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Examples from our practise-working with children and their drug using parents in the sunflower garden scheme

Abstract

This article is about the screening and work with children in the "Sunflower Garden" scheme, who were influenced by drugs during their mothers' pregnancy. Further, the article is about early intervention for these children. It focuses mainly on working with parent's competence as well as on developmental diseases of said children. Outcomes and findings come from direct work with clients with such experiences. The purpose of the article wasn´t originally based on research; therefore, the group of children, whose mothers stayed abstinent, is very limited. Cases of 104 children were under observation in the years of 2010–2015. Information comes from The Drop in Centre of Prevention and Treatment of Drug Addiction, o.p.s., and The Centre for Family and Addictology Outpatient Department. Methods used to complete the study were as follows: Analysis of documentation and interviews. Also the Developmental Scale according to Hošková was used.[1] "Worksheets" were made by the implementing team. We found it very important for the right development of children, to use a system of exercises with a Senzoric Integration background. As a resulting output, with following target group and examination, we realised that using a multidisciplinary approach was really effective. It has been proven that supporting the biological mothers in care of their children prevents the risks in children's development better than being in foster care, especially due to the higher interest in cooperation.

Keywords: anamnesis, drugs, screening, centre for family, drop in

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Simona Sedlackova,[1] Lidmila Hamplova,[2] Zdenek Vesely,[3] Hana Kone[4]
[1]University of Defense, Faculty of Military Health, Czech Republic
[2]Medical College, Duškova 7, Prague 5, Czech Republic
[3]Charles University Hospital Prague, Czech Republic
[4]Charles University, Czech Republic

Correspondence: Simona Sedlackova, University of Defense, Faculty of Military Health, Center for family and clinical addcitology, z.ú.. Gallašova 10, Prague 6, 163 00 Clinic of addictology and childern with special education needs, Tel 00420603 291 593, Czech Republic, Email cpdropn@gmail.com

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Practical examples-working with children and their parents who used addictive substances in the sunflower garden program

System of work at the screening facility Sunflower Garden-Center for Family, Drop In o.p.s. was launched on the basis of the implementation of the EU Priority Axis 1 grant: Initial Education, Area of Support 1.2: Equal Opportunities for Children and Pupils, including Children and Students with Special Educational Needs within the Operational Program "Education for Competitiveness".[2] The implementation of the project started in 2010, when the initial contact with clients, pregnant women, started and continued throughout their treatment in our facility. To evaluate and assess psychological needs of their children and offering an individual work plan for each child, we used papers, which were based on our practice presenting specific practice-tested methods used in working with parents and children from this target group. The program included 113 children in years of 2010 and 2015, of which 23 were prenatally influenced by opiates and 73 by stimulants. We were not able to investigate 5 children.[3]

The general focus was on the identification of ADHD, followed by hyperactivity, impulsivity and inattention, fine and gross motor skills, sensory integration, specific learning disabilities and school-age behavioural difficulties as well as the stability of the social environment.[4] It is important to note that this is a presentation of experience from the practice of a clinical workplace, not a research study and so that is not ruled out for favourable factors in the future.

Methods

The methods of work varied according to the client's needs resulting from the analysis of the medical documentation, the screening results and the bio-psycho-social model of praxis. The aim of the scheme was to strengthen parental competencies and focus on developmental disorders in children and the treatment of such disorders. These were the current work with the parents and their children, and the following methods were used: study of medical documentation, anamnestic interviews with parents and children, assessment of children's abilities through scales (tests for maturity of the child and "Indicative developmental scale according to Hošková"), follow-up diagnostic assessments of children, application of corrective methods for children in the area of sensory integration and special pedagogy (fine, gross motor skills, education, empowerment of self-service skills, analysis and synthesis of thinking, cognitive and learning ability). Application of movement exercises and axes in the area of dyspraxia. Parents'needs dominated in education and cognitive behavioural therapies.[5]

Client acceptance and initial screening of children

Acceptance of clients and their partners in the facility was connected to the recommendation of the center for psychosocial services-the Family Center, which works with parents on the level of secondary prevention. This is a target group of mothers (parents) from a disadvantaged environment who have undergone an ambulatory treatment program for addictological outpatient clinics or some of the established aditology workplaces. They were already abstinent parents, especially mothers who have a history of substance abuse or previous experiences with addictive substances or alcohol. In fact, the task of the professional staff was also the screening of clients, and so it was necessary to proceed very carefully to the observance of ethical principles when presenting a program or establishing contact

with parents.[6–9] It was already taken into account in the creation of promotional materials-leaflets and web pages for the project. Clients can be recruited from many sources in other ways, but in practice CFF (Center for Family) recommendations have proved to be very effective in terms of client's motivation and credibility of the Center's staff,[10] which emerged from previous subjective ratings of clients. At the beginning of the collaboration, it was important to explain to parents, first of all, what kind of benefits they would gain from the project with regard to the development of their child and to motivate them to work regularly.[11]

Most parents, if they fully understand the impact and purpose of regular contact with experts, and can imagine how it can positively influence the development of their child, are more motivated to cooperate. Parents attend an interview with a social worker and then with other professionals, a educational psychologist or an educator for childern with special needs, clinic psychologist and pediatrician. It is important to emphasize the personality and multidisciplinary skills of the specialists who use their empathy and listen, they have not to relate to previous or current lifestyle of clients/ parents, but encourage them and show them that they can achieve results and have a positive influence on the development of their child. For this purpose, the workers who have previous experience with such clients, for example from previous therapy and treatment, are advantageous.[12]

Another advantage is the existence of a comprehensive medical documentation of parents, which allows a more objective assessment of all the information obtained.[13]

Input screening

This screening was attended by all children from the age of 3 and the pupils who participated in the implementation of the scheme. Medical screening is performed to identify possible illnesses and disorders, even in people without significant apparent symptoms and in good health. The examinations were carried out by experts experienced in the field, and based on the findings; they compiled a complete picture of the current developmental level of the child as well as assessed their health status. Therefore, the developmental level of the child was evaluated in terms of psychological, neurophysiologic health and social status.[14,15] For children it was necessary, with the written consent of the parents, to establish documentation where the outcomes of the individual initial assessment and control examinations were recorded on a continuous basis. When the child was admitted, an initial assessment was carried out by the team of specialists - a psychologist and an educator or an educational psychologist. This was the initial acquisition of information from parents, a history of the child - health, social conditions, cognitive behavioural stage, analysis of the progression of childbirth and previous child development. Due to the young age of the child, additional supplementary interviews took place in the presence of parents or parents themselves.[16–20]

The screening included neurological, psychiatric and psychological examination and assessment of the child's motor development. All examinations were performed by relevant experts (neurologist, child psychiatrist, psychologist, special pedagogist and rehabilitation specialist). Children of 4 or more years of age can be evaluated for inhibition of primary reflexes. Blythe[1] comments on the issue of postural reflexes as follows: "Postural reflexes occur after birth and develop in about 3.5 years. Until the child reaches school, these reflexes should be fully developed, and there should be no signs of primary reflex activity "(p. 26). It is worth to note what these reflexes are. "Postural reflexes fall into the more advanced system of free movement. They represent automatic responses driven by man's will that maintain attitude, balance, and posture in the gravitational environment.[1]

In addition, a social worker was involved in the initial screening, focusing on the child's social history, family and social background. Based on complete screening, additional procedures of individual work and exercise with child were recommended. The initial examination was conducted by an educational psychologist to point out children's special needs, or by the clinic psychologist or the addictologist who received an informed consent from the parent prior to the initial examination. In the case of the replacing/ADOPTIVE Family care, they were guided by the competencies specified by the office OF social and legal CHILD protection. In cases where there was a written consent of the parent, the documentation, photo documentation or video recordings for further work within the project were also taken. Main examinations included a collection of personal and family histories in the area of health and social field. Special educational and psychological examinations of children with special education needs

When the client entered the program, they were appointed a professional guarantor (psychologist or addictologist), who led the entire case of the particular client and monitored the progress of the client's cooperation until the end of their inclusion in the program. At the same time, the guarantor was tasked with studying all the child's documentation, including all available information and supplementary information from parents.

The examination was usually carried out in the presence of parents, especially in case of young children. For the evaluation we used child maturity tests and the "Indicative developmental scale according to Hošková".[2] In cases where the child showed deficiencies, a system of strengthening sensory integration and developing a given area according to "Worksheets" was proposed.[3] In case of parents' consent, the child's documentation was requested from the hospital and from the pediatrician. The evaluation was focused on self-service, cognitive and motor skills, analytical and system thinking, social maturity and health status, including neurophysiologic development. After the evaluation and screening processes had finished, an individual plan of work with the child and their parents or legal representatives was proposed. The best practise to keep the child documentation records were to write them in so-called contact sheets. A scale evaluation was also used as a supportive assessment tool. The tools were created by the implementation team, which was evaluated according to Orienteering Development Scale and anamnestic sheets according to Hoskova,[3] which were created by the author and member of the Center for family Drop in team. Hošková created sheets for this purpose and based them on models of certified authors in developmental psychology.[21,22]

Children who completed the required tasks in range from 0% to 29% were sent to a specialized health facility or a special pedagogical center. Children who completed the required tasks in range between 30-79% were the main clients of the scheme and the aim was to improve the weakened area. Children who reached over 80% success rate in these tasks were included in a category where deviations from the scales were minimal, and there was no need for them to participate in the scheme.[23]

Social assesment

Information was gained from the questionnaires and supplementary information obtained from parents or guardians who cared for the child at the time. Interview was usually carried by a social worker assigned

to the program. Screening of The child's social history focused on mapping the following areas: how does the child coorporate and settle in the family, the family members, family background, home environment, social skills of parents, social background, economic situation, hygienic habits, self-care, etc. In the social field, an overview was made based on direct work with parents, attitudes of parents to the observance of the daily regime, consistency, satisfaction of the child's basic needs and their influence on the child's development. The social worker then included the children in the program and according to overview; they were offered one or more possibilities of corporation:

a. Individual therapy with a parent

b. Family therapy with a parent and a child

c. Group therapy of children

It was usually also recommended by a psychologist who was a member of the therapeutic team.

Psychological assessment

The psychologist focused on examining the child's psychomotor development and any delays or deviations in development. The assessment did not include a test of intellectual ability in preschool children, only an orientative test of knowledge or, in indicated cases, only a field of verbal intelligence, which for the purpose of the programme was valuable enough. School children were diagnosed according to Act No. 561/2004 Coll., On pre-primary, basic, secondary, higher, vocational and other education and Decree 116/2011 Coll., On the provision of counseling services in schools and school counselling facilities and 147/2011 Sb. on the education of children, pupils and students with special educational needs and of children, pupils and students of extraordinarily gifted, exclusively at the appropriate school workplace designated for that purpose. Such a facility is a pedagogical-psychological counselling center or a special pedagogical center, which usually requires a psychiatrist's statement. The initial psychological assessment focuses on the following areas: social inclusion, co-operation with the examiner, instructional alert, speech, gross and fine motor skills, graphing and correct holding of writing tools, hand-eye coordination, perception functions, drawing of the figure, drawing on a predefined topic, general overview. In the case of educational or behavioral issues, further expanding tests focus on family backgrounds and family relationships, self-assessment questionnaires, or other projective techniques suitable for children of a given age. The result of such an assessment looks like an outreach report with possible recommendations and identifying areas in need of development.[24]

A regular check-up is recommended at three-month intervals with monitoring of individual problem areas. Importantly, with the help of the parents, it is beneficial to deliver the medical reports from hospital and request the latest available pediatric and neurological examinations, including their conclusions and recommendations, or supplementing the documentation on previous psychiatric or psychological examinations. In addition, it is necessary to examine children by the rehabilitation specialist and to assess the level of physical development of the child. The psychologist has documented the dossier and has proposed a further procedure for working with a child and a parent. The "Social Survey Questionnaire" was used for evaluation.[3] The guarantor analyzed these documents and designed an individual plan to work with parents and their children. The individual plan was also designed based on the outcomes of the expert working group meetings.

Evaluation by an educator for childern with special education needs

A mental health specialist evaluated and assessed the child during the initial examination. He used the observation of the child's direct work on the assigned task, the spontaneous play, the group of other children, the group work, the communication with the parent, etc. In a controlled interview with the parent or in the case of school children with the child, the anamnestic data and information about the health condition are taken into account. Questions were oriented on skills and habits of the younger age of the child. The examination of children's abilities and habits was used as part of the pilot verification of the "Indicative developmental scale of to Hošková".[2] Here the following areas were considered: child self-care, gross and fine motor skills, right and left orientation, speech, thinking, perception, inhibition of primitive reflexes, sensory integration capability, and presence of ADHD-confirming phenomena as well as the social development of the child. An evaluation of product activities has been used in terms of practical and creative skills. The neuromotoric status range was also evaluated in group activities by a rehabilitation specialists and neurologists.[25]

The quality of the relationship with the parent was evaluated in the joint activities of parents with children using video training, drawing of a common house, etudes, eg waiting for the means of transport and recording the whole process of activity was used as an assessment method.[2] to the outputs are expressed as follows: "The output is a comprehensive assessment of the child's development, namely psychological, psychiatric, and neurophysiologic and neuromotorical. This is a qualitative and quantitative examination".[26]

Target group

The activity was designed specifically for children who underwent screening. The group described were children whose development was influenced by addiction, alcohol, or other chemical or physical influences during their mother's pregnancy, children from disadvantaged backgrounds and children of former users and users of addictive substances. The Idea in the project was to link the counselling center with the aditology workplace where the mothers of children were treated and evaluated. This advantage has made it easier to get in touch with parents of high risk children. Information about services provided to parents and their children on the addictological clinic for the individual districts of Prague, Central Bohemia and South Bohemia. Parents received an ethical codex which contained information about the benefits of Work with Children and Work with Parents. They were informed about the risks of drug abuse during pregnancy and about the importance of cooperation, which requires monitoring of their children and ensuring that their children are not affected by dysfunction resulting from prenatal risks.

Breakdown by age

For group activities and development, children were divided into the following groups:

Group

I. Age 3-4 years

II. Group: age 5-6 years

III. Group: younger school age

IV. Group: older school age

However, some activities are more effective when carried out in a mixed age group or a combined group of children and parents.

School age

Younger school age group

Children of this age should be included in one group. It is important to carry out a joint program; the program must be designed to enhance individual skills for all children in the group. In the case of individual work, it is possible to work with maximum of four children or to strengthen their skills individually. In the case of school work, the whole class is working, but with a maximum of 25 children. In this case, it is necessary to elaborate methodology and to implement specific primary prevention programs in school attendance.[4]

In the Netherlands, the United Kingdom, the US, and other countries, screening is broadened by evaluating the inhibition of primary reflexes, the importance of this is expressed by Voleman[5] "In the presence of primary reflexes, cannot postural reflex have right development, which are the basis for proper posture. Changing the body position does not automatically change the position of the head and thus there are problems with reading, writing, the child is unable to focus on one point, etc."(p.10). In the case of inhibition of primitive reflexes in children, especially developed exercises can be applied and at some schools the INPP School Intervention Programs are being continuously implemented. The programs can be implemented by specially trained professionals in the fields of psychology, special education and addictology in a specially certified program.

Group of older school age children

Here, the emphasis is placed especially on social communication, prevention of misbehaviours, and functioning in a social group. It is mainly introduced at schools or in cooperation with educators.[4] Perhaps there is individual supplementary work in the facility, if the child is interested and parents consent. It is advisable in this case to recommend a pedagogical-psychological counselling center, an educational psychologist or a school prevention methodologist.

Individual plan

Based on the screening output, an individual plan for working with the child was designed. This plan was a summary of the design of an individual plan of a special educator, psychologist, social worker, rehabilitation specialist and other involved specialist. On the basis of a screening survey in the first stage of screening, a child was not selected from the selected group to be diagnosed as having a proven disability or disability. The aim was to detect high risk areas before they could disadvantage a child in pre-school or school education. There was a recommendation to strengthen some areas with deficits identified in early evaluation. If not enough attention is paid in these areas, there are known consequences, such as school immaturity, behavioral difficulties and learning disorders. The development can be significantly influenced by parents in the postpartum period, but the program was designed for children from 3 years of age. However, it may work with some primary care facilities. The task of the team was not only to design an individual plan for work with the child, but also to monitor the best practices.

Direct work with the child involves training in the areas of fine and gross motor skills, which is provided by a special educator, rehabilitation specialist, neurologist, occupational therapist. Practical skills training is led by a special pedagogist, ergotherapist, training of regime situations-a special educator, an ergotherapist, a health and social worker; training and re-education of individual competencies (communication, processing of acquired information)-a special pedagogist, a psychologist. It also includes training of rehabilitation procedures-sensory integration-by a rehabilitation worker. Thematic units are focused on movement and coordination and various forms of interactive games, drawing-the aim is to incorporate the right stereotypes in children's development.

Motion exercises

The Family Center Sunflower Garden scheme also included exercises aimed at coordinating individual muscle groups and developing dynamic practice, retaining attention, improving concentration, relaxing tensions and overall relaxation. During these activities, it was possible to evaluate areas where the child needs to be strengthen "In children, but also in adults, where we notice a significant problem in the motoric field, coordination of movements, dynamic practice, it is recommended to investigate the spatial orientation with focus on dyspraxia, gross and fine motorics. This can reveal a specific developmental disorder of schooling skills. The exercise will monitor the interaction of children with parents and other children, including social contact capabilities. At the same time, these activities also contribute to adhering to the rules and developing the right parenting habits, such as timing and timely arrival. The choice of a different environment has a positive influence on the course of activities".[3]

Fine motoring

These are activities where it is possible to strengthen specifically fine motor skills based on movement, drawing, art activities (beads, dice, castle construction, etc.). Use worksheets or instructions that are recommended for the area. Enhancing parental responsibility. The often mentioned importance of cooperation with parents within the scheme includes also the implemented activities. The most beneficial practice here was video training, which can also be used in other activities where the parent interacts with the child. A collaborating parent is a prerequisite for its use. When working with parents, the video is then reviewed by the team and later parents can monitor their interactions with the child. Parents often unknowingly trigger a child's problem, such as obesity, anxiety, etc., without knowing how their approach can affect the child. "For example, our mother reminded me when she arrived that she and her daughter had taken over and immediately gave her daughter chocolate. Using video analyzes, the parent can look at their automated parental approaches and reactions".[3]

Game with rules

For the 1st group of children aged 3 and 4 years, the regime of the center itself is often significant. First you need to master the center mode, pass on instructions to parents, identify interactions between children, and interact with your parent. Subsequently, it is possible to play small games with children and parents, such as Pexeso, Man's Mind, etc. The Sunflower Garden project helps parents to better apply rules and maintain consistency i with instructions, attendance, parents were taught additional regime measures.

Rehabilitation exercises in cooperation with experts

Based on the recommendations of RHB intervention, monitoring of the activity was important in cooperation with the parent and rehabilitation specialist. It is advantageous if one of the team has a multidisciplinary education focused on rehabilitation. In this case, a team member can help parents with exercises that they do not remember well. At the same time, possible misunderstandings

between rehabilitation workers and parents can be solved, especially due to the fact that parents do not regularly take part in exercises,

Working with a child ranges from 6months to 3years in the basic program, if necessary; children could continue to use the services. The specific indicator was screening, based on the outputs, whether the activities for the child were effective and whether the program could be terminated. Even after the end of the training, the child had to be monitored for at least 6 months to 1 year. Parallel to individual and group work with the child, cooperation.

Conclusion

Field Workplace the DROP IN Family Center has been working with mothers who were addictive drug users for 17 years. In the years 2010-2015 the work of the centre was supported by the ESF and extended to work with the target group of children of such mothers. Field work with both target groups continues after the end of ESF financial support as a normal scheme. Based on the evaluation and findings from the implemented project, it can be stated that for the development and success of the child, a safe school environment, family background and socially stable conditions are vital, but it is also necessary to put emphasis on psychomotor development.

At present, attention is paid to the family and school environment, especially in the time of inclusive education, proper diagnosis is being carried out, but methods are not applied sufficiently to solve problems and deviations in the development (eg specific disorders of school skills, dyspraxia etc.). The deficits of children and pupils with specific school-related skills disorders are already accepted by the school, education and co-operation with teacher assistants are ongoing, but it is important to apply further modern solutions to this problem. These may include psychomotor exercises closely related to neurodevelopment therapy is a common practice in different countries. These are specific procedures where it is necessary to include the child in special exercises, again throughout the developmental stage, so as to inhibit primary reflexes. They are often dysplastic children who are less able to adapt to new situations, as mentioned above.

This often leads to bullying, a child's detachment of from a group, and may later lead to risky behaviour, such as the use of addictive substances. However, the solution is not to include a dyspraxic child in a sports section, where it will again be unsuccessful, but systematic work in the area of psychomotor immaturity, where individual movement-related stereotypes are assembled so as to lead to effective results. In addition, the situation in the Czech Republic is complicated by the fact that specialists who control the methods of neuromotoric exercises are physiotherapists and occupational therapists such as Marja Volemanova and Lucie Pultarová. The reimbursement of this therapy is from general health insurance at the recommendation of doctors, otherwise parents have to pay for it. The basic problem, however, remains in the fact that these therapeutic procedures are not extended within the scope of pedagogical-psychological counselling, between psychologists and special pedagogists, public health workers and adictologists. With regard to teaching public health in the field of addiction, it could be viable if interdisciplinary areas were to be interconnected. Practice recommendations are based on the fact that pre-school childhood examinations have been carried out and multidisciplinary intercourse, including knowledge of applied therapeutic methods such as neurodevelopment therapy, not only with physiotherapists but also with psychologists and special pedagogists or addictologists as well as it is abroad. For example Slovakia is working on similar principles Institute of Psychotherapy and Sociotherapy. The team at the Sunflower Garden scheme is prepared to work using these methods in collaboration with other experts. In conclusion, it is not possible to confirm an increased incidence of ADHD in monitored children. Only 4 children out of 104 children with diagnosed ADHD disorder were reported in the target group. For other children, it was rather a lack of parental arrangements, a higher age of foster parents, or the overweight and comfort of parents that prevented children's activities what was present.

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Conflicts of interests

Author declares that there is no conflict of interest.

References

1. Blythe Goddard S, Beuret L, Blythe P. *Attention, balance, and coordination: the A.B.C. of learning success.* Wiley: Malden; 2009.
2. Sedlackova S, Hoskova K, Bulvova, H akol. *Examples of our practice-Working with children and pupils from a disadvantaged environment Sunflower Garden.* Praha: 2013.
3. Sedlackova S, Keblova A, Hoskova K a kol. *Parental Methodology-Are you afraid of problems with the behavior and learning of your child?* Praha: 2013.
4. Miovsky M, A kol. *Primary prevention of risk behavior in education.* Praha: 2010.
5. Volemanova M. *Persistent primary reflexes: neglected factor of learning and behavioral problems: how to recognize them and when to turn to an expert.* Praha: 2013.
6. Binder T, Vavrinkova B. *Addictive substances during pregnancy.* Prague: 2006.
7. Cermakova M, Papežová H, *Uhlíková P. Attention and hyperactivity disorder.* 2015.
8. Drobna H, Veleminsky M. *Problems of drug addictions of mothers and newborns.* Ceske Budejovice: Health and Social Faculty of the South Bohemian University. 2000.
9. Dunovsky J, Dytrych Z, Matejcek M, et al. *A tired, abused and neglected child.* Grada Publishing: Praha; 1995.
10. Hjerkinn B, Lindbaek M, Skogmo I, et al. Neuropsychological screening of children of substance-abusing women attending a Special Child Welfare Clinic in Norway. *Subst Abuse Treat Prev Policy.* 2010;5(17*)*.
11. Hulinsky P, Hamplova L, Nemcova J. Preventing the spread of HIV/AIDS in selected communities. *Health and Social Work, Supplementum.* 2014;9:56–59.
12. Hulinsky P, Hamplova L. Addressing HIV/AIDS in the Czech Republic. *Health and social work.* 2013;8(3):8–17.
13. Chang G, Wilkins-Haug L, Berman S, Goetz MA. Brief intervention for alcohol use in pregnancy: a randomized trial. *Addiction.* 1999;94(10):1499–1508.
14. Kalina K. *Drugs and Drug Addiction-Interdisciplinary Approach I. A II* . Prague: Council of Europe/Office of the Government of the Czech Republic; 2003.
15. Kastnerova M, Sedlackova S, Zizkova B. *Care system for pregnant drug users, drug addicted mothers and their children.* Ceske Budejovice: Health and Social Faculty of the South Bohemian University. 2006.
16. Kessler RC, Adler L, Barkley R, et al. The prevalence and correlates of adult ADHD in the United States: results from the National Comorbidity Survey Replication. *Am J Psychiatry,* 2006;163(4):716–723.

17. Libra J, Miovsky M, Mravcik V. *Konceptice of the network of health services in the field of addictology*. Prague: Society for Addictive Diseases of CzMA JEP. 2012.

18. Miovsky M. Problems of interdisciplinary approach to addiction treatment. In K. Kalina. et al. *Drugs and Drug Addiction: Interdisciplinary Approach I and II*. Prague: Office of the Government of the Czech Republic.2003.

19. Preslova I. Options and limits for working with pregnant drug users. In M Veleminsky MB. Zizkova, *Care of Pregnant Women Using Psychotropic Substances in Pregnancy*. Praha: 2008.

20. Rozsypal H, Rozsypalova B Vyznam. Search serological examinations in pregnancy. *Modern gynecology and obstetrics.* 2006;15(3):436–445.

21. Sedlackova K, Zizkova B. The use of psychoactive substances in pregnancy. *Sister.* 2007;7(8):35–36.

22. Sedlackova S, Zizkova B. One of the care systems for pregnant drug users, drug addicted women and their children in the Czech Republic. *Prevention of injuries, poisoning and violence.* 2007;3(1):45–50.

23. Sedlackova S. *Prevention of specific developmental disorders in children whose mothers used in pregnancy addictive substance, Sunflower Garden.* Prague: 2009.

24. Travnickova I. *Pecific aspects of drug abuse among women.* Prague: Institute for Criminology and Social Prevention; 2001.

25. Vavrincikova L, Miovsky M, Libra J. *The concept of a network of specialized addictological services in the Czech Republic.* Prague: Society for Addictive Diseases of CzMA JEP; 2013.

26. Wilke JD, Kamata *A,* Cash SJ. Modeling treatment motivation in substance-abusing women with children. *Child Abuse Negl.* 2005;29(11):1313–1323.

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