Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs

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Children Whose Parents Use Drugs

Report of focus groups held in February 2021

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1. Background

Between November 2020 and January 2021, the Pompidou Group of the Council of Europe (PG hereinto) developed a preliminary study on children whose parents use drugs. This project was proposed in response to the Council of Europe's invitation to participate in the Inter-Secretariat Task Force on Children's Rights to contribute to the discussions on the themes which should appear in the new Council of Europe Strategy on the Rights of the Child (2022-2027). The PG Secretariat made the following proposal: "To include actions to develop practical tools to protect children of parents who use drugs under the "equal opportunities" pillar of the draft Strategy, as they were deprived of their childhood and had been disproportionately affected by the pandemic".

Subsequently, a preliminary assessment was developed, based on 16 Pompidou Group countries' responses to a questionnaire, literature review -including international normative and standards- and quantitative data.

A report and its executive summary were produced and shared with the 20 countries which manifested their interest in the project, the Children's Rights Division of the Council of Europe and the international organisations (EMCDDA, WHO and UNODC) and NGOs that contributed by sharing information or perspectives (Pompidou Group, 2021).

In February 2021, the Bureau of the PG took note of the developments under this new project and entrusted the Secretariat to follow it up as appropriate and the second phase of the project began. Its purpose is to further deepen on the existing good practices, challenges and gaps in relation to this particular vulnerable group of children, in order to develop a set of recommendations that can help develop child-centred interventions that take children whose parents use drug into account in the field of drug policy -law enforcement, prevention, treatment and harm reduction- and, simultaneously, social and child protection services that do include the drug use variable in data gathering, interventions with children and families, and referral and cooperation with other institutions and civil society organisations.

The second phase will last until December 2021 and comprises several activities, namely:

- Focus groups with the countries that manifested their interest in participating in the project (in alphabetical order): Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Morocco, Norway, Romania, Poland, Switzerland and Turkey.
- Focus groups in selected countries -maximum 7-.
- Semi-structured interviews in selected countries with a maximum number of 6 people per country.
- Updated literature review.
- Feedback with focal points from selected countries.

In the next pages, the contents of the focus groups are reported. In the following pages, the information is presented by the following topics: i) Legal framework on children in relation to parental drug use; ii) Data gathering; iii) Law enforcement in the sphere of drug use and drug possession; iv) Availability of services for children with adults who suffer from drug dependence or risk drug use.

Not all the countries' responses are reproduced, but rather the information is selected on the basis of two criteria: whether it represents a challenge or a gap or whether it stands out as a practice that can be promoted and up-taken by others. It must be underlined that the countries participating in the focus groups have very different situations in terms of territorial and population size, socio-economic situation and drug use issues. By no means the analysis or the preference given to some information is meant as a comparison between countries but rather as the product of a collective contribution based on different contexts and inputs.

Each section begins with a small introduction before reporting the countries' practices. Remarks on the different topics are included in the conclusive section "Final remarks: gaps and promising practices".

During the focus groups and in following interactions, different areas of intervention emerged that require more research into the countries' practices for more coordinated, integrated and participatory processes of policy design and implementation, referral and cross-referral and information gathering and sharing. Section 8.5. "Further elements that call for policy

development and interventions" points them out, recognising the need to understand more specifically what is already available in some countries and can constitute an example for others and what, on the other hand, seems to be existing at a very early stage and could be thought through and developed collectively among the parties interested in it. These areas are: a) Data availability; b) Data gathering and link with stigmatisation; c) Data gathering from different data collection systems in different services; d) Data analysis from different systems by one monitoring body; e) Setting up a national mechanism of identification; f) Putting in place protocols for local cooperation, sharing information and avoiding segmentation of services; g) Setting up an on line communication platform; and h) Children's participation and the need to end stigma against people who use drugs.

At the time of finishing this draft (May 2021) the author has carried out national focus groups with Ireland and Cyprus -both in April 2021- and is currently engaging practitioners, professionals and service users from the abovementioned countries in semi-structured interviews aimed at gathering more in-depth information on services -the way they work, the populations they reach, the institutions, NGOs and other actors they collaborate with, the challenges they face and the positive outcomes they achieve- targeted at i) children in context on vulnerability -including parental or family drug misuse; ii) people who are in treatment for drug use and have children and iii) women who use drugs and are pregnant/have children or are victims of domestic violence and have children. In May the consultant will carry out a focus group with Iceland and in June with Croatia. Simultaneously, she will plan and carry out semi-structured interviews with experts from Ireland, Cyprus, Greece, Mexico, Iceland, Croatia and Italy, with further countries being explored and reached out to.

The information gathered through these meetings will be included in a subsequent report, which will present and analyse the different services and practices regarding children whose parents use drugsand their environment, in order to provide countries, experts, NGOs, practitioners and families and children with a range of experiences that can illustrate paths of intervention, rehabilitation, empowerment and recovery for children, families and communities.

2. Development of the focus groups

In February, the PG' s consultant carried out three focus groups with ten countries (see Annex 1) following a methodology that was distributed previously among the participants and can be consulted at the end of the document (Annex 2). The activity revolved around the following themes, divided in 14 questions: i) inclusion of children whose parents or primary caregivers use drugs in the legal framework and data gathering; ii) implementation of legal measures related to drug use and drug possession and impacts on children; iii) programmes and services available for children in the realm of social services, mental health, prevention, drug treatment and harm reduction; iv) aspects to be addressed and improved in the topics under discussion.

Given the wide range of topics, the participants to the focus groups were informed that they were not expected to have the answer to each single question, but that the activity was mainly envisaged as a collective space of listening, sharing and reflection, aimed at building knowledge, identifying gaps and promising practices based on each country's unique experience and each participant's personal and professional contributions. The three meetings were recorded with the participants' consent.

The ten countries that were invited to participate in the focus groups[1] did so through designated experts that generously attended the meetings and provided information, examples and thoughts that constitute the backbone of this report. The attendance varied from country to country: in some cases more than one person per country attended the meeting, in order to address the different spectrum of the questions. In others, experts from academia or civil society with experience in research and in the field shared their knowledge, whereas in other cases participated one or more experts from a particular sector. Out of 16 people, 4 were not from drug-related services or institutions, but came from child-related services.

[1] Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Romania, Poland and Turkey. Switzerland participated by sending written answers.

Because of the above, the information is not homogenous, but depends on the experts' professional field, on the one hand, and on the availability of policies and services in each particular context, on the other.

3. Conceptual framework

The preliminary assumptions that constitute the framework of this document are: i) most people in the world do not use drugs (UNOCD, 2020: 10)[2]; ii) most drug use is not harmful or dependent (UNODC, 2020: 11)[3]; iii) not all parents with drug problems have difficulty caring for their children (EMCDDA, 2012 a: 7); iv) drug-using parents are stigmatized and live with fear of being considered neglectful and that their children will be taken away from them, with this point being particularly acute in the case of women (UNODC, 2020 a: 25; EMCDDA, 2009: 16; Pompidou Group Publication, title Benoit and Jauffret-Roustide, 2016: 26); v) interventions aimed at child-rearing adults -or adolescents- must encompass child-focused approaches and mainstream the best interest of the child; vi) simultaneously, child-focused interventions with children whose parents use drugs should consider family separation only as a last, extreme resort and provide programmes and services which are child-friendly, based on human rights and harm reduction as well as reduce criminalization and stigma of people who use drugs.

The terms child and children are used to refer to "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier", as defined by article 1 of the Convention on the Rights of the Child.

The term "drug use" is adopted here not to refer to all forms of drug use, but only to drug use disorders, based on the definition provided by WHO and UNODC *International standards for the treatment of drug use disorders*[4] (WHO and UNODC, 2020).

[2] In 2018, an estimated 269 million people worldwide had used drugs at least once in the previous year (range: 166 million to 373 million). This corresponds to 5.4 per cent of the global population aged 15–64 (range: 3.3 to 7.5 per cent), representing nearly 1 in every 19 people (UNODC, 2020: 10). Of these, 192 millions used cannabis, 58 millions used opioids, 27 millions amphetamines and prescription stimulants, 21 millions ecstasy and 19 millions used cocaine (UNODC, 2020: 17).

[3] Among the estimated 269 million people who used drugs in the past year, some 35.6 million people (range: 19.0 million to 52.2 million) are estimated to suffer from drug use disorders, meaning that their pattern of drug use is harmful, or they may experience drug dependence and/or require treatment. This corresponds to a global prevalence of drug use disorders of 0.7 per cent (range: 0.4 to 1.0 per cent) among the population aged 15–64 (UNODC, 2020: 11).

[4] "According to the 11th revision of the International Classification of Diseases (ICD) (WHO, 2019a) the term "drug use disorder" comprises two major health conditions: "harmful pattern of drug use" and "drug dependence". The harmful pattern of drug use is defined as a pattern of continuous, recurrent or sporadic use of a drug that has caused clinically significant damage to a person's physical (including bloodborne infection

Conversely, people who use drugs are referred here as people who are involved in "'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms' (EMCDDA, 2013 in EMCDDA 2015: 2).

The terms "drugs" and "substances" refer to substances controlled under the international drug control conventions and their non-medical use (UNODC 2020: 5), nicotine and alcohol, given that "that large numbers of parents with alcohol problems may generate more problems overall for children in the European Union than the smaller numbers of children affected by parents with illicit drug problems (EMCDDA, 2010: 30).

from intravenous self-administration) or mental health (such as substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others. Substance dependence is defined in ICD-11 as a pattern of repeated or continuous use of a psychoactive drug with evidence of impaired regulation of use of that drug which is manifested by two or more of the following: (a) Impaired control over substance use (including onset, frequency, intensity, duration, termination and context); (b) Increasing precedence of drug use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that drug use continues or escalates despite the occurrence of harm or negative consequences (including repeated relationship disruption, occupational or scholastic consequences and negative impact on health); and (c) Physiological features1 indicative of neuroadaptation to the substance, including: 1) tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; 2) withdrawal symptoms following cessation of or reduction in the use of that substance; or 3) repeated use of the substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms". "Disorders due to drug use" comprise a broader category of health conditions that include drug intoxication, withdrawal syndrome and a range of drug-induced mental disorders. Drug use disorders often go hand-in-hand with a significant urge to use psychoactive drugs, which can persist, or easily be reactivated, even after a long period of abstinence. Very often drug use disorders are associated with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence (WHO and UNODC, 2020: 4).

4. Legal framework on children in relation to parental drug use

Both in the questionnaires answered during the preliminary assessment as well as in the focus groups, countries shared that children whose parents use drugs are not usually named as a specific group -with the exception of Ireland through the Hidden Harm Strategy (illustrated further on)- but rather they are encompassed by a set of legislative measures focused on child protection -see the case of Iceland in this section-, domestic violence and family laws. In the sphere of drug policy, children are addressed mainly as potential users, hence from the prevention and treatment aspect, or as possible victims of incitation or exposure to drug use. Seemingly, the countries' legislation hold a human rights, age and gender perspective in their framing and implementation. However, the participants underlie the importance of distinguishing between the legal text -which can be impeccable- and the implementation gap.

Croatia

In the questionnaire presented for the preliminary assessment, Croatia reported that children whose parents use drugs are not identified as separate from other groups. Measures for children with parents who use drugs have been implemented within health and social care as regular operative measures. Applicable measures for parents with drug use disorders are stated in the family law and the social welfare legislation as well as in the law against domestic violence and in the Strategy for Children, which is protective of children in different spheres.

Separation from the family is applied in some cases as well as warnings in case of neglect and omissions of care. The fact that both parents or one parent is a person with a drug use disorder, however, does not automatically condition the restriction of parental rights, but requires effective supervision of the social welfare system. The National Drug Strategy focuses on prevention and treatment and children are protected by such measures.

In the focus group, the country's representatives reinforced how children whose parents use drugs are not identified as a particular group but rather they are protected from the intersection of various legislations. An interesting feature of the intervention is that the fact of not including children whose parents use drugs specifically is explained a means to avoid

any kind of discrimination against these children. This approach is presented as an issue of protection of personal data. Such focus is contrasted by Ireland and Cyprus' legal tools, by instance, and will be further discussed.

Cyprus

In the case of Cyprus, the informant previously provided a written response compiled by several professionals. In relation to the legal framework, the response from the country is that Cyprus' *National Strategy for Addressing Dependence 2021- 2028* is an integrated Strategy which addresses the use of licit and illicit substances and pathological gambling. It consists of the following pillars:

- Prevention;
- Treatment;
- Social reintegration;
- Harm Reduction;
- Supply Reduction;
- Research, Evaluation, Training;
- International Cooperation.

An objective in the Prevention Pillar is to identify vulnerable groups in different settings and provide multilateral support, according to the needs of each individual -such as psychological support, social support in the economic sphere or in the fields of education and health, leisure and sports activities and so on. More information on these programmes is provided in the sections on data and services. The National Strategy states which groups are considered vulnerable and the children whose parents use drugs are one of these groups[5].

[5] Other vulnerable groups according to the National Strategy are the following: school drop-outs; students that are experimenting with the use of substances/gambling; children whose parent/s are imprisoned; children whose parents face mental illness; children who faced/ are facing any form of abuse; children under the custody of the State; immigrant children/teenagers, children/teenagers with delinquent behaviour; children living in poverty; children with ADHD and other learning difficulties; pregnant women who use alcohol and/or other substances; unemployed and seniors vulnerable for pathological gambling.

Iceland

The country's Child Protection Act (Ministry of Welfare, 2002) does include children affected by parental drug use. The following articles reflect the current measures outlined in the legal text:

Art. 16. *Public duty of notification.*

[All persons shall be obliged to notify a child protection committee if they have reason to believe that a child:

a. is living in unacceptable circumstances of upbringing,

b. is exposed to violence or other degrading treatment or

c. is seriously endangering his/her health and maturity.

Furthermore, all persons are obliged to notify a child protection committee if there is reason to believe that *the health or life of an unborn child is being endangered due to the unacceptable or dangerous life-style of an expectant mother, e.g. in the form of alcohol abuse or the consumption of drugs, or when an expectant mother is exposed to violence, or if there is reason to suspect that an expectant mother is exposed to violence, or of any incidents which may be regarded as falling within the child protection committee's concerns*.]

Article 17. *Duty of notification by those who deal with children.*

[All persons involved in matters concerning children or expectant mothers, through their position or occupation, are obliged to notify a child protection committee, if they become aware of circumstances as described in Article 16.]1)7

Pre-school heads and teachers, child-minders, school heads, teachers, clergy, physicians, dentists, midwives, nurses, psychologists, social workers, developmental therapists, [career councelors]1) and those providing social services or counselling are under an especial obligation to monitor the behaviour, upbringing and conditions of children as far as possible, and to inform the child protection committee if the child's circumstances appear to be of the nature described in the first paragraph.

The duty of notification provided in this Article takes precedence over provisions in law or codes of ethics on confidentiality within the relevant professions.

Article 18. *Police duty of notification and questioning of children.*

[If the police become aware that a child is in circumstances as described in Article 16, they shall notify a child protection committee. When there is a suspicion that a child has committed, or has been the victim of, an offence under the General Penal Code or under this Act, or an

offence under another act that may entail a punishment of more than two years' imprisonment, the police shall, as soon as it receives such a case for treatment, notify a child protection committee and give it the opportunity to follow the investigation of the case.]1) The child protection committee shall notify the parents of the child in such a case, unless the interests of the child make this inadvisable.

[A representative of a child protection committee shall be given the opportunity of being present at the questioning of a child suspected of having committed a criminal act, in accordance with the Code of Criminal Procedure, and of a child who is a victim or witness. This shall apply both to questioning by the police and by a court. Other matters regarding the taking of testimony from children shall be subject to the provisions of the Code of Criminal Procedure and regulations issued thereunder.]2)

1) Act No. 80/2011, Article 9. 2) Act No. 52/2009, Article 2.

Art. 29. *Loss of custody.*

A child protection committee may take court action for a parent or parents to be deprived of custody if the committee believes:

[…]

d. that it is certain that *the child's physical or mental health or his/her maturity is at risk because the parents are clearly unfit to have custody, due for instance to drug use*, mental instability or low intelligence, or that the behaviour of the parents is likely to cause the child serious harm.

Deprivation of custody shall only be requested if it is not possible to apply other and lesser measures for improvement, or if such measures have been tried without acceptable results.

Art. 82. *Rights of the child and coercive measures.*

[…] The Minister shall issue regulations on receipt of proposals from the Government Agency for Child Protection:

[…]

b. *which aim to prevent alcohol, drugs and other dangerous substances being brought into the home*

[…]

In the focus group, the participants from the Government Agency for Child Protection underlined that such provisions set the basis for good statistical information, which will be

discussed later. Also, they pointed out that besides the national law there are national and local action plans aimed at protecting and guaranteeing children's rights.

Ireland

Ireland's representative shared that the establishment of the Department of Children and Youth Affairs[6] has had a really strong effect on placing an emphasis on children's wellbeing. The creation of the Department implied the development of a National Strategy for Children[7] which included the participation of 64,00 children for them to convey what mattered to them.

In terms of services, the institution in charge of providing funding, guidelines, policy tools and services themselves is the Child and Family Agency, Tusla. As reported in agency webpage[8], "on 1st January 2014 the Child and Family Agency, Tusla, became an independent legal entity, comprising HSE Children and Family Services, the Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender-based violence. The Child and Family Agency is now the dedicated State agency responsible for improving wellbeing and outcomes for children. It represents the most comprehensive reform of child protection, early intervention and family support services ever undertaken in Ireland. The Agency operates under the Child and Family Agency Act 2013, a progressive piece of legislation with children at its heart and families viewed as the foundation of a strong healthy community where children can flourish. Partnership and co-operation in the delivery of seamless services to children and families are also central to the Act".

In terms of alcohol and other drugs, the National Drug Strategy was written in partnership between, among others, the police, the Department of Justice, Customs, the Department of Education, the Department of Children and Youth Affairs and civil society organisations. The inclusion of people who use drugs and families in the drafting of the strategy is reported as particularly significant. The strategy's full name is *Reducing Harm, Supporting Recovery.*

[6] https://www.gov.ie/en/organisation/department-of-children-equality-disability-integration-and-youth/.
[7] Information available at https://www.gov.ie/en/organisation/department-of-children-equality-disability-integration-and-youth/.
[8] https://www.tusla.ie/about/.

A health-led response to drug and alcohol use in Ireland 2017-2025[9] and encompasses psychoactive drugs and alcohol in one document, based on the recognition of the issue of substance misuse in the country and that alcohol is part of it, thus being the first drug and alcohol integrated strategy. Its core values are i) compassion; ii) respect; iii) equity; iv) inclusion; v) parternship; and vi) evidence-informed. The strategy's vision departs from a criminal law towards a health-led approach to drug use.

Goal 1 of the Strategy is "Promote and Protect Health and Wellbeing". Objective 1.3 states "Develop harm reduction interventions targeting at risk groups". One of these groups is "Children at risk", which includes children exposed to parental drug misuse, young people with substance use problems and young people leaving care and detention services. Children whose parents use drugs are identified as a group at risk of experiencing more physical, psychological and emotional harm than those whose parents do not use alcohol or drugs, although it is also recognised that not all children living in families with substance misuse experience harm as a result. Therefore, it is argued for a coordinated response from services (Department of Health, 2017: 28).

Strategic action 1.3.9 "Mitigate the risk and reduce the impact of parental substancemisuse on babies and young children" outlines the following actions: a) Developing and adopting evidence-based family and parenting skills programmes for services engaging with high risk families impacted by problematic substance use; b) Building awareness of the hidden harm of parental substance misuse with the aim of increasing responsiveness to affected children; c) Developing protocols between addiction services, maternity services and children's health and social care services that will facilitate a coordinated response to the needs of children affected by parental substance misuse; and d) Ensuring adult substance use services identify clients who have dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector.

[9] Available at https://www.drugsandalcohol.ie/27603/1/Reducing-Harm-Supporting-Recovery-2017-2025.pdf.

This strategy is intimately connected to the Hidden Harms Strategy[10] (Tusla and HSE, 2019) on drugs and alcohol, developed by the Child Protection Agency -known as Tulsa[11]- which is a cross-department and independent legal entity and the Health Service Executive (HSE). Hidden Harms is the terminology used to name the impacts of parental drug misuse on children, on the one hand, and the lack of identification of these children by services, on the other. This document is particularly relevant to this project and is presented in Box 1.

Box 1. The Hidden Harm Strategy, Ireland

A stated in the Foreword of the Hidden Harm Strategic Statement (Tusla and HSE, 2019):

> The experience of children living with, and affected by, parental problem alcohol and other drug use has become widely known as Hidden Harm. The term Hidden Harm encapsulates the two key features of that experience: those children are often not known to services; and that they suffer harm in a number of ways as a result of compromised parenting which can impede the child's social, physical and emotional development. The key to the success of Hidden Harm work will be both the willingness and capacity of all services to work in a collaborative fashion.

With this in mind, the statement[12] is intended to bridge the gap between adult and children's services in favour of a more family-focused approach that considers the needs of dependent children and other family members (Tusla and HSE, 2019: 18). It is produced by the Child Protection Agency and the Health Service Executive (HSE) Drug and Alcohol Services.

Given the link between problem alcohol and other drug use and mental health problems, partnership between Mental Health services, Drug and Alcohol services and child protection and welfare services is paramount in the support and safeguarding of children, and the treatment of parents with alcohol and other drug problems.

[10] Available at https://www.tusla.ie/publications/hidden-harm/.
[11] Avaibalble at https://www.tusla.ie/.
[12] Hidden Harm is included as a theme within *Better Outcomes Brighter Futures: The National Policy Framework for Children and Young People 2014-2020* (Department of Children and Youth Affairs, 2014).

The Strategic Statement also applies to all voluntary and community groups funded by Tusla and HSE and are inclusive of the Drug and Alcohol Task Forces and their funded projects. It is also relevant for all agencies supporting children and families experiencing problems associated with parental alcohol and other drug use.

The statement is built on the recognition of the importance of an interagency approach, as well as the need for consistency in processes, protocols and delivery of services.

Based on the above, some of the key features and objectives of the Strategic Statement are:

- **Naming** Hidden Harm as a key risk factor in all the work with children and families in both Tusla and HSE and statutory voluntary and community partners.
- **Process and practice shifts** by Tusla, the HSE and voluntary and community funded services, to identify and meet the needs of children and of adults in their parenting roles.
- **Shared training** to skill all practitioners within Tusla and HSE and voluntary and community- funded services to work within a new framework of care to identify and meet the needs of children affected by parental problem alcohol or other drug use.
- Advance a **coherent continuum of support** for children and families impacted by parental problem alcohol and other drug use and improve timely access to local supports.
- Support **national screening and brief intervention**, including screening for maternal alcohol consumption.
- **Identify tools in screening and assessing parenting capacity** when problematic alcohol and other drug use is an issue in the home.
- **Utilise existing models of evidence based practice** developed by Tusla and the HSE to address Hidden Harm inclusive of Meitheal[13], Signs of Safety and the SAOR model.

[13] Meitheal is the Tusla-led Early Intervention Practice Model to ensure that the needs and strengths of children and their families are effectively identified and understood and responded to in a timely way so that children and families get the help and support needed to improve child outcomes and to realise their rights. Sign of Safety is internationally recognised as the leading participative approach to child protection casework. The SAOR (Support, Ask and Assess, Offer assistance and Reference) model facilitates screening and brief intervention (Tusla and HSE, 2019: 9 &11).

- **Recognise and implement role clarity**, supporting complementary practice and mutual understanding of each other's roles.

The overarching principles of the Strategy include listening to children and families in planning, design, development, delivery and evaluation of services, partnership as an essential element and hidden harms as a national priority. Joint working[14] with key partners and external stakeholders is necessary to advance actions on Hidden Harm across the life span of the child and across levels of need.

The Strategic Statement is completed by a Hidden Harm Practice Guide (Tusla and HSE, 2019 a). The guide is meant to be used in the training of practitioners and to support the development of joint working between HSE Drug and Alcohol Services and Tusla Child welfare and protection services on Hidden Harm (Tusla and HSE, 2019 a: 15):

> In essence the Practice Guide is concerned with developing practice to enhance children's safety and well-being by:
> • Promoting **early identification and intervention** at every level by all relevant agencies in order to reduce risk to a child or young person.
> • Promoting **a 'whole-family' approach** to care and provision of services.
> • **Focusing on the care of children and families who have unmet needs**: where there are concerns about the health or wellbeing of the child/unborn child or young person, and where these are linked to the impact of parental problem alcohol and other drug use on parenting capacity.
> • **Providing information on mutual roles and responsibilities of practitioners** across services working in this area. Thus, staff working in the area of problematic alcohol and other drug use and child welfare and protection are clear about what is expected of them, separately and together, in the context of Hidden Harm.
> • **Supporting and maintaining the focus on multi-agency and joint working** amongst professionals involved in the support and care of children and families affected by parental problem alcohol and other drug use.

[14] Joint working is a term used in the Statement to denote where more than one agency works together in a planned way. 'Agency' refers to the range of organisations who support children and their parents, families and communities and who are named in this Practice Guide (Tusla and HSE, 2019: 9).

Tusla and HSE have designed tools to disseminate and train practitioners on Hidden Harms and the use and implementation of the strategy and the practice guide, such as e-learning and in person workshops. However, as reported in the national focus group hosted in April, COVID-19 related activities and lockdowns have slowed the pace or practically impeded the full reach of the training process.

There is a general acknowledgment that there is an implementation gap and the Hidden Harm strategy has not completely permeated at the local level yet.

Italy

Italy also counts on good legislation regarding children, although implementation is not uniform throughout the country. Seemingly to other countries, Italy has laws that protect and support children, particularly the 1997 "Provision for the Promotion of Rights and Opportunities for Children and Adolescents", which encompasses all the rights of these populations. One of the principles of this law is that children should not be removed from their families, but rather that families should be supported to guarantee an improvement of the general living conditions of the children's environment.

2011 a pilot project began, called "P.I.P.P.I", an acronym for Program of Intervention for the Prevention of Institutionalization of Children[15]. On the objectives of the program is to innovate the interventions carried out in families where child neglect occurs, in order to reduce the risks of child maltreatment and the subsequent separation of the children from their family nucleus.

Subsequently, in 2017, the Ministry of Social Services and Labour issued the guidelines *The intervention with children and families in vulnerable situations* (Ministero del Lavoro e delle Politiche Sociali, 2017), which envisage actions, provisions and models in order to support families and children. The guidelines include provisions on families with dependent drug use, specifically the drafting of Memorandum of Understanding (MoU) between services for

[15] Information available at https://www.minori.gov.it/it/il-programma-pippi.

children and services for adults, particularly with regards to mental health and drug abuse prevention and treatment in order to act cooperatively and provide a full-range support to families.

Local services are usually provided by municipalities in a coordinated way with different actors and services, as it will be deepened further on in this document.

San Patrignano's representative shared with PG an example of the MoU, which is described in Box 2.

Box 2. Example of MoU, Italy

The MoU shared by the participant is based in the Italian region Emilia Romagna, specifically in the provinces of Rimini and Riccione.

The document states that one reason for paying attention to the importance of integrated work between services is the awareness of the need that children have of the relationship with their parents. Therefore, child protection needs to incorporate the protection of such link, even more so when pathologies occur.

The document refers to "multi-problematic family" as those families in which more than one member presents physical, psychological and social disturbs. It is also defined as such when its members establish multiple contacts with several social and health services.

There is a recognition that services usually work with the individual, and that there is a need for integrated work with multi-problematic families. The MoU explains that to act in response to the complexities of such families requires:

- To build a project that takes into account and is built on the needs of each member of the family;
- To define a priority in relation to the needs of the weaker subjects;
- To build a project that defines and activates the roles of each operator in relation to the subject's needs;

- The activation of the project.

The MoU is considered as a strategic means of work and integration aimed at improving the life of the people reached by the services.

The document presents different forms of cooperation between the agencies responsible for primary health care and, within that, the Operative Unity of Pediatrics, Psychology and Child Protection. The Child Protection area of the Unit consists of social workers, educators and psychologists and is concerned with the psychosocial protection of children (0 to 18 years old) through socio-assistance, psychological and educational interventions. It also works closely with judicial authorities. Among the services provided there are:

- Socio-economic help to families;
- Socio-educational interventions with children and families;
- Monitoring in cases of risk for children;
- Monitoring of children in conflict with the law;
- Support and guidance in adoption and foster care processes.

The Department of Mental Health and Pathological Dependences includes an Operative Unit for Pathological Dependences (SERT) which guarantees prevention, treatment and care of drug use disorder and other compulsory behaviours.

The MoU sets the basis and the steps for these services to work collaboratively, in an integrated way, specifically between the Operative Unit on Pathological Dependences and the Child Protection Area. It outlines how both agencies can consult each other in the cases of children with families affected by drug use disorder as well as when children use drugs themselves. It provides the steps to be followed and the formats to be used.

The collaboration implies identification of the case, communication between agencies, referral and cross-referral as well as joint working -depending on each case- through an appointed person -and a substitute- which acts as a bridge between the agencies and guarantees the articulation of services. The appointed professional will also monitor the

development of the project and suggest modifications, if needed. Depending on the type of cooperation, only one or both agencies will have the direct contact with the user.

As part of the final remarks, the document underlies that such MoU aims at structuring services that address multi-problematic families, thus avoiding fragmentation and allowing each service to reach the users. However, it is indicated that its implementation finds several barriers, among them i) specific institutional areas of work and its interpretation as limitative; ii) lack of resources and iii) operators' turnover. Furthermore, the formats included in the MoU are not always used or are employed mainly by the Child Protection Service than the other areas involved, thus indicating a sub-use of the Protocol and a lack of integrated approach.

Naming is an essential part of identifying a situation or, in this case, a specific group of people. In order to reach children impacted by parental drug use disorders and to support families, the first step is to name children whose parents use drugs as a group *per se*. The examples provided in the previous pages show the importance of visibilizing children exposed to parental drug use, on the one hand, and lack of integrated services, on the other, in a way that fosters i) data gathering; ii) integrated policy interventions at the local level based on articulation and cooperation between agencies and with civil society and families; iii) early detection and interventions; iv) children's participation and v) the support of families as a means to reduce family separation and the institutionalisation of children.

This next section reflects the countries' experiences in terms of the quantitative dimension of the phenomenon.

5. Data gathering

Counting children is an indispensable pre-assumption for making children count. In the focus groups, countries agree that there is a lack of integrated quantitative information on children whose parents use drugs.

The Demand Treatment Indicator (TDI hereinto) (EMCDDA, 2012) currently represents the best source of information. However, it is limited to people who actually seek treatment and reports on how many adults have children, but does not necessarily inform on the number of children or their situation. In some countries, such as Mexico and Iceland, information on the age and gender of children is also included. However, personal data can only be obtained with parental authorization.

As informed by the European Centre on Drugs and Drug Addiction (EMCDDA, 2012 a: 14) "No precise information is available on how many drug users live with children in Europe. The only data that are available concern drug users entering treatment. This population, however, is only a partial representation of all drug users who live with children, and not all countries in Europe collect this information".

The following charts -reproduced from the previous report and based on EMCDDA's Statistical Bulletin 2020- transcribe the data reported in the section "Treatment"/Living with children" and reflect the absolute numbers of people living with children, first in cumulative terms and then separating male and female.

Table 1. Total of people in treatment living with children, all drugs

Country	Year of Treatment	Not living with children	Living with children	Not known / missing	Total
Austria	2018	581	361	30	972
Belgium *	2018	8700	2244	943	11887
Bulgaria	2018	1368	316	240	1924
Croatia *	2017	5149	1393	615	7157
Cyprus	2018	185	119		304
Czechia	2018	456	319	36	811
Denmark	2018	4443	594	2240	7277
Estonia	2016	239	37	14	290
Finland	2018	549	85	42	676
France	2018	7661	6729	1183	15573
Germany	2018	29316	5274	5652	40242
Greece	2018	188	176	3334	3698
Hungary *	2013	417	991	2577	3985
Ireland	2018	8119	1350	430	9899
Italy	2018	322	769	14371	15462
Latvia	2013	482	292	769	1543
Lithuania	2018	383	166	756	1305
Luxembourg	2018	276	22	8	306
Malta	2018	1577	308	13	1898
Netherlands	2015	6388	1153	3446	10987
Norway					
Poland	2018	1066	801	137	2004
Portugal	2018	2893	566	2	3461
Romania	2018	315	394	371	1080
Slovakia	2018		393		393
Slovenia	2018	43	26	0	69
Spain	2017	11725	8165	337	20227
Sweden *	2018	151	18	4	173
Turkey	2018	1220	2242	7867	11329
United Kingdom	2018	82017	21505	11230	114752

Source: EMCCDA, Statistical Bulletin 2020- treatment demand-living with children-all drugs-total, https://www.emcdda.europa.eu/data/stats2020/tdi_en.

Table 2. Male people in treatment living with children, all drugs

Country	Year of Treatment	Not living with children	Living with children	Not known / missing	Total
Austria	2018	450	236	21	707
Belgium *	2018	6852	1530	766	9148
Bulgaria	2018	642	166	133	941
Croatia *	2017	4398	997	497	5892
Cyprus	2018	158	97		255
Czechia	2018	291	153	20	464
Denmark	2018	3463	437	1800	5700
Estonia	2016	198	23	10	231
Finland	2018	396	53	29	478
France	2018	6242	4638	911	11791
Germany	2018	24458	3618	4684	32760
Greece	2018	160	132	2882	3174
Hungary *	2013	307	802	2253	3362
Ireland	2018	6266	771	309	7346
Italy	2018	267	630	12190	13087
Latvia	2013	398	173	631	1202
Lithuania	2018	298	118	660	1076
Luxembourg	2018	208	11	6	225
Malta	2018	1309	236	11	1556
Netherlands	2015	5189	824	2820	8833
Norway					
Poland	2018	857	553	119	1529
Portugal	2018	2567	444	2	3013
Romania	2018	249	324	333	906
Slovakia	2018		281		281
Slovenia	2018	30	18	0	48
Spain	2017	9363	6507	181	16051

Sweden *	2018	89	10	4	103
Turkey	2018	1127	2186	7502	10815
United Kingdom	2018	64726	14872	8468	88066

Source: EMCCDA, Statistical Bulletin 2020- treatment demand-living with children-all drugs-total, https://www.emcdda.europa.eu/data/stats2020/tdi_en.

Table 3. Female people in treatment living with children, all drugs

Country	Year of Treatment	Not living with children	Living with children	Not known / missing	Total
Austria	2018	131	125	9	265
Belgium *	2018	1828	711	173	2712
Bulgaria	2018	146	87	16	249
Croatia *	2017	751	396	118	1265
Cyprus	2018	27	22		49
Czechia	2018	165	166	16	347
Denmark	2018	980	157	440	1577
Estonia	2016	41	14	4	59
Finland	2018	153	32	13	198
France	2018	1419	2091	272	3782
Germany	2018	4847	1654	964	7465
Greece	2018	28	44	452	524
Hungary *	2013	108	176	290	574
Ireland	2018	1846	575	119	2540
Italy	2018	55	139	2181	2375
Latvia	2013	84	119	138	341
Lithuania	2018	85	48	96	229
Luxembourg	2018	67	11	2	80
Malta	2018	268	72	2	342
Netherlands	2015	1199	329	626	2154
Norway					
Poland	2018	208	247	18	473
Portugal	2018	326	122	0	448
Romania	2018	66	70	38	174

Slovakia	2018		112		112
Slovenia	2018	13	8	0	21
Spain	2017	2353	1650	156	4159
Sweden *	2018	62	8		70
Turkey	2018	93	56	365	514
United Kingdom	2018	17291	6633	2762	26686

Source: EMCCDA, Statistical Bulletin 2020- treatment demand-living with children-all drugs-total, https://www.emcdda.europa.eu/data/stats2020/tdi_en.

Table 1 shows that in all countries for which data are available, and with the exception of Italy, Hungary, Romania and Turkey, most people in treatment do not live with children -or do not disclose it-. The same result applies in the case of male people in treatment. When looking at female in treatment, again prevails the number of women not living with children or not reporting it. In Czechia, France, Greece, Hungary, Italy, Latvia, Poland and Romania women living with children outnumber those that are not. Although the number of women living with children (15,874) is lower than that of men in absolute terms (40,840), it is proportionally higher: 17.83 per cent of the total male population in treatment (229,040) lives with children, against 26.55 per cent of the total female population in treatment (59,784).

It is important to stress that in some countries, namely Greece, Hungary, Italy, Latvia, Lithuania and Turkey the number of cases in the category "not known/missing/" is higher than the sum of the categories "living with children" and "not living with children". In the case of Slovakia the information is incomplete and there are no data for Norway.

During the focus groups, the participants reported that, usually, the quantitative information on children is fragmented between services -drug treatment services, child protection services, local *vs* national agencies, hospitals and maternity units, etc.- and is not systematized in a unified way that permits to develop an estimate on how many children might be affected by parental drug use disorders, if and how they are reached by social services and, conversely, how many children under the care and protection of social services have family members that might cope with a risk drug use and require treatment.

Data gathering usually occurs in institutions which operate under different ministries and use different methodologies. Also, issues related to privacy emerge and need addressing in order to guarantee that the data are collected without putting the children at risk of stigmatization.

Romania, Turkey and Croatia point out that, in some cases, people who use drugs are afraid that they might lose custody and have their children taken away from them and thus choose to not disclose their parental status.

Generally speaking, the informants and the review of the information reported by EMCDDA under the Treatment Demand Indicator show that in the field of drug-related policies *there is not enough public information available to develop an estimate on how many children might be affected by hidden harms in its double meaning, that is, as a consequence of parental or family drug misuse or because they are not identified and reached by services.*

The lack of data gathering and reference and cross-reference between services is made up for at the local level, where information is collected and shared and local operators have a full grasp of the situations existing in the communities, but not necessarily uniformly across the national territory. Where the information is actually collected and integrated - such as in Cyprus- tailored public policies can be developed and implemented in specific territories addressing the communities' needs and realities.

In the next paragraphs, the experiences of Cyprus, Iceland, Ireland, Italy, Poland and Switzerland are reported.

Cyprus

In the case of Cyprus, data on whether people who use drugs have primary caregiving responsibilities are gathered through the above-mentioned Treatment Demand Indicator (TDI).

Another key source of information is the prevention programmes implemented at the local level by NGOs in coordination with local government and services and to which children whose parents are in treatment can be referred. More information on these programmes and their operation is provided in the section on services; however, in terms of data, it is important to share that they represent a source of information on whether the children participating in them have parents who use drugs or some other condition of vulnerability and also if they live with their parents, other family members or in state institutions. This information is reported to the National Addictions Authority of Cyprus (NAAC), which actually funds the programmes through a call for tenders. This implies that the NAAC gathers both the information on people in treatment with children and children whose parents use drugs participating in NAAC's funded programs at the local level, thus being able to cross it and derive a quantitative, socio-demographic and geographical picture of the problem.

Such information is used for several purposes: at the institutional level, it justifies the use of funds before the government and allows the support of the programmes themselves. It also supports the argument that government income produced by taxes on legal drugs are also used for prevention. Finally, and most importantly to the ends of this study, it underlies the development of evidence-based interventions that actually respond to the local dimension of the phenomenon. As shared by the participant as an example, in an area close to the capital, three villages presented a serious problem of drug misuse that had not been identified. NAAC started a project that began with social workers in schools because education centres did not know how to handle this growing problem of parental drug misuse in front of the children. Social workers could work with the children and the families and had a concrete impact on the situation. This is a described a lesson derived directly from data collection and analysis.

The sources of information reported here are not the only ones available in the country: maternity clinics and hospitals, by instance, also collect data on women who use drugs. However, the NAAC role in compilating the information both from treatment centres and prevention programmes stands out as a good practice of data integration and use for policy intervention.

Iceland

In the country there are 27 Child Protection Committees and each of them collects annually numerous data, including on children living with parents who use drugs or alcohol. During the focus group, it was reported that between 2019 and 2020 there was an increase of 27.5% of children with parents who use alcohol and other drugs. Notifications on neglect and violence also increased alarmingly during 2020 in the context of confinement due to the COVID-19 pandemic.

Subsequently, the informants shared by email the latest information available in English, which show that the first cause for report to Child Protection Committees in 2020 is suspect neglect (43.1%), followed by abuse (28.6%) and youth's risk taking behaviour (27.1%). It is important to point out that in 2018 and 2019, youth's risk taking behaviour represented the second cause of report. The increase in reports due to abuse might be linked to the pandemic and confinement.

Each category includes several forms of neglect, abuse and risk behaviour. The category of neglect contains "Parent's substance abuse" as one of its manifestations and it represents the second cause for report, after neglect in safety and care. This position is stable in the period 2018-2020.

Another source of information is nurses visiting new mothers who, by law, are also required to report to Child Protection Agency on the use of alcohol and other drugs. Prenatal care also is a source of information on drug misuse

In Iceland, information on unborn children can be reported to Child Protection Agency if the unborn is considered at risk. Therefore, the Child Protection Agency counts with multiple sources coming from hospitals, local committees, home visits and treatment centres.

While the Child Protection Agency has the right to access information gathered by other ministries and agencies, this does not happen the other way around.

On the drug policy side, treatment centres represent the main source of information, although this is not on children specifically, but on parental status: data is collected on whether people have children and the children's age. If parents do not finish treatment and there is a risk that he or she might go back to consuming, the case is reported to Child Protection Agency, thus avoiding that children "slip" through the services. Estimation shared in the focus groups refer that between 30 and 50 per cent of people entering the main national treatment centre have children under 18 years old living with them; that translates into about 1,000 children for the approximately between 1,600/2,000 people entering treatment annually.

It is important to point out that Iceland has a very low threshold for entering drug treatment: people who use drugs are generally perceived as patients by the health sector but also by the general population, thus reducing the risk of stigma and discrimination. Drug treatment services are accessible, available and free. Also, the law foresees that people who enter treatment are on sick leave and do not lose their job or income. The reduction of cultural, social and structural barriers to treatment are key factors for an early and opportune detection and follow-up of children with parents who suffer from drug dependence.

Nevertheless, despite the richness of multiple data gathering and the low barriers that people who use drugs face to actually disclose their parental status and receive support, one of the current gaps is the lack of integration of this information, mainly due to the fact that different institutions belong to different ministries, methodologies also differ and the implications of privacy law.

Ireland

Ireland recently changed and updated significantly its National Drug Treatment Reporting System[16] in 2015/2016. The form[17] included questions (see question 7) on children, collecting information on number of children per age range and situation of care: living with client; in care; living with other parent; living elsewhere; Living status not known.

[16] https://www.hrb.ie/data-collections-evidence/alcohol-and-drug-treatment/.
[17] Available at https://www.hrb.ie/fileadmin/user_upload/NDTRS_Data_Collection_Form_2018.pdf.

Italy

At the local level, the collaboration between social services and drug treatment services already pointed out on the legal aspects also leads to the sharing of information and data which permits to assess and address what families and children need support. Therefore, even if there is no national estimate on how many children are affected by parental drug use disorder, local actors do have a clear picture of the problematic in their territory.

Also, the informant pointed out in her written response that an online tool has been realized under the pilot project P.I.P.P.I.[18]: it is the RPM online -Report, Plan and Monitor-. Developed by the University of Padua. Through this method and tool, the operators can create a file for each child and upload and update information. In this way, the situation of the child and its surrounding can be understood and shared with the child, his or her family and the social actors involved. It sets the basis for the design and development of a collaborative plan of action which includes the participation of the child. Finally, it works as a monitoring and assessment tool. In order to be successful, each operator of the multidisciplinary team will have to connect and use the RPMonline, uploading and updating the information, following ethical standards[19]. The spreading and the use of this informatics tool could be of great help to develop child-centred interventions.

Poland

In Poland data are collected at the local level, by units dealing with dysfunctional families, by instance probation officers and family assistants. Every "voivodeship" -province- is obliged to do an annual assessment called "Social welfare resources assessment based on the social and demographic situation". These reports contain data on how many children were put into foster care due to parents' drug misuse and represent the largest and most updated source of data on children whose parents use drugs. However, such data are not

[18] More information in English on PIPPI can consulted at Francesca Santello, Sara Colombini, Marco Ius and Paola Milani, "P.I.P.P.I.: What has changed? How and why? The empirical evidence", *Rivista Italiana di Educazione Familiare*, n. 2 - 2017, pp. 111-136, https://www.researchgate.net/publication/345692648_PIPPI_What_has_changed_How_and_why_The_empirical_evidence.

[19] Information available at https://elearning.unipd.it/programmapippi/course/view.php?id=14.

collected nationally and reflect only severe cases of child neglect, where there is the need to separate children from their families.

Another important point underlined by the informant in her written response is that "because of the strong stigma around the drug use topic in Poland, most of the people who use drugs do not admit to it, especially when he or she is a parent. Fear of losing custody of their children because of drug misuse discourages potential respondents and it's making collecting such data almost impossible".

Therefore, what we witness in Poland is a triple challenge: in the first place, quantitative information is available only for severe cases; second, such data are not unified at the national level but only exist at the local level; finally, people who enter treatment are discouraged from revealing chid-caring responsibilities because of the fear of losing custody.

Switzerland

Switzerland did not participate in the focus groups but provided PG with information based on a collective reply to the questions. In regard to quantitative information, the answer indicates that "the amount of children affected by parents who use drugs can only be calculated through responses of parents on consumption and their information given on family-composition. There is no systematic survey addressing the question to kids themselves".

According to the last data of the Federal Office of Public Health, in Switzerland , 5.8 per cent of children aged under 15 live in a family where one or both parents show heavy alcohol consumption. 31.3 per cent are raised in an environment where the parents consume products containing nicotine (e.g. tobacco products, e-cigarettes) on a daily basis. The proportion of children whose parents make heavy consumption of illegal drugs (e.g. cannabis, cocaine, heroin) is low (1.8 per cent). "Illegal drug using parents", in this case, are defined as people consuming ecstasy, heroin or other drugs within the last 12 months, cocaine within the last 30 days or cannabis multiple times a week. Cannabis

excluded, the number shrinks to 0.5%. Further results on the subgroup of parents who use illegal drugs show that single-parent-families and people with lower incomes are disproportionately affected by illegal drug use[20] (Hümberlin *et al*, 2020). Some children's parents show multiple heavy substance consumption. This is the case, in particular, with alcohol and nicotine (1.9 per cent) [21].

The country also collects data based on the project Act-*Info*[22], which is a monitoring network combining five different questionnaires on drug treatment (outpatient, stationary patients, opioid substitution therapy and heroine prescription) and dependence for drug-related problems -including alcohol-, thus providing a national data bank As it is pointed out in the responses to the questionnaire for the focus groups "there are no questions being asked, however, on primary care-giving-responsibilities within the monitoring. By adding it to the questionnaires, further data could be generated on the topic. The monitoring act-*Info* does not include all institutions of therapy in Switzerland. Hence, the dataset could be improved by adding more institutions to it. An institution-survey is being done every year, to calculate the coverage of the monitoring-network and to estimate the amount of people in drug-related-treatments all over Switzerland[23]. Those estimations of people in treatment for drug use could be combined with the indications on children and family situation, to make a new, more "problem-focused" estimation of the number of "children whose parents use drugs" in our country".

[20] Information available at https://www.bag.admin.ch/bag/de/home/das-ag/publikationen/forschungsberichte/forschungsberichte-sucht.html#accordion_1873774968161395617 4449.
[21] Information available at https://www.obsan.admin.ch/en/indicators/MonAM/children-families-heavy-substance-consumption-age-0-14.
[22] Information available at https://www.addictionsuisse.ch/recherche-scientifique/act-info/
[23] Information available at https://www.suchtschweiz.ch/fileadmin/user_upload/DocUpload/BAG_act-info-2018_D.pdf.

6. Law enforcement in the sphere of drug policy

As it has been remarked, the impacts of stigma and the risk of criminalisation constitute objective and, sometimes, insurmountable barriers for people who use drugs and have children and might prevent them from seeking help, thus endangering their health and, sometimes, that of their children and families. Therefore, the development of a health-based approach to drug use, on the one hand, and interventions in the criminal justice system, on the other, are both essential and complementary for guaranteeing that people who have a drug use disorder feel safe to disclose it and that the apparatus that receives them is capable of properly addressing not only the drug use but also the parental responsibilities.

The United Nations Conventions on Drugs[24], while establishing the basis for criminal sanctions for people who possess drugs, also envisage the referral of people who use and possess drugs for personal consumption to measures such as treatment, education, aftercare, rehabilitation and social reintegration, i.e. rehabilitative rather than deterrent or retributive responses in addition to or as substitution of a criminal sanction. Such provisions are outlined in article 36 (b) of the Single Convention as amended and article 3.4.(d) of the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

The European Drugs Strategy 2021-2025 includes in Strategic Priority 7 "Risk- and harm-reduction interventions and other measures to protect and support people who use drugs" as priority area to address number 4 "Provide alternatives to coercive sanctions" (Council of the European Union, 2020):

> 7.4 Although all Member States employ at least one alternative to coercive sanctions, for drug-using offenders and for people arrested, charged with or convicted for drug-related offences or people found in possession of drugs for personal use, stepping up efforts and mainstreaming the implementation of effective measures should be progressed. In this regard, drug consumption and/or drug possession for personal use or possession of small amounts do not constitute a criminal offence in many Member States, or there is the option to refrain from

[24] The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

imposing criminal sanctions. More comprehensive and in-depth data and exchange of best practices between Member States is needed in this area.

As analysed in the EMCDDA report *Alternatives to punishment for drug-using offenders* (EMCDDA, 2015), based on the options provided by the international drug control legal framework, the rehabilitative measures of treating, educating or reintegrating drug users as alternatives or additions to conviction or punishment are established in the laws of many countries in Europe today. These include a wide span of provisions that address different needs and are aimed at a variety of target groups and at different stages. The measure may be given by a court, the prosecution, or the police and may be available for people on remand or also those already convicted. It can encompass educative and prevention measure for non-dependent drug users, while focusing on treatment interventions for people who suffer from dependence. Referral to treatment can be added to or substitute an administrative or penal sanction and completition of the program can be a requisite to dismiss the criminal case. Treatment can be offered and voluntarily accepted or be imposed as quasi-compulsory, representing a pre-condition for being diverted from the criminal justice system and the elimination of a criminal record.

The stage at which alternatives are implemented, the target population, referral mechanisms and the procedures depend on each country's legal framework, the police and prosecutors discretional powers but also on the cultural sensitivity and social attitute towards people who use drugs, since these will influence the actions and decisions of prosecutors, courts and treatment services. The lower the stigma attached to people who use drugs and the higher the health-based approach, the more likely alternatives to punishement and conviction are to be implemented, even in the cases where drug possession constitutes a criminal offence or derives into an administrative sanction.

It goes beyond the scope of this report to look into the nuances of alternatives to the criminal justicie system or imprisonment; however, it is important to stress that usually their design and implementation pursue objectives that do not include parental responsibilties and children's rights.

As pointed out by the EMCDDA (2015: 2) report:

> These alternatives or additions to punishment or coercive sanctions may be implemented to solve a variety of problems at different levels. The first is at the level of the individual -to deliver a proportionate response to an offence, to treat addiction and reduce the stigma attached to it. The second is at the level of society -to reduce drug-related crime such as acquisitive crime, as treatment has been shown to be effective at reducing such crime (Holloway et al., 2008), or to reduce disease transmission and other public health and societal harms. And the third is at the level of state structure -to reduce the pressure on the criminal justice system and the resources used by courts and prisons. The objectives of the policy can therefore be manifold.

The study does not refer parental or primary caregiving responsibilities as a factor to be considered when imposing an alternative to punishment; the information provided by the focus groups also leads to the conclusion that having children is not an aspect included in the administrative or criminal measures regarding people who use drugs and are accused of a civil or criminal act related to their drug dependence or use. On the contrary, some interventions in the criminal justice realm and in the case of activities related to drug supply, can take into consideration caregiving responsibilities as a mitigating factor when handing down a sentence, deferring or suspending it or opting for home detention or other alternatives to imprisonment in the case of people who are primary or sole caregivers of small children, with such measures usually focusing on pregnant women and women who are mothers.

The next charts indicate the number of drug-related offences in 30 European countries, and the absolute numbers of offences related to use and supply[25].

[25] As explained in the EMCCDA page "Methods and definitions" (https://www.emcdda.europa.eu/data/stats2020/methods/dlo), "Reports of offences against national drug legislation (use, possession, trafficking, etc.) reflect differences in law but also the different ways in which the law is enforced and applied, and the priorities and resources allocated to specific problems by criminal justice agencies. In addition, information systems on drug law offences/offenders vary considerably between countries, especially as regards recording procedures, definitions and statistical units (see below). The term 'reports for drug law offences† covers different concepts, varying between countries. Drug law offences usually refer to offences such as drug production, trafficking and dealing as well as drug use and possession for use. Although

Table 4. Drug law offences, total number of offences

Country	2018	2017	2016	2015	2014	2013	2012	2011	2010
Austria	47880	42610	36235	32907	30250	28227	23797	25892	23853
Belgium	54749	51774	49416	47083	48727	42935	39181	41661	39307
Bulgaria	2382	2433	4886	4195	9340	9521	8322	6167	6577
Croatia	11179	11353	11551	9551	9999	8229	7295	7767	7784
Cyprus	1168	945	895	948	1082	996	1030	936	851
Czechia			5564	5549	7438	6803	5317	5003	4200
Denmark	29139	26717			26290	24058	21498	21211	17825
Estonia	4505	5809	5653	4982	4162	4538	4616	3821	2977
Finland	29176	27680	25075	23399	21781	22636	20153	20469	19783
France	223509	223509	218731		216110				157341
Germany	344947	325102	302594	292227	282177	253525	237150	236478	231007
Greece		17995	17741	23748	22422				
Hungary	8591	6959	6473	6617	6487	5545	5219	5989	5789
Ireland	18346	16880	16119	15119	15895	15328	16117	11250	12119
Italy *[26]	75023	73804	65679	61145	62845	65839	73527	76891	79245
Latvia	4445	5173	6488	7521	6244	6554	10215	9240	7864
Lithuania	3218	2622	2288	2524	2730	2354	3006	2258	2220
Luxembourg	2284	2525	2624			2069	1802	2225	2546
Malta	626	739	775	472	537	429	403	388	445
Netherlands	18064	18687	21118	20503	21387	17130	18200	17420	14905
Norway	31633	33585	36184		48152	48428	45070	42101	44741
Poland	30873	32600	31008	30638	29060		76239	74535	72375
Portugal	12901	16970	17073	16102	14105	14288	14779	13076	13635
Romania	8487	4952	4002	4224	2407	2459	2872	3456	3852
Slovakia		1692		969	1147	1191	1214	1204	1135
Slovenia			4235		4519	5329	5392	5616	4174
Spain	395233	389229	405348						
Sweden	106521	100447	90883	94035	95324	99175	97379	91997	90070
Turkey	144819	118482	81222	73017	77664	98933	83133	67099	81960
United Kingdom		108033	106862	115377	128260	139803	144434	154212	152451

Source: EMCCDA, Statistical Bulletin 2020- Drug law offences, number of offences, https://www.emcdda.europa.eu/data/stats2020/tdi_en.

in some countries, drug use and/or possession for use are not considered as criminal offences and attract administrative sanctions, reports for these were included in the data presented here".

[26] Offenders instead of offences.

Table 5. Drug law offences by type: use

Country	2018	2017	2016	2015	2014	2013	2012	2011	2010
Austria					28067	25348	20554	21884	20306
Belgium	40688	38573	35847	33782	35320	30312	26500	26447	23458
Bulgaria					5432	5249	4906	3716	4077
Croatia	8903	8874	8722	6709	7292	5546	5189	5269	5132
Cyprus	1008	811	737	802	917	816	854	792	669
Czechia			881	856	2836	2600	1911	1544	1364
Denmark	22243	20672	16704		21412				
Estonia	3020	4289	4352	3633	2862	3619	3842	2999	2278
Finland	19286	17315	15715	15170	13681	12738	11308	12121	12185
France	161000	164113	159702	166390	176652	170337	161325	157024	135447
Germany	274787	255344	231926	213850	209514	189783	173337	170297	165880
Greece		13693	13213	17386	16872				
Hungary	7018	5587	5219	4985	2425	4868	4584	5231	4952
Ireland	13415	12211	11486	10972	11274	11188	11625	7731	8304
Italy	39278	38614	32687	33427	33371	33509	39993	41796	42120
Latvia	2098		5289	6017	5291	5621	5439	4692	3520
Lithuania	2403	2045	1590	1682	1543	1411	1258	1240	1318
Luxembourg	1541	130	354			1015	1068	1218	2382
Malta	498	623	627	359	407	322	254	259	285
Netherlands									
Norway	17060	17494	19686		24671	25310	23467	22116	22787
Poland	27915	29159	27460	27133	25274		50614	50086	46847
Portugal	10445	12232	10765	10380	9059	8729	8573	6898	7315
Romania-B					13	58	61	59	76
Slovakia	490	898		416	565	537	626	626	629
Slovenia			3730		4069	4010	3606	3691	3707
Spain	381100	376271	392900	390843	398422	397713	370848	391649	336308
Sweden [27]	45771	91284	82943	84494	84575	84656	82768	80919	79134
Turkey	112113	91876	61962	54972	60447	81363	71734	58204	72826
United Kingdom		80974	67490	73180	82762	89322	93077	100722	98304

Source: EMCCDA, Statistical Bulletin 2020- Drug law offences, number of offence, offences by type, use https://www.emcdda.europa.eu/data/stats2020/tdi_en.

[27] Sweden: in 2018, cases of use-related offences were reported in the drug related "use and supply" category.

Table 6. Drug law offences by type: supply

Country	2018	2017	2016	2015	2014	2013	2012	2011	2010
Austria					2173	2128	1949	2245	2112
Belgium	11756	11130	11503	11269	11248	10468	10603	12985	13166
Bulgaria	2360	2401	4886		1330	2048	1529	1275	1325
Croatia	2276	2479	2829	2842	1899	2683	2106	2498	2652
Cyprus	143	114	158	146	165	180	176	144	182
Czechia			4635	4668	4566	4110	3381	3428	2812
Denmark	6896	6045	3835		4878				
Estonia	1460	1502	1276	1301	1271	795	702	745	699
Finland	4540	7656	6550	5491	5441	1238	1031	1045	1086
France	14575	14575	13515	12127	12781	12772	11843	12334	10889
Germany	61832	61430	62464	59427	54323	46834	47667	50791	49622
Greece		4302	4528	6362	5550				
Hungary	1542	1343	1167	1371	3953	677	570	721	762
Ireland	4387	4175	3982	3653	3939			2783	2980
Italy	35745	35190	32992	27718	29474	33676	35381	37226	39182
Latvia	1551		1189	1342	747	680	763	715	835
Lithuania	815	577	698	704	192	787	1646	907	821
Luxembourg	291	27	37			88	171	189	483
Malta	128	116	148	113	130	107	149	129	160
Netherlands	5078	14207	11624	11051	11354				8868
Norway	14573	16091	16498		23481	23118	21603	19985	21954
Poland	2929	3398	3444	3429	3715		22944	22646	23049
Portugal	994	1427	2091	2376	2151	2265	2603	2631	2636
Romania-B					604	855	820	506	479
Slovakia	508	429		533	559	615	541	551	490
Slovenia			505	505	430	1319	1786	1719	1292
Spain	21664	20422	21180	20314	21581	28994	29432	23705	24422
Sweden	9257	9163	7940	9541	9851	14519	14611	11078	10936
Turkey	32706	26606	19242	18045	17217	13840	11397	8895	
United Kingdom		19029	27396	27981	29883	30889	31269	31007	30760

Source: EMCCDA, Statistical Bulletin 2020- Drug law offences, number of offence, offences by type, supply https://www.emcdda.europa.eu/data/stats2020/tdi_en.

As shown in the previous charts, the number of conducts related to drug use that are legally determined as a criminal offence or that derive into an administrative sanction outnumber by far the amount of criminal offences related to supply. Of course the criminal or administrative character of the conduct and the sanction carry a different weight on people's lives, with the

seconds reducing the harms caused by the criminal justice system on the individual and families.

With regards to the countries included in this study, the general agreement is that drug use and drug possession do not lead to incarceration but conduct to an administrative sanction and treatment is offered. Even when it is a criminal offence, usually the first response is voluntary or quasi-compulsive referral to treatment. Generally speaking, parental responsibilities are not taken into account, but rather the referral is based on consideration of the type of conduct, the amount of drug involved and the existence of a condition of dependence.

Croatia

In Croatia, drug use is not a criminal conduct but, if done in public, faces an administrative sanction. If the person suffers from drug dependence, the court shall sentence him or her to mandatory treatment[28]. Possession of drugs for personal use is a (non-criminal) misdemeanour, punishable by a fine of EUR 650 - 2,600 or by imprisonment up to 90 days. "As well as the fine or imprisonment up to 90 days, an offender who is addicted to drugs will be given a measure of obligatory treatment in a medical institution or in an institution for social care, lasting from three months up to one year. If offender is an experimental drug user, with a fine or imprisonment up to 90 days, will be given measure of compulsory psychosocial treatment in institutions lasting from one month to two years. (Art. 32. Amendments of the Law on combating drugs abuse from 2019.)"[29].

If the person goes to prison or to residential treatment in a therapeutic community, legal custody of his or her children will be temporarily removed and children will be allocated with other family members -or the other parent-.

[28] Information available at https://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=HR and https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

[29] Information available at https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

Cyprus

In Cyprus both drug use and possession are criminal offences. The first is punishable by up to life imprisonment[30], whereas possession of controlled drugs for personal use (defined by quantity limits) is punishable by up to 12 years imprisonment (for Class A drugs), up to 8 years imprisonment (for Class B drugs), up to 4 years (for Class C drugs). "Penalty for the first conviction cannot exceed one year (applicable only to offenders up to 25 years old, on the condition that the offence is related to personal use of narcotics and the offender has never been convicted of drug-related offence). Narcotic Drugs and Psychotropic Substances Law of 1977, s.30(2)". It is important to point out that although in theory penalties for drug use in Cyprus could reach life imprisonment for all classes of drugs, this has never been implemented in practice (Pompidou Group, 2020: 18).

The participant in the focus groups reported that in April 2016, the law for the "Treatment of accused or convicted drug users or drug depended individuals" was approved. Its name has since been changed into "Treatment of accused drug users or drug depended individuals" to exclude convicted persons, since there is no option of appeal for this group under the provisions of this legislation, once the sentence has actually been passed (Pompidou Group, 2020: 18).

Under this legislation, at the trial stage, the accuser can apply for a referral to treatment in lieu of a prison sentence, by instance when she or he is accused of a minor offence, such theft. After an evaluation procedure the court will decide whether the accuser will receive a prison sentence or will be referred to treatment. This legislation also covers children in contact with the criminal justice system.

NAAC is involved in the Counseling Commitee and participates in the evaluation processes of the offenders, reporting back to the court. It also provides training to police officers, judges and lawyers in order for them to be aware of the law and actually implement it.

[30] Information available at https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

The informant reports that there are numerous cases of women who are mothers and face several trials related to their drug dependence and the courts would refer them to treatment instead of giving a prison sentence, no matter how many subsequent offences the women are accused of. The legislation has been implemented since 2018 and is the result of years of debate around the rights of people who use to drug to acces treatment, the importance of a health-based approach, the need to reduce stigma and criminalisation as well as to guarantee the human rights of people who use drugs.

Ireland

According to EMCDDA[31] "Possession of cannabis is punished by a fine of up to: EUR 381 (first offence, summary conviction), EUR 508 (second offence, summary conviction), EUR 1270 and/or imprisonment up to 12 months (third or subsequent offence, summary conviction). For conviction on indictment, the penalty ranges are elevated: fine up to EUR 635 (first offence), fine up to EUR 1270 (second offence), then up to 3 years imprisonment (third or subsequent offence). Punishment for possession of drugs other than cannabis: up to 12 months imprisonment (summary conviction), up to 7 years imprisonment (conviction on indictment)." In the case of drug use, this is not regulated by the law, with an exception of use of prepared opium which is explicitly prohibited and punished by imprisonment not exceeding 12 months and/or a fine up to EUR 1270 (on summary conviction) or imprisonment not exceeding 14 years and/or an unlimited fine.

In both cases of use or possession, following conviction, the court has the option to send an offender to medical treatment instead of imposing penalty (decision is based on a medical report prepared by a health board or court welfare officer).

In the focus group, professor Comiskey reported that in Ireland drug possession used to be a criminal offence but the law was changed recently; while it remains a criminal act, people caught in possession of drugs are given the possibility of substituting the sanction with treatment. This chance is given on two occasions and prevents the person from having a

[31] Information available at https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

criminal record. This provision is established by section 28 b) of the Misuse of Drugs Act, 1977[32] "Power of court to remand persons convicted under section 3, 15, 16,17 or 18 and to obtain a report and in certain cases to arrange for the medical treatment or for the care of such persons":

> (b) Where a person is convicted of a first or second offence under section 3 of this Act in relation to which a penalty may be imposed under the said section 27 (1) (a) or an offence under section 17 or 18 of this Act, or of attempting to commit any such offence, and the court, having regard to the circumstances of the case, considers it appropriate so to do, the court may remand the person on bail for such period as it considers necessary for the purposes of this section, and request a health board, court welfare officer or other body or person, considered by the court to be appropriate, to […]

Also, police have discretionary powers, therefore arrest in the case of drug possession is not automatic.

Italy

In Italy since 1990, drug use and possession of small amounts of drugs are not a criminal offence. Drug possession is punished by various administrative sanctions (e.g. suspension of driving license, firearms license, passport, residential permit) and a socio-rehabilitation and therapeutic programme may be offered in addition to administrative sanctions. Since 2014, there is no obligation for addiction service workers to notify competent authorities of breaches of these programmes. "Penalty does not vary by quantity, but quantity exceeding limits established by the Ministry of Health and Ministry of Justice could be considered as possession for supply (Art 75 (1b), DPR 309/90)" [33]. In case of the first offence, when considered "particularly minor", a warning might be issued, with various administrative sanctions for the second offence onwards (article 75 q-14 DPR 309/90).

[32] Available at http://www.irishstatutebook.ie/eli/1977/act/12/enacted/en/print.html?printonload=true.
[33] Information available at https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

The representative before the focus group pointed out that under the same law, people who commit crimes related to their drug use and sanctioned with a penalty of up to four years can change the sentence for a recovery program, which totally substitutes the prison sentence (art. 73.5-bis, DPR (309/90).

Also, adolescents accused of an offence which might be related to drug use can be derived to mandatory treatment under judicial supervision. If the program is completed, the criminal record is erased.

In the case of women who live with small children, the general rule is to substitute a prison sentence with home detention.

The information provided by the people participating in the focus groups and the review of the current legislations[34] show that, generally speaking, the countries do not recur to the incarceration of people who use drugs or are found in possession of drugs for personal use as the first or only response, and that referral to treatment is implemented either as an opportunity or a condition which is added to or substitutes the administrative or criminal sanction. Nevertheless, the data reproduced in tables 4, 5 and 6 indicate that the possession of drugs still represents a much larger cause for an administrative or criminal response by the authorities, than conducts related to drug supply. As underlined by EMCDDA (2015: 17-18):

> While it is widely agreed that the general deterrent of punishment has little effect on consumption levels of illicit drugs, drug use, together with its associated problems, continues to be considered by many as a criminal justice issue with a concern about moving too far away from punitive sentencing.
> […] Few countries in Europe have chosen to adopt widespread rehabilitative approaches, with most opting for simpler policies of decriminalisation or depenalisation, alternatives to prison, but not alternatives to punishment.

[34] Information available at https://www.emcdda.europa.eu/publications/topic-overviews/content/drug-law-penalties-at-a-glance_en.

It is also important to take notice that the provisions analysed and reported do not mention child caring responsibility as a factor impacting on the administrative or criminal response to drug possession for personal use.

7. Availability of services for children whose parents use drugs and adults with drug dependence and parental responsibilities

While most people using drugs do not develop dependence and parents with a drug use disorder can provide optimum care and a loving environment for their children, for some families it can be challenging to cope with alcohol and drug dependence and parental responsibilities at the same time. Recognising such challenges with compassion, support and integrated social services is the first step to help children fulfil their rights to grow up in a family environment and enjoy the highest levels of health, access to education, development and wellbeing while treating drug use from a health perspective that takes into account the multiple needs and composites of a person's life.

As outlined in the Irish Hidden Harm Strategy and the P.I.P.P.I. program in Italy presented earlier in this document, there is a growing recognition for the need of holistic approach to drug use and families, which go beyond the individual-centred scope of most interventions related to dependent drug use. Parallelly, children whose parents use drugs are at risk of slipping through the services and remain undetected and unprotected unless there is a deeper comprehension of drug-related issues -and less stigma- by social services and more integrated interventions between social and child protection services, local operators -such as municipal governments and NGOs-, police and prosecution officers and drug treatment and harm reduction services.

Services must be tailored to local needs and address families and children from a multifocal and on a case by case perspective which provides support in the economic and legal area as well as through psychosocial support, economic, material or logistical and human support to access education, sports and other leisure activities for children, parental skill and gender-specific interventions, particularly in the case of women suffering from drug use disorders and violence or being the sole or primary caregivers of their children. Temporary allocation of children with other family members or in foster care can be needed in some cases in order to improve the parents' wellbeing and recreate the conditions for them to uptake again their children's care -with the support of social services if needed-; however, separation from family and loss of custody shall only occur as last resort and if the child is at risk.

Childcaring responsibilities are mentioned in the European Union Drugs Strategy, but only in relation to women's particular situation and barriers they face in accessing treatment (Council of the European Union, 2020):

> 6.5. Measures need to be taken to better identify and address the barriers that women face in engaging with and pursuing counselling, treatment and rehabilitation services. These barriers include domestic violence, trauma, stigma, physical and mental health issues, pregnancy and childcare issues, all of which may be aggravated by demographic, socio-economic, situational and personal factors. Effective service delivery should be sensitive to the specific needs and life experiences of women with drug-use problems and should recognise that patterns of drug use and problems may differ from those experienced by men. Women-only service options should be developed, as should services that take care of accompanying children and that offer other forms of specialist care, such as close working partnerships with care providers and with services working with vulnerable women and victims of domestic violence.

Based on the above, this section looks at the availability of services which take into account childcaring responsibilities in the case of people who undergo treatment, on the one hand, and service for children and families impacted by parental drug use. Also, it points out at existing programmes with regards to women who use drugs. The presentation is organised by country; the information provided by the countries under analysis is divided by target population and, within each section, by the type and source of the services provided.

The overall result is a mosaic of interventions that can lie the basis for proposals to be replicated in other countries and local realities.

Croatia

Children with parents who use drugs

The Family Law, the Welfare Law and the Law on Domestic Violence establish a set of provisions aimed at children who suffer from neglect, violence or other circumstances. Seemingly to the other countries participating in the focus groups, a wide range of measures exist to protect children while supporting the family, spanning from warnings, home

visitations, professional assistance to both the extended and immediate family to the termination of legal custody rights and separation from the family.

Families where the children are allocated are provided with financial supports. Similar to what was pointed out by Italy and Ireland, grandparents tends to be a common option when the separation is temporary -by instance, for the duration of the treatment- but it is not always the best, since drug use and other problems can be rooted in the family of origin and reproduced by the children's parents. Therefore, the grandparents can further put the child's wellbeing at risk instead of providing better care.

The issue of privacy and non-stigmatisation is risen in order to explain why children whose parents use drugs are not identified a particular group by social services and child protection services. However, the informants reflect on the importance of including them in drug treatment services. Currently, there is a lack of direct interventions with the children, who are, however, indirectly benefited from parenting-skills courses.

Children with mothers in treatment

In Croatia, as well as in other countries under analysis -Cyprus, Poland, Ireland and Italy, by instance-, women are allowed to live with their children in some therapeutic communities. However, the informants signal some legislation gaps in terms of social services, which should be addressed by new regulations coming up in 2021: basically, in order for the women who do not have full legal custody of their children, the permission of welfare social services is needed for them to enter the community together with them.

Cyprus

Children with parents who use drugs

In terms of prevention, the National Addictions Authority of Cyprus (NAAC) is in charge of funding, through a call for tender procedure, several prevention programmes that aim to identify and support vulnerable children -children with mental disabilities, deprived of their liberty, etc.-, among them children whose parents use drugs. These programs operate locally in the communities, articulating services and providers in order to reach children whose

parents use drugs. The scheme is illustrative of an integrated service provision under the umbrella of the drug authority; more information is currently being gathered through collective and individual interviews and will be presented in the subsequent report.

As described by Leda Christodoulou -executive secretariat officer at NAAC-, NAAC assigns the projects to NGO and provides them the ground methodology, which can be developed further by the local operators. Such programmes reach vulnerable children identified by local social services or drug enforcement units, as well as by drug treatment centres. They offer educational and psychological support, free access to sport and other leisure activities -including sport equipment-, transportation, among other services which are tailored to the specific needs of each child. The connection with drug treatment services is key to make referrals with the children of people in treatment.

Children are spotted through a mechanism of identification and connected to the different services. Such mechanism of identification is not unique and uniform, but is implemented by the local programme depending on the specific characteristics of the community. It is also crucial to have municipalities and communities on board and include them in the programmes.

During the lockdowns related to the COVID-19 pandemic, these prevention programmes did not operate as usual; some of their services were moved online or were temporarily postponed. Also, they diverted their services to provide basic needs for families and carried out home visitations, thus maintaining their presence in the families even if the programmes were not implemented as such. Besides, the Ministry of Education provided families with internet connections and computer devices, for all children to be able to attend school online. Although these actions did not prevent domestic violence and drug use from raising during lockdown and do not guarantee that all children who needed help because of violence or neglect had the actual tools to reach services, still they represent practices that can reduce the barrier between children confined with possible aggressors and social services.

Social services intervene in the cases where child neglect occurs or if drug use happens in front of the children. The services will monitor the families through visitations and providing different supports, such as legal support, counselling and referral to NAAC, which functions as a liaisons with different services, although it does not provide them directly. Both families and children are followed up by social services. If the situation puts the children at risk, then they are put under the custody of the State.

The informant refers another NAAC-funded programme, which operated since 2018 and is run by an NGO in collaboration with social welfare services. The NGO follows up families who are at risk of losing custody or already have lost custody of their children; the aim of the programme is to improve the family situation in order to re-establish the conditions for the child's re-entry into his or her family It provides services such as discovering family dynamics, strengthening the family relationships, developing communication skills, responding to family critical incidents such as family death and referring family members and children to other related services.

The informant reports that the prevention programmes described in this section constitute a good practice, insofar as they are based on collaboration, referral and cross-referral and adjusted to the needs of children and families. Nevertheless, when discussing gaps in policies, she points out at the need for drug treatment and harm reduction services to address children directly as part of their interventions, and not only to refer children to the prevention programmes. By instance, in adolescents services parents and families are summoned in groups activities; such practice, could be replicated in adult treatment services, including partners and children with parents in treatment.

Pregnant women

Since 2021, a protocol for identification and referral is being implemented. Professionals working in the health services are being trained to function as liaisons for pregnant women who use alcohol or other drugs and are identified by any services -social services, local doctors, etc-. Women are referred to the services they might need, such as financial support, drug treatment services, counselling, etc. The protocol is at its initial stages. More

information regarding this practice will be provided in the following report, based on an interview with its coordinator, above-mentioned Leda Christodoulou.

Women in treatment who are pregnant or mothers

In the case of women who are in treatment and are pregnant or have children, there is also a specific programme. Women can receive in-patient treatment and their children are supported to attend school and other services they need, while living with their mothers. The same programme is applied in the case of girls who are pregnant or have children, in a different facility.

Women who are victims of violence and use drugs

As pointed out in the Pompidou Group's study on women who use drugs and violence (Benoit and Jauffret-Roustide, 2016: 52):

> The fact that women who are active users cannot be cared for in anti-violence centres is a major problem. On the one hand, women users cannot obtain places in shelters or apartments for women who experience violence, which keeps them in situations of exposure to violence. On the other, women who are the victims of violence and are accommodated in shelters have to keep quiet about their, in many cases, problem use of psychotropic medicines for fear of being excluded.

This requires for facilities that contain services and trained personnel to attend both issues ad where women are accepted with their children.

In the case of Cyprus, such facility does exist and belongs to the organisation Spavo[35] - Association for the Prevention and Handling of Domestic Violence-, an NGO that provides shelters, among other services. This NGO implements several of the NNAC-funded prevention programmes and does accept women who are dependent on drugs and victims of violence in their shelters. There is a mechanism in place by which women can attend treatment while being accommodated in the shelter.

[35] Information available at https://domviolence.org.cy/en/.

Such gender-sensitive interventions are not available in the case for women prisoners, thus representing a gap at the policy level. However, there is an out-patient programme available for people in prison, who can leave the prison to attend treatment during the day.

Greece

The participant from Greece underlined how there is no connection between drug treatment services and child protection. Child protection agencies -which the where the informant works- are referred cases by schools; however, during the meeting the emphasised that there is a need for referral from drug treatment centres. The law establishes that information on patients is anonymous, therefore data on children whose parents enter treatment can only be accessed with parental authorization.

Social services are available for families in the communities, through which they can receive psychosocial and financial support, depending on the specific agencies. The offer is wider in larger cities, whereas in smaller cities or communities services are available for people who drugs, on the one hand, and families and children that need social services, on the other, but these are not integrated.

Organisations that provide drug treatment services include programmes for families and parents.

The informant stress that, generally speaking, services are available for people who use drugs as well as for families and children who need social services. However, there is a gap in relation to detection of cases and integration of services.

The procedure in the case of abuse, neglect or violence against children is similar to that of other countries: the cases are assessed on an individual basis and removal from the family is applied as a last resort. Differently to Iceland -described in the next section-, foster families do not receive financial support by law. Some institutions do provide funds to the foster families but this is not a general rule, therefore it depends on the institution in charge of the case.

On the contrary, families where there is a person with drug dependence, a stipend of 300 euros per month is provided, together with other services and goods.

During lockdown for COVID, the government of Greece -as in Cyprus- provided computer devices to families. However, the informant explains that most families with which child protection agencies work, have technological barriers which made online contact and attention less feasible and effective. Some child protection agencies continued to make home visitations and provide services in presence, but this was not common to all agencies, so in some cases or communities the services were interrupted.

Another action that is reported by the informant Athina Manouka -from Minors' Protection Association of Athens- is the work carried out with adolescents whose parents use drugs. The prevention programmes are implemented through individual or therapeutic teams interventions with the aim of developing communication skills and resilience as well as strengthening self-esteem not only through counselling but by different means including theatre, sports, play therapy, media coaching, etc.

Children with mothers who use drugs

Early detection and prevention are pointed out as crucial, with information gathered in hospitals with mothers or pregnant women who use drugs being particularly important. Women are assessed and if they are found not to be able to grow her child alone, the child will be allocated with a foster family, extended family or adoption, depending on the case. If she is assessed to be suitable to raise her child but in need for support, she will receive support and be monitored.

Also, the Psychiatric Hospital of Athens has a programme for mothers who use drugs and have children less than five years old. Women can attend therapy accompanied by their children. This programmes is deemed very relevant insofar as it allows to treat women while maintaining and strengthening the bonding with her children and it is included in the final report of this project.

Iceland

Child protection services interventions and children

When children face a family situation that can put them at risk, be it neglect, violence or drug use or other conditions, the case is assessed through home visitations, interviews with parents, family members, children and other people who can provide information.

The firs intervention is to provide support to the family and to follow-up every two or three months to review if the situation is improving or the family needs extra support.

In cases where no other family members can take care of the child, he or she will be put on temporary care. The informants report that every year about 6,000 children are assessed by child protection services; of these, less than 300 hundred (5%) are allocated outside their family and sometimes only for a few days. The families where the children are placed will receive economic support by Child Protection Agency. If the parent completes successfully the treatment, he or she will gain back the legal custody.

Even though the number of children annually placed outside their family is low, it must be highlighted that the main cause for separation is drug and alcohol use inside their family.

Children with parents in treatment

Since 2008 a programme is implemented with children from 8 until 18 years old who have parents who use drugs and have not started using drugs themselves. Any child can access the services and referral come through different channels, such as parents in treatment reporting their children, child protection agencies and schools. The psychological intervention is based on 8 interviews with a trained psychologist; its aim is to educate children on drug dependence, but also to foster their self-esteem and help them overcome the guilt and shame these children often feel in relation to their parents' drug use. Issues such as anger, anxiety, self-isolation and other feelings and emotions they might be struggling with are also addressed.

The programme relies not only on the interviews with the psychologists but also on interactive activities with computers, which makes it more dynamic and entertaining.

Another point raised in the intervention is that the adult population that undergoes treatment is very fond of the programme and acknowledges that they did not receive that support when they were children and were struggling with their parents' drug use.

The programme is carried out in the largest treatment centre in the country (out of a total of three) run by an NGO and counts on two trained psychologists. The informants report that the programme is successful but encounters funding adversities.

The recent establishment -January 2019- of a Ministry of Social Affairs and Children is reported as an important step both by the participants from the drug policy sector and child protection services, because it can push for more integrated services that gather around children, rather than expecting children to go to the services.

Women victims of violence who use drugs and have children

Whereas the country does not have treatment centres for women where they can live with their children, there are shelters for women who are victims of violence and have a drug use disorder. The informants report the experience Konokut[36] an emergency shelter for homeless women, located in the Hlíðar area of Reykjavík. The shelter is open from 5 p.m. to 10 a.m. the following day, the goal is to provide homeless women with access to basic needs in terms of housing, hygiene and food. Another place for women survivors of violence and their children to which women who use drugs are also admitted is Bjarkahlid[37].

Ireland

Children temporarily removed by parents who use drugs

In the case of Ireland, the aspect of kinship care was risen: if children need to be temporarily separated from their parents, usually they are allocated with their grandparents. However,

[36] Information available at https://www.rotin.is/english/visibility-of-gender/.

[37] Information available at violenchttps://reykjavik.is/sites/default/files/baelkingur_bjarkarhlid_litill_ensku.pdf.

such arrangements are informal. The grandparents are in contact with the social workers who follow the children and their parents cases, but have no formal, legal recognition. While this arrangement is beneficial insofar as it avoids legal procedures in terms of the suspension of legal custody which are hard to retrieve, it leaves grandparents with the full responsibility of the children but without the legal authority to undertake any step: by instance, they cannot speak with schools and schools' principals are not permitted to share with them information on the children, they cannot take health-related decisions and do not receive financial support.

Children with mothers in treatment

Therapeutic communities offer women the possibility to live with their children. However, there is only one in the country. Also, as much as this measure is beneficial to mothers and children, some nuances must be taken into account. As explained by Professor Comiskey "There is treatment for women but the only place that would take children would be the residential therapeutic communities; but from our research, a lot of the women who use drugs have older children and younger children and so many times is the older child that is.. forgotten… because the mother was younger… this is the child that they have lost and now they are trying to work with the younger children, so there is a real gap with the older children".

In the national focus group carried out in April 26th and that counted with the participation of 14 people -spanning from Tusla, HSE, Drug and Alcohol Task Forces, social workers, NGOs and legal practitioners- abundant insights and information on programmes and services were collected and are currently being deepened into through individual virtual interactions. Although not reflected here, they will be meticulously described and analysed in the next report.

Italy

Children who live in families with neglect, violence or drug use

As explicated in the legal text and implemented in practice, child removal in Italy only happens as a last resort, after numerous attempts to address the needs of the families. Interventions with families where drug use, neglect and/or violence occur are multiple: some

examples are i) home education, by which trained educators regularly visit the families; ii) day centres for children, in which they receive educational and psychological support from qualified volunteers; iii) another project involves the relatives that live around the problematic family nucleus: extended family members are recruited and trained in order to provide support to the family where the problem lies; iv) regular meetings are hold between social workers and parents or caregivers in order to assess the situation and monitor the interventions; v) financial support is provided to families who need it; vi) schools and other settings where the children are, also are involved for detection and the collection of specific information in order to develop a case by case response; vii) finally, psychological, neuropsychiatric and other specialised interventions are put in place if needed, particularly in the case of drug dependence.

In the case of child removal from the family nucleus, children are allocated in foster care. Grandparents can be the option, but they do not always represent the best solution, since drug use and dysfunctional families can have transgenerational origins and thus allocation with grandparent can perpetuate the problem. This aspect was risen also by Croatia.

Children with mothers in treatment

There are therapeutic communities which welcome women in treatment with their children. According to San Patrignano's informant, this represents an optimal solution because during the recovery process the mother and the child can improve their relationship an re-create a reciprocal trust.

The best interest of the child is the principle which underlies the decision to allocate the child with the mother or outside the community with other family members. The child's willingness to actually accompany the mother -more unlikely in the case of older children and adolescents- is another criteria to be taken into account. Usually the child or children enter the community after the mother has undergone part of the insertion into the therapeutic process and the parenting programme can begin. The possibility for women to live with their children is also founded on the evidence-based fact that children with parents with drug use

disorders are more prone to develop drug dependence themselves, therefore early interventions are essentials.

It is pointed out that in the country, while there is a considerable number of communities that welcome mothers with other vulnerabilities -such as girls who are mothers or women victims of violence-, only a few accept mother with drug use disorders.

Pregnant women

In Italy, as well as in other countries and in accordance with international standards (WHO, 2014) women who are dependent on heroin receive opioid substitution treatment and have a close monitoring during pregnancy and in the months immediately after the child is born. However, such follow-up does not continue. On the contrary, such monitoring should be maintained in order to make sure that the child is properly cared for and that mothers receive the support they need.

With regards to this point, it is worth mentioning the Danish programme described in EMCDDA (2012 a: 11) report *Pregnancy, childcare and the family: key issues for Europe's response to drug*s:

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

Mexico

Children with parents in treatment

Dr. Ricardo Sánchez Huesca, the participant from Youth Integration Centres (Centros de Integración Juvenil[38]) -the most extended net of inpatient and outpatient semi-public treatment facilities in the country- reports that they have prevention and treatment strategies for the children of people in treatment. In the case of children who do not use drugs, the intervention is based on an assessment of the child risk level in order to determine the selected or indicated prevention strategy. Therapeutic support is algo given for a short time. The prevention strategy includes activities aimed at socio-emotional competences, safe-care, healthy habits, values, cyberbulling, school violence, tobacco and alcohol use.

Children whose parents are in treatment can also participate in the family therapy programme. In case of mental-health issues, the lack of mental health institutions in the country, especially for children, constitutes a barrier for the referral of those children who have developed more serious challenges. One way to address is through the specialization of personnel at the Youth Integration Centres.

In case that the child or adolescent has already developed drug dependence they are offered treatment.

Poland

Children with parents who use drugs

The informant reports that usually social services' interventions happen at a late stage, that is, when neglect is quite advanced. Every case of parental drug misuse related to child neglect or violence against children is assessed individually by an interdisciplinary team consisting of probation officers, judges and social workers.

If drug dependence of a parent does not negatively impact the possibility to raise children in proper conditions, such family will receive support from a "family assistant" who works through a case-management methodology. The family assistant recognizes the family' s needs and adapts solutions to the problem. Such an individual approach allows to monitor

[38] Information available at http://www.cij.org.mx/.

family's situation constantly and react quickly. The family assistant has a variety of possibilities to help a family: for example he or she can refer the parent to parenting skills classes.

When one of the parent is using drugs and is being violent to the child, there is a possibility to put such family into a "blue card system". Blue card system is a tool for police for easier monitoring of violent situations in families. The police keeps a record of the number of interventions in a family so they can determine whether the problem has stopped or is growing and threatening the welfare of the child.

The informant points that courts privilege the limitation of legal custody over termination, since the latter is more difficult to revert. However, if the child's welfare is at risk and there is no extended family member who can take custody of the child, then the process of termination of parental rights is implemented. It is also worth mentioning that children whose parents have their parental rights terminated, are not institutionalised; instead the court appoints a foster family.

Women with mothers in treatment

Given that caregiving responsibilities usually fall upon women, services are gender-sensitive and take into account women's needs and situation. By instance, women in treatment with children under the age of three, can participate in programmes where they are taught child-raising skills.

In regards to women who use drugs, there is a centre where women can undergo treatment and live with their children who are up to 16 years old. There is room for up to 15 women and 20 children and is run by an NGO with state funds.

Also, there are two prison facilities where women can live with their children until they are three years old.

Women who are victims of violence and have children

Poland has intervention hostels, that is shelters where women who are victims of violence can live with their children up to six months. However, one requisite for entering these spaces is to be sober.

The informant reports on the need to count with more facilities for women who use drugs and are victims of violence and also for legislation that sets the basis for such programmes and services to be expanded and for the allocation of appropriate funds.

Romania

Children with parents in treatment

The National Anti-Drug Agency has a network of 47 out-patient treatment centres. According to information provided during the first part of this project, in December 2020 there were 1671 people in treatment, receiving integrated services, including evaluation and medical attention, psychological and social counselling, as well as methadone substitution treatment services. Of these, 237 of them were parents, and the total number of children was 311, most of whom are under 12 years old.

The Agency develops programmes aimed at addressing the children. These include day-care facilities and counselling and the focus is mainly on prevention of drug use. All these centres count on specialised social workers, doctors and psychologists. The support programmes for children with parents in treatment is voluntary and available in the 47 centres. The interventions can be individual or with a group. It is important to point out that because of the pandemic of COVID-19, the services have moved online, which has implied a decrease in the number of children participating in them, both because not all the centres count with the tools to shift to this format and also due to children's response to the online version.

NGOs are acknowledged as important actors for providing services, such as needle exchange programmes, prevention, alcohol dependence-related issues, etc. They gather data on children who are reached by their programmes but these are not always accessible to the National Anti-Drug Agency. Another aspect is that they tend to be underfunded.

In terms of drug use-related services, currently there are little or no interventions directly addressing the issue of children whose parents use drugs. With regards to child protection, the informant reports a need for more actions, including legal changes, to reduce existing barriers to withdraw legal custody of children from parents who use or sell drugs in front of their children, and guarantee their allocation with foster or adoptive families.

Children with mothers in treatment

Women who enter treatment are asked if they are pregnant and are given priority in regards to services. Also, for two years an opioid-substitution treatment has been implemented for women who are pregnant and use heroin. Another programme, implemented through an NGO, provides women with skills aimed at their employability. However, there is no measure specifically aimed at addressing child-caring responsibilities.

Women in prison

In Romania there is only one female prison facility, to which all incarcerated women are allocated. In this prison operates a therapeutic-community for women who are six months or less from being released.

Turkey

Turkey reported that the Ministry of Family, Labour and Social Services carries out of provide psychosocial interventions with children whose parents use drugs. More information was provided in the response to the questionnaire applied in the pre-assessment and is reproduced here.

Services for children whose parents have substance use disorders are carried out with the support and cooperation of the Ministry of Family, Labour and Social Services, the Ministry of Education, and the Ministry of Youth and Sports. For example, if there is a history of violence in people with substance use disorder the family is conveyed to institutions affiliated to the Ministry of Labour and Social Services. The socialization of the person and family members is supported by the participation in sports activities in the institutions affiliated to

the Ministry of Youth and Sports and providing an employment is carried out by referring them to the institutions affiliated to the Turkish Employment Agency and the Ministry of Education.

In the questionnaire, the experience of the the Diyarbakır Addiction Counselling and Training Center affiliated to Diyarbakır Provincial Health Directorate was reported:

> The centre does not only work with individuals with substance use disorders but also family members. Even though the substance user does not accept treatment services, interviews are held with family members, and household visits are made to individuals who do not want to come to the centre in order to create treatment motivation and direct them to treatment services. The centre provides serves not only the patient but also to the family members who want to benefit from the services. The centre provides services from the moment of the first contact with the substance user, to the treatment services process and for a 1-year period thereafter. In addition, psychosocial, economic or other problems detected in the household during the visits are also addressed and refer to find solutions and support through the relevant institutions. Meetings with families and their children are also provided at the centre, including psychosocial support. The centre also presents the problems identified in the field to the Provincial Coordination Board for Combating Addiction, which determines the policies for combating drug dependence at the provincial level.

8. Final remarks: promising practices and current gaps

This report reproduces the information provided by experts and practitioners in the field of drug policy, child protection, social services for families where drug use occurs and services for women who use drugs. It is part of a larger study which is currently under development, the aim of which is to review the literature, the legal apparatus and the national and local practices existing in the countries of the Council of Europe on children whose parents use drugs, in order to develop proposals that can be translated into concrete policies and programmes.

The experiences and voices of the people that generously participated in the focus groups nurture its pages and the next paragraphs, in which the main gaps and promising practices are summarised, setting the basis for the development of proposal that will conclude this study.

As explained in the introduction, the author is currently carrying on national focus groups and semi-structured interviews, besides literature review, that will allow to know more in depth some of the practices and programmes described in this report as well as others. The finding of the actual research will be presented in a subsequent report.

8.1 Legal framework on children with parents who use drugs

The ten countries that participated in the focus groups and Switzerland have national legal dispositions to guarantee the protection and wellbeing of children whose parents use drugs.

However, these are not usually named as such, but are part of children in general or children with vulnerable situations. The cases of Iceland, Italy and Cyprus constitute example of the inclusion of children affected by parental drug use as a specific group for which tailored and integrated interventions are needed. In the first case, however, this specification lies in the field of child protection and has mainly a focus on the protection of children from possible harms in the family, thus focusing on the child as the subject and drug use disorders as the problem. In Cyprus and Italy the legal texts under review provide a contribution from the side of drug-related policies and the need for families suffering from drug use of interventions

aimed at protecting children, strengthening families and providing treatment and help for the individual.

The Irish Hidden Harms Strategy, together with the national drugs and alcohol strategy, offer a conceptual framework for naming children whose parents use drugs and indicating actions in terms of services. The term hidden harm in its double facet of harms experienced by some children living in drug abusing families and as well as by the lack of reach from services conveys the need for three fundamental steps: detection, referral and attention, with the latter encompassing the provision of integral and integrated services for the child and treatment -if needed- and support for the person who uses drug from a holistic, family approach.

Naming hidden harms provides the basis for the proper development of services and programmes which simultaneously look at the person who uses drugs not only as an individual with a health condition, but as composite person with multiple needs, inserted in a social and family context, while taking into consideration the children needs in terms of wellbeing and, if it is the case, protection from neglect or even violence.

This is a positive and much needed step to acknowledge children's rights, on the one hand, and drug-use related issues in people with parental responsibilities, on the other. However, it must also take into account women-specific needs, not only in their reproductive or caring roles, that is as pregnant women or mothers, but, as it is often the case, survivors of gender-based violence and primary or sole caregivers that face higher stigma and encounter multiple barriers to access treatment or other form of support.

Also, children need to be understood not as a homogenous group, but a composite of age-specific groups with other identity markers and factors of accumulated discrimination or vulnerability such as gender, nationality, ethnicity, legal status, socio-economic condition, etc.

8.2 Data gathering

The countries agree on the importance of gathering quantitative information on children whose parents use drugsin order to develop public policies and specific interventions that target children and families where parental drug misuse can negatively impact on the children's development.

The Treatment Demand Indicator (TDI) currently is the best source available in terms of drug-related policies, but has five main caveats: in the first place, it only gathers information on people who actually seek and enter treatment. Depending on the country's cultural and social context, there might be a larger or smaller gap between people needing and wanting to enter treatment and those who actually undertake a treatment. Such breach depends largerlyon current drug-policy related factors, namely discrimination, stigmatisation and criminalization against people who use drugs (UNODC, 2008). Secondly, it shows episodes of treatment of people who enter and might drop out and be counted again if and when re-accessing treatment. In the third place, people who use drugs might prefer to not reveal their parental status and caring responsibilities for fear of losing their children as a consequence of their drug use, a fear that is justified in some cases, depending on a country policy and attitudes towards people who use drugs. Fourth, even when information on people who use drugs and have children is collected, it does not provide an estimate of how many children are affected by parental drug use disorders nor does it convey further elements to determine what the situation of the children is and if they need to be referred to social services in order to have access to support -economic, educational, psychological, etc.-. Another limit is that treatment centres do not have access to personal information on the children, since this can be disclosed only upon parental authorization. Finally, the quality of the information will also depend on the country's capacity to actually collect it and analyse e it. Therefore, this indicator is a key element in drug epidemiological terms but remain insufficient from a children's rights perspective.

On the side of child protection and social services, there seem to be also gaps in generating information. Croatia reinforced the anti-discrimination end of not collecting specific information on parental drug misuse, in order to avoid children's stigmatization. The issue

of privacy was raised by other countries and should definitely be addressed. However, the Croatian position seems to be contrasted by other examples, such as Cyprus', where information on children and parental drug misuse, collected by both drug treatment centres -based on the TDI- and local prevention programs is indispensable to implement tailored interventions.

Even when data are produced abundantly, such as in the case of Switzerland and Iceland, there is still a need to better analyse and interpret information.

The result of these gaps in data is that there is not an estimate of how many children might be affected by parental drug misuse and thus might need social services' interventions and support for their families.

Professor Catherine Comiskey[39] -Ireland's representative before the PG for this project- has conducted pioneer research on the topic under discussion, developing estimates on the number of children affected by parental drug use disorders.

The paper "Hidden Harms and the Prevalence of Children Whose Parents Misuse Substances: A Stepwise Methodological Framework for Estimating Prevalence in a Community Setting" (Galligan and Comiskey, 2019) indicates:

> Key challenges that exist relate to a dearth of available systematically collected information in relation to parental substance misuse. This is in relation to both the 'children' of parents who use drug services, and the status of parental substance use for children in receipt of child and family services (Advisory Council on the Misuse of Drugs, 2003; Horgan, 2011; Hay et al., 2005; Dawe, Harnett, & Frye, 2008; Manning, Best, Faulkner, & Titherington, 2009). Secondly, many national estimates and routine data sources may be composed of episodes of service, as opposed to unique individual cases, making accurate estimates locally difficult to apply. There is a possibility that people could be counted more than once as cases are not always named and people may enter treatment a number of times in one year. Not all treatment

[39] Professor Catherine Comiskey, Trinity College Dublin, The University of Dublin, Ireland and Chair of the Scientific Committee of the EMCDDA.

> services provide regular or timely returns to centralized systems (Horgan, 2011). Thirdly, accessibility to existing sources may be limited, with certain data sources only available with governmental level approval (Horgan, 2011). An additional challenge in establishing a definitive prevalence estimate relates to the hidden and illegal nature of much drug use, with the consequent risk that children may be isolated from potential sources of support that might foster resilience (Advisory Council on Misuse of Drugs, 2003; Dawe, Harnett, & Faye, 2008; Hay et al., 2005; Kroll, 2004; Manning, Best, Faulkner, & Titherington, 2009). Steps to address these issues are being taken to varying degrees but these changes will take time to implement (Advisory Council on the Misuse of Drugs, 2003, Hidden Harm National Steering Group, 2015).

In the paper, the authors develop a methodological framework for estimating the prevalence of children with potential hidden harms. As shown in the paper, from the audit and multisource enumeration, a ratio of 0.88 children to every one client known to local treatment services was estimated.

This estimate can set the basis for national and local calculations. However, the "child-centred" services providers could also serve as a basis to estimate hidden harms, by instance, by creating a benchmark/multiplier methodology such as Galligan and Comiskey on the basis of number of children known with parents affected by drug misuse. This estimation is possible in countries where information on parental drug misuse is actually collected by child protection agencies, such as Iceland and Italy -at the local level-.

In this regard, the updated National Drug Treatment Reporting System of Ireland as well as the NAAC data gathering of Cyprus can constitute good practices that should be further explored.

The aim, in terms of data, should be to collect, share and trace children whose parents use drugs in social services, child protection agencies and drug treatment services in order to detect and count them, address them and follow them up so that they do not slip through the services and these are adjusted to the family needs and situation.

8.3 Law enforcement

With regards to the countries included in this study, the general agreement is that drug use and drug possession do not lead to incarceration but conduct to an administrative sanction and treatment is offered. Even when it is a criminal offence, usually the first response is voluntary or quasi-compulsive referral to treatment.

However, the quantitative information provided by EMCDDA on people accused of a criminal or administrative offence for drug use or possession shows that the first far outnumber the latter. The EMCDDA's report on alternatives to conviction stresses on the prominence of non-criminal sanctions among European countries for people who use drugs, but also highlights the permanence of a tendency to punish.

Generally speaking, parental responsibilities are not taken into account, but rather referral to treatment is based on consideration of the type of conduct, the amount of drug involved, the existence of a condition of dependence and the number of times a person is caught in possession of controlled substances. The debate on how to regulate drug use and possession for personal consumption goes beyond the scope and purpose of this study. Nonetheless, it is important to take notice that the provisions analysed and reported do not mention child caring responsibility as a factor impacting on the administrative or criminal response to drug possession for personal use, differently to what happens in the case of criminal conducts, which might actually take into account caring responsibilities as a cause for imposing a non-custodial sanction.

There appears to be a need for evaluation the criminal or administrative sanctions -including voluntary or quasi-compulsory referral to treatment- which are consequence of drug use or possession from the perspective of its impacts on children and families. For instance, Iceland provision according to which people who enter treatment do not lose their job or income certainly constitutes an incentive for the individual while not exposing his or her family to the risk of a worsened economic situation. In fulfilment of article 3, par. 1[40] of the Convention

[40] "1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration".

on the Rights of the Child, all measures in the administrative or criminal sphere regarding parents or primary caregivers who use drugs should be assessed against their consequences for the children, particularly criminal or compulsory sanctions.

8.4 Services

In the section on services, four main spheres of action are reported; i) services aimed at children exposed to a level of neglect or even violence that requires the intervention of child-protection agencies; ii) children whose parents use drugs that require prevention programmes in order to reduce or eliminate the risk of further harm for the children; iii) people in treatment; iv) women who use drug and are pregnant, mothers or survivors of violence.

In the first case, countries report a general scheme of case by case assessment of the child's situation and support to families and children through different means, such as counselling, parenting skills, financial support or provision of basic needs, home visitations, supervision by authorities and or through other family members, etc. Temporary removal of children from families are usually referred as a last and not frequently applied resource, happening only in those cases where children are at serious risks and when previous attempts of working with the family have failed. Foster families are often appointed, relying on the extended family when possible. Grandparents are a common option but do not always represent the best solution, as they themselves might share the same drug-related issues or other problems as the children's parents.

Iceland offers a good example since it pays the families for the children's-related costs. This, on the contrary, does not happen in other countries, such as Ireland and Greece.

In the case of children in families who use drugs, the prevention programmes reported by Cyprus, the MoU from Italy and the cooperation schemes at the local level described by both countries constitute examples of promising practices: local territories where multi-problematic families live can provide collaborative support based on the concerted action of social services, minors' protection, drug treatment services, shelters for women and drug treatment services. In order to do this, detection is key as well as the articulated action of all

these actors through a case by case approach. The work of state-funded programmes run by NGOs is particularly fruitful, insofar as it can bring specialised interventions that social services often lack, while also overcoming some of the main limits of local social services, particularly work overload, rotation of personnel -and thus, loss of capacity and training- and, sometimes, the perdurance of lack of knowledge or stigma around drug-use related issues.

Integrated, integral and family-approach interventions are those that offer the best solution for children in family settings where parents cope with drug use disorders and face other challenges related to social disadvantage.

For these programmes to be successful, two key elements are detection and cross-referral. Schools, communities, family members, hospitals, antenatal care clinics, hospitals, mental health and treatment services are the main vehicles for detection. With schools being closed -for different periods of time- during COVID, mechanisms such as providing families with internet connection and computer facilities might help reduce the barrier for children to seek help. However, the ongoing presence of social services is essential to reach families and children, given the technological barriers that some families might face even when provided with the inputs, and children's increased level of risk and isolation.

In the case of cross-referral, again what seems more successful is the coordinated action and communication between minors' protection services at the local level, social welfare services and drug treatment services through a case manager, liaisons or similar figures. For this to happen, services must be aware of each other, the threshold to access services must be sufficiently low and the personnel needs to be trained to work cooperatively and to understand drug use and children's rights and welfare as part of a communal issue that needs individual-based interventions but within a framework of family-intervention approach aimed at restoring and strengthening -when possible- the individuals -adults and children- abilities, skills and resilience as well the family bond and reliance.

In the field of drug prevention, treatment and harm reduction, an interesting feature is that services remained open during COVID and intensified the reach of patients, thus

guaranteeing continuity to treatment and harm reduction services. However, generally speaking, the approach is individual-based. Families can be taken into account in group activities -such as Cyprus report with adolescents- or children themselves -such as is the case of Mexico and Romania, but these seem to be spot-on interventions which are not part of a larger conception of holistic approach to drug use disorders. An interesting programme is the one developed in Iceland with children between 8 and 18 years old.

One of the problems the informants agree on is that treatment centres do not always function as an efficient point of referral to other services, due to basic barriers such as lack on information on children or because, even when referral is done, it is not followed up.

For detection of children to take place, an essential feature is that people actually seek treatment-if they need it- and that feel safe to disclose their parental status, on the one hand, and to reach out at local social services and disclose their drug use, on the other. Unfortunately, the perdurance of stigmatising attitudes towards people that use drugs and the risk of facing a criminal or administrative sanction act as obstacles for children to be detected.

It is also fundamental to enhance mechanisms, frameworks, awareness, narratives and social attitudes that make children aware of what they are experiencing and in a condition to communicate it without feeling shame or being afraid of putting their parents at risk.

Social and cultural barriers to seek and access treatment are more acute for women. As highlighted in several international reports (Benoit and Jauffret-Roustide, 2016; EMCDDA, 2012; INCB, 2017; UNODC, 2018) guidelines (UNODC, 2016) and standards (WHO, 2014 & 2020), women suffer from higher stigma for using drugs and even more so if they are pregnant or mothers. This again puts children and women at risk. Early interventions are possible only if women feel comfortable and safe to reveal their drug use to health professionals and to actively seek prenatal care. As pointed out by several countries, hospitals and nurses following up on new mothers are a key component of detection and prevention. However, in countries where stigma is high and parental rights withdrawal common, women will not feel safe to attend health clinics and hospitals and to comment on their use of substances. In this sense, Iceland's example is illustrative on the cultural, social and structural

changes that are needed in order to make treatment an accessible, affordable and stigma-free reality for those who need it.

Gender-sensitive measures centred on women shall include women-only spaces and flexibility for women to attend treatment while coping with other responsibilities, such as caring and working. A positive experience shares by some countries -Ireland, Poland and Italy, by instance- is that of therapeutic communities where women are welcome with their children.

Particularly important are also programmes aimed at detecting women during prenatal care and providing counselling and other forms of support as well as harm reduction services. However, these interventions are more likely to be successful for the women and the children if follow-up is maintained for a period of time after the child is born.

8.5 Further elements that call for policy development and interventions

During the focus groups and in following interactions different areas of interventions emerged, that require more research into the countries' practices. This section points them out, recognising the need to understand more specifically what is already available in some countries, and can constitute an example for others and what, on the other hand, seems to be existing at a very early stage and could be thought through and developed collectively among the parties interested in it.

a) Data availability

In terms of data, for the countries reporting to EMCDDA or for the countries which have put in place a monitoring system of Treatment Demand reporting, there is a need for i) widening the information generated under the TDI EMCDDA indicator, to include at least questions that permit to a) develop an estimate of how many children have parents in treatment; b) know their gender, age range and situation of care.

The countries interested in getting such information, should signal it.

At the national level, such questions should be complemented by information on c) contact point (family, friends or other personal contacts, social workers, NGOs, or whoever the

patient feels comfortable with) in order to be able to include the children in the patient's process and to refer them, if necessary, to other services.

b) Data gathering and link with stigmatisation

The perdurance of stigmatising attitudes against people who use drugs and the fear that some of them might experience towards social services and social workers because of past experiences or believes, act as a potential barrier against the disclosure of this information about the fact that they have children or not. Even if they should be free and willing to reveal such information, the patients should be encouraged to do so in order for other social organisations and services to detect and address their children if needed.

Identification of drugs or alcohol misuse in the family by social workers and child protection agencies should be a trigger for voluntary referral to treatment and to build-up a quantitative estimation of children affected by hidden harm.

c) Data gathering from different data collection systems in different services

Other sources such as maternity clinics, hospitals, refuges for women victims of domestic violence legal aid agencies, etc. also produce information -directly or indirectly- regarding this population, although, as it is proposed with the TDI protocol, there should be a review to make sure that the questions are sufficient and that actually convey information on the children and that the data are easily accessible from different services.

d) Data analysis from different systems by one monitoring body

Besides the identification of children whose parents use drugs, sharing and integrating the information also represent a challenge; the basic question is how to make sure that the data collected from different surveys, ministries, departments, agencies, legal practitioners and the voluntary sector can be put together and analysed jointly. One first step would be i) to identify what questions are lacking in the different systems of data gathering in order to count this population, ii) try to develop the missing questions in a homogenous way so that the information is comparable and aggregable, and then iii) identify what governmental or non-governmental body should be in charge to accumulate the information -either at the national

or local level or both- and develop analysis and policy proposal which are tailored to local needs while national in scope.

e) Setting up a national mechanism of identification

Another apparent missing point is what here is called "national mechanism of child identification, tracing and follow-up", basically a system that, without undermining privacy considerations, creates an online file on children addressed directly or indirectly by services -by instance, a child attended by a municipal social service whose parent is under treatment- and where information regarding the child and his/her environment can be uploaded and updated constantly, seemingly to the Italian experience described above, the RPMonline. Such mechanism would aim at making sure that children do not slip through services and are not "lost" in case they move, or change their status of care, or other circumstances.

Parallelly, a tracking method of people entering treatment should be guaranteed -more information on this was collected in the focus group with Cyprus and will be shared in the near future-, with the purpose of keeping a file of patients' treatment record and, indirectly, on their children.

The inclusion of the Individual Health Identifier (IHI) in Ireland's National Drug Treatment Reporting Systems can serve as an example for both mechanisms of identification.

f) Putting in place protocols for local cooperation, sharing information and avoiding segmentation of services

Even when both at the national and local level there is an abundant provision of state or NGOs (sometimes state-funded) services targeting the populations of interest to this study -i) children in context on vulnerability -including parental or family drug misuse; ii) people who are in treatment for drug use and have children and iii) women who use drugs and are pregnant/have children or are victims of domestic violence and have children- these are not always aware of each other, which reduces the scope of referral and cross referral and the integration and joint-work of services and actors involved in their provision and reception.

The creation and effective implementation of protocols or MoU is thus a key element for the local cooperation among services.

g) Setting up an on line communication platform

Another key element is the actual dissemination of the information regarding the services and their providers. By instance, an online platform -with its corresponding app- could be created, in which state services, state-funded programmes, NGOs and legal practitioners could share and access information on what services exist, who provides them, how to contact them, who the targeted populations are and which requisites they have to fulfil for accessing the service or programme.

Such platform should be available for families and children -in an adapted format- too.

The challenge would be to identify who would be in charge for developing such tool -by instance, it could be Tusla and HSE in lreland together with a partner NGO- and how to keep it updated.

h) Children's participation and the need to end stigma against people who use drugs

Including children in decision-making processes and having their voice actually and effectively heard represent a major challenge. So far, some insights into children voices inclusion has been made by the consultant only with regards to the legal process, with an Irish barrist.

There is a need for further investigation of successful practices of children's involvement at the macro level as well as in their participation in the programmes, services and decisions that concern them directly and indirectly.

One current practice is the Silent Voices campaign[41] -Ireland-, focused on children affected by parental alcohol misuse and which aims "to ensure the right supports are available to children today coping with parental alcohol misuse -and those adults dealing with the impact

[41] Available at https://alcoholireland.ie/campaigns/silent-voices/.

of a childhood trauma in later life". The campaign includes voices of adults and children affected by parental alcohol misuse[42] and helps breaking stigma and shame, factors which both reduce children's capacity to name what they are experiencing and to seek for help.

Children's participation should be encouraged at all levels of decision making, including, in the first place, those regarding their own immediate life and status of care. Children's voices need to become part of what is said about hidden harms and how it is said. However, such inclusion should not become an indirect vector for blaming parents and families or neglecting the needs and traumas that sometimes people affected by dependent drug use experience themselves. In order to make children visible, heard and taken into account at the macro, international level as well as in the everyday concrete decisions that affect them directly or indirectly, the drug and alcohol misuse must be addressed from a health perspective and a holistic approach, looking at the individual in his or her complexity and life story, not just as "a substance user", dispossessing narratives and practices around drug use from stigmatising attitudes and mentalities as well from its individual-centred current approach.

Stigma still represents a powerful repressor factor for both adults who suffer from alcohol and drugs dependence or problem use and for families who live with a drug-misusing parent. It undermines people's trust in services and prevents them from seeking help; it can also mislead professionals' decisions and interventions, possibly influencing their actions. Finally, it fosters children's feeling of loneliness, shame and responsibility and contributes to their isolation with regards to the situation they are living in their family.

Therefore, detecting, acknowledging, tackling and eliminating stigma around drug use, its motives and impacts, is indispensable to make sure that children and their parents are properly heard and supported.

As recommended by the Commission on Narcotic Drug Resolution (CND, 2018: op 1-3) *Promoting non-stigmatizing attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users*:

[42] https://alcoholireland.ie/silent-voices/shared-voices/.

1. Encourages Member States, as appropriate, within their national and regional contexts, to promote, among their relevant agencies and social service sectors, non-stigmatizing attitudes in the development and implementation of scientific evidence-based policies related to the availability of, access to and delivery of health, care and social services for drug users, and to reduce any possible discrimination, exclusion or prejudice those people may encounter;

2. Requests Member States, as appropriate, within their national and regional contexts, to continue to enhance inclusiveness in developing relevant programmes and strategies, to seek opinions and contributions from drug users and from organizations and family and community members who work with them and support them, to facilitate the development of scientific evidence-based policies regarding the availability of, access to and delivery of health, care and social services;

3. Urges Member States, in accordance with their national and regional contexts, as appropriate, and cultural traditions, to include in their existing training programmes information on the effect that stigmatizing attitudes have on the availability of, access to and delivery of services to drug users;

Fulfilment of Sustainable Development Goals 3. -Ensure healthy lives and promote well-being for all at all ages, 4. -Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all-, 5. -Achieve gender equality and empower all women and girls- and 16. -Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels- requires that people are guaranteed the optimum circumstances to access services. This does not only mean that services must be available, affordable, accessible, adapted to cultural, ethnical, disability and other circumstances, age and gender sensitive and low-threshold, but also that social and cultural barriers must be eliminated. Such elimination implies legal changes, funding and training.

Training social workers, lawyers, nurses and medical staff, psychologists, psychiatrists, teachers, police, prosecutors, judges and other related professionals in both the fields of hidden harms for families and children but also on drug and alcohol dependence as complex, interrelated issues that cannot be addressed from an individual or unilateral framework and

that can spur unintentional discrimination -and thus address it- is a practice that should be adopted by international and national agencies and universities.

Annex I. List of Participants

Name	Function	Country (in alphabetical order)	Date of FG
Jadranka Ivandić Zimić	Head of Unit for International Cooperation in the drugs field. Department of National Information Drugs Unit and International Cooperation Affairs. Service for Combating Drugs Abuse. Croatian Institute of Public Health.	Croatia	Feb 22nd
Mia Mardešić	Senior Advisor. Croatian Institute of Public Health. Service for Combating Drugs Abuse.	Croatia	Feb 22nd
Leda Christodoulou	Executive Secretariat Officer for the National Addictions Authority of Cyprus (NAAC).	Cyprus	Feb 15th
Athina Manouka	Minors' Protection Association of Athens.	Greece	Feb 23rd
Halla Björk Marteinsdóttir	Sociologist. Department of Consulting and Education. The Government Agency for Child Protection.	Iceland	Feb 23rd
Guðrún Jónsdóttir	Social Worker. Department of Consulting and Education. The Government Agency for Child Protection	Iceland	
Inguun Hansdóttir	Director of Clinical Services. National Centre for Addiction Treatment	Iceland	
Rafn M Jónsson	Specialist. Alcohol and drug prevention. Division of Pulic Health. Directorate of Health	Iceland	Feb 23rd
Catherine Comiskey	Academic-Trinity College, Dublin. Chair of the Scientific Commette; EMCDDA	Ireland	Feb 22nd
Monica Barzanti	International Relations- San Patrignano.	Italy	Feb 22nd
Ricardo Sánchez Huesca	Normative Adjunct Executive Director, Centres for Youth Integretation.	Mexico	Feb 23rd

Paulina Vázquez	Specialised Doctor, General Direction of Psychiatric Attention Services, National Commission Against Addiction.	Mexico	Feb 23rd
Monserrat Lovaco Sánchez	Director of Prevention, Community Development and Operation, National Commission Against Addiction.	Mexico	Feb 23rd
Roksana Karczewska	National Bureau for Drug Prevention.	Poland	Feb 15th
Carmen Oprea	National Anti-Drug Agency	Romania	Feb 15th
Peyman Altan	Chief of Drug control. Tobacco & Drug Control Department. Ministry of Health.	Turkey	Feb 22nd

Annex II. Children Whose Parents Use Drugs
Methodology for focus groups to be carried out in February and March 2021

In February and March 2021, focus groups (FG) will be carried out virtually with all the countries that manifested their interest in participating. This section explains the methodology that will be adopted.

Each FG will include 3 to 4 countries and the national focal points will be invited to participate. If they esteem it pertinent, other country representatives could be invited to join the discussion. The countries participating in the project are (in alphabetical order) Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Morocco, Norway, Poland, Romania, Switzerland and Turkey.

The objective of the focus group is to identify member states' policy interventions aimed at children whose parents use drugs from a children's rights and drug policy perspective. The discussion will revolve around eleven triggering questions -outlined below- with the purpose of sharing national practices and have a collective discussion and interchange on the most relevant points with the regard to children whose parents use drugs. The participants do not need to have an exhaustive knowledge on each particular point, but rather to draw a general picture of where his/her country stands in relation to this group, in terms of regulation, data gathering, policy interventions, gaps and promising practices.

A date and time will be agreed between all the participants.

They activity will be carried out as follows (time estimates can vary according to the organization of each focus group and the number of participants).

Total duration: 3 hours

1. Presentation of the project, its objectives and next steps, as well as the dynamic of the activity, to be carried out by the consultant;
Duration: 10 minutes

2. Presentation of the participants;
Duration: 5 minutes

3. Collective discussion around the following questions:
1) How are the children whose parents use drugs included in national laws, strategies programmes and plans on children and violence against children?
2) Are age, gender and human rights perspectives included in national drug policy? How?

3) Does your country collect data in order to identify if people who use drugs have primary caregiving responsibilities? If so, in what data set are children included? How do you consider data gathering could be improved?
4) What are the impacts of law enforcement on people who use drugs and children?
5) How do child protection services act in case of parental drug misuse and child neglect or violence against children?

Duration: 1 hour

3. Break
Duration: 15 minutes

4. Second round of collective discussion around the following questions:

6) Are children with parents who use drugs taken into account in prevention strategies and how?
7) Are children with parents who use drugs taken into account in treatment services and how?
8) Are children with parents who use drugs taken into account in harm reduction services and how?
9) Do you have encountered successful stories through which children have helped their parents to live a balance and whether the ingredients for it have been identified? For example, the children have been identified early as being vulnerable/at risk and they have benefited from the support from social services without being stigmatized so in fact the support was for the whole family.
10) Is there support given to children whose parents suffer from psychiatric disorders and if yes should a similar support exist to children whose parents use drugs because in both cases the parents suffer from a disease (addiction) or several diseases (mood disorder and addiction) ?
11) What has been the impact of COVID on the services provided to people who use drugs and their families?
12) What gaps have you identified in relation to interventions that can benefit parents/families/women who use drugs and their families and children?
13) Could you refer of any good practice in the field of drug-related policies, on one hand, or child protection, on the other, that stands out as an example of how to enhance children's rights in the case of parental drug misuse?

Duration: 1 hour

5. Conclusions and proposals, all participants
Duration: 30 minutes

14) Based on your country's experience and the discussion developed in this activity, do you consider the current approach to children's rights in the field of drug policy and the perspective on drug policy in the sphere of children rights could be improved? And if so, how?

References

Benoit, T. and Jauffret-Roustide, M. (2016) *Improving the management of violence experienced by women who use psychoactive substances* (Strasbourg: Pompidou Group), https://rm.coe.int/improving-the-management-of-violence-experienced-by-women-who-use-psyc/168075bf22.

Council of the European Union (2020), *EU Drugs Strategy 2021-2025*, (Brussels: Council of the European Union), https://data.consilium.europa.eu/doc/document/ST-14178-2020-INIT/en/pdf.

Department of Children and Youth Affairs (2014), *Better Outcomes Brighter Futures: The National Policy Framework for Children and Young People 2014-202*0 (Dublin: Department of Children and Youth Affairs), https://assets.gov.ie/23796/961bbf5d975f4c88adc01a6fc5b4a7c4.pdf.

Department of Health, *Reducing Harm, Supporting Recovery. A health-led response to drug and alcohol use in Ireland 2017-2025*, (Dublin: Department of Health), 2017, https://www.drugsandalcohol.ie/27603/1/Reducing-Harm-Supporting-Recovery-2017-2025.pdf.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2015) *Alternatives to punishment for drug-using offenders* (Lisbon: EMCDDA), https://www.emcdda.europa.eu/system/files/publications/1020/TDAU14007ENN.pdf.

EMCDDA, (2012) *Treatment demand indicator (TDI). Standard protocol 3.0. Guidelines for reporting data on people entering drug treatment in European countries* (Lisbon: EMCDDA), https://www.emcdda.europa.eu/system/files/publications/675/EMCDDA-TDI-Protocol-3.0_392671.pdf.

EMCDDA (2012 a) *Pregnancy, childcare and the family: key issues for Europe's response to drug*s (Lisbon: EMCDDA), https://www.emcdda.europa.eu/system/files/publications/671/TDSI12001ENC_396469.PDF.

EMCDDA (2010) *Children's voices. Experiences and perceptions of European children on drug and alcohol issues* (Lisbon: EMCDDA), https://www.emcdda.europa.eu/system/files/publications/618/TP_ChildrenVoices_206942.pdf.

EMCDDA (2009) *Women's voices. Experiences and perception of women who face drug-related problems in Europe* (Lisbon: EMCDDA), https://www.emcdda.europa.eu/system/files/publications/549/EMCDDA-TP_women%27s_voices_133363.pdf.

Galligan, K. and Comiskey C. (2019) "Hidden Harms and the Prevalence of Children Whose Parents Misuse Substances: A Stepwise Methodological Framework for Estimating Prevalence in a Community Setting", Substance Use & Misuse, Volume 54, Issue 9, pp. 1429-1437.

Hümberlin, O., Läser, J. and Kessler, D. (2020) *Kinder aus Familien mit risikoreichem Substanzkonsum*, (Bern: Berner Fachhochschule), https://www.bag.admin.ch/bag/de/home/das-bag/publikationen/forschungsberichte/forschungsberichte-sucht.html#accordion_1873774968161395617 4449.

INCB (International Narcotics Control Board) (2017) *Annual report 2016* (Vienna: INCB), https://www.incb.org/documents/Publications/AnnualReports/AR2016/English/AR2016_E_ebook.pdf.

Ministero del Lavoro e delle Politiche Sociali (2017), *Linee di indirizzo nazionale. L'intervento con bambini e famiglie in situazione di vulnerabilità. Promozione della genitorialità positiva* (Roma: Ministero del Lavoro e delle Politiche Sociali), https://www.lavoro.gov.it/temi-e-priorita/infanzia-e-adolescenza/focus-on/sostegno-alla-genitorialita/Documents/Linee-guida-sostegno-famiglie-vulnerabili-2017.pdf.

Ministry of Welfare (2002) *Child Protection Act, No. 80/2002, as amended by Act No. 62/2006, No. 88/2008, No. 52/2009, No. 162/2010, No. 80/2011, No. 85/2011, No. 126/2011, No. 138/2011, No. 58/2012, No. 134/2013, No. 85/2015 and No. 80/2016*, https://www.government.is/media/velferdarraduneyti-media/media/acrobat-enskar_sidur/Child-Protection-Act-as-amended-2016.pdf.

Pompidou Group (2021) *Children whose parents use drugs: A preliminary assessment and proposals*.

Pompidou Group (2020), *Human rights and people who use drugs in the Mediterranean region: current situation in 17 Mednet countries* (Strasburg: Council of Europe), https://rm.coe.int/2020-ppg-med-4-human-rights-and-people-who-use-drugs-eng/16809e504d.

Santello, F., Colombini, S., Ius, M. and Milani, P. (2017) "P.I.P.P.I.: What has changed? How and why? The empirical evidence", *Rivista Italiana di Educazione Familiare*, n. 2, pp. 111-136, https://www.researchgate.net/publication/345692648_PIPPI_What_has_changed_How_and_why_The_empirical_evidence.

Tusla and HSE (Health Service Executive) (2019), *Hidden Harm Strategic Statement. Seeing Thorough Hidden Harm to a Brighter Future* (Dublin: Tusla, Child and Family Agency), https://www.tusla.ie/uploads/content/StrategicGuide.pdf.

Tusla and HSE (2019 a), *Hidden Harm Practice Guide*, (Dublin: Tusla, Child and Family Agency), https://www.tusla.ie/uploads/content/PracticeGuide.pdf.

UNODC (United Nations Office on Drugs and Crime) (2020) *World Drug Report 2020. Booklet 1 Executive Summary. Impact of COVID-19. Policy Implication* (Vienna: UNODC), https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf.

UNODC (2018) *World Drug Report 2018. Booklet 5. Women and drugs. Drug use, drug supply and their consequences*, (Vienna: UNODC), https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf.

UNODC (2016) *Guidelines on drug prevention and treatment for women and girls* (Vienna: UNODC), https://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf.

UNODC (2008) *World Drug Report 2008* (Vienna: UNODC), https://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf.

UNODC and WHO (World Health Organization) (2020) *International standards for the treatment of drug use disorders*, (Geneva: WHO and UNODC), https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.

WHO (2014) *Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (Geneva: WHO), https://www.who.int/publications/i/item/9789241548731.