [Trans.]

Proceedings on the subject of adoption (*Ley 21/1987, de 11 de Noviembre de modificación parcial del Código Civil y de la Ley de Enjuiciamiento Civil en materia de adopción*). This law introduced important changes, such as speeding up child-protection procedures by transferring powers vested in the official bodies responsible for child protection at national level to the Autonomous Regions.
Subsequently, Organic Law 1/1996, 15 January 1996, on the Legal Protection of Children, partially modifying the Civil Code and Law of Civil Proceedings (*Ley Orgánica 1/1996, de 15 de Enero, de Protección Jurídica del Menor, de modificación parcial del Código Civil y de la Ley de Enjuiciamiento Civil*) arose in response to the gaps existing in the application of the previous law, such as for example, when parental consent for fostering was withheld the child had to be made a ward of court, thus the public bodies could only rely upon care of children being possible in residential centres, even when members of the wider family had declared their willingness to take in the child.
This law envisages the possibility of action by the public authorities in the child's interests to integrate the child in a foster family even if the parents are opposed, and for the child to remain with that family until there is a court order to the contrary.

Fostering is a solution that can be offered when the child's circumstances advise, and it consists of integrating the child in a family with parents other than his biological parents. The fostering relationship will last until the child can be re-incorporated in his original family or in his social milieu on reaching adulthood, becoming legally emancipated or being adopted. The foster parents may receive payment and no family ties are created.
In order to prevent the original family from discovering the identity of the foster family, all details permitting their identification must be kept confidential, except in the case of temporary fostering within the family, provided it is not against the child's interests.

The law envisages three different modes of fostering:

- Temporary: which is transitory in nature until the child can be reintegrated with his family or a more stable caring environment.
- Permanent: constituted when the child's return to his original family is unlikely, and the child is to remain with the foster family permanently until he becomes independent or other appropriate measures are taken.
- Pre-adoptive: this is a prior step taken before full adoption while the child is being integrated within the new family or his integration is being evaluated.

In response to this legislation, specific foster-family programmes have arisen involving professional or paid foster parents. These include special foster parents for children with special needs, "open families" (support families, taking in children for weekends or the holidays), and full adoption when it has been determined that the child cannot be returned to his original family. This latter option can only be used when it has been shown that the child's parents have not complied with the objectives of the family care programmes in their locality.

For it to work properly and efficiently, fostering requires a significant provision of physical and professional resources and support. However, in practice, the general and specific social services departments are often overworked and suffer from shortcomings on a number of levels, making it difficult to provide adequate care and respond correctly and to the issues raised by drug-addicted mothers.

ANNEX 3

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