Integrating gender and children's rights in services for families affected by drug use

Children and families affected by parental drug use
Practical guide

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Groupe Pompidou

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Introduction

> ” Teachers and services must be patient with children. They must hear the voice of the child and... the silence of the child. It helps to be supported in everything without the danger of losing your house and being in an institution. It helps if the child can have a quiet home, a therapist for the parents, a school that understands and a network that supports with food, clean clothes, a clean house, quiet sleep, studying, going to school on time. Therapists are helpful but children do not like going to therapy.

This opening quote is from Alexis,[1] a young boy from Greece. Straightforward and reflexive, his statement defines what these guidelines envision: children who are provided with safe spaces and people who listen to them in such a way that even their silence is understood. Children who can live in a safe home with the people they love, without having to be taken away and allocated to other families or to institutions. Boys, girls and non-binary children who see their rights to health, care, education, protection and participation fulfilled. Children who do not feel uncertain about their caregivers' love for them.

Alexis' vision does not end with children's rights but encompasses their parents, since it is with them, as primary caregivers, that children are imagined in this holistic perspective, so frankly articulated by this assertive young boy and yet so hard to attain in the daily lives of families affected by substance dependence.

His comments were collected as part of the Pompidou Group project Children Whose Parents Use Drugs, which began in November 2020 and is currently ongoing at the time of publishing this guide.

1. Background

Children Whose Parents Use Drugs is a human rights-based project that lies at the intersection of children's rights to health, education, development, participation, an adequate standard of living as well as the right to not be separated from their families, and people's rights to not be stigmatised, discriminated against and criminalised because of substance dependence. It aims at building and consolidating narratives and practices that, while looking at parents and children in their own rights, address them also as a family.

It also intends to be a contribution to the development of a wider children's rights perspective in drug policy and a more aware drug policy perspective in the children's rights agenda. The project was born as a response to the invitation to the Pompidou Group secretariat to contribute to the discussions on the Council of Europe Strategy for the Rights of the Child (2022-2027).

1. The names of people interviewed and whose testimonies are reproduced in the document are pseudonyms. Alexis participated in the Pompidou Group's study *Listen to the silence of the child – Children share their experiences and proposals on the impacts of drug use in the family* (Giacomello 2023a).

Between November 2020 and December 2022, the project involved 18 countries[2] and more than 300 people, particularly experts from academia, the public sector and non-profit organisations working in the fields of children-centred programmes and services aimed at strengthening protective factors and resilience; families with multiple vulnerabilities; prevention, drug treatment and harm reduction; and services for women victims and survivors of domestic abuse.

The information and reflections that nurture the project, its findings and recommendations have been collected through questionnaires, international and national focus groups, and semi-structured interviews with policy makers, experts, practitioners, women who use substances and children and young adults living in families affected by substance dependence. The products are a dedicated web page,[3] two reports (Pompidou Group 2021a, 2021b) and four publications: Volumes I, II, III and IV of the series *Children and families affected by parental drug use* (Giacomello 2022, 2023b, 2023a, 2023c):

- *Children whose parents use drugs – Promising practices and recommendations* includes the analysis of 29 practices from 11 countries[4] in the fields of a. family and children-oriented services that take drug use into account, including national strategies; b. programmes and services for people who use substances and their children and families, including data gathering and awareness raising; c. drug treatment services targeted at pregnant women, mothers and their children; and d. services for women who are victims and survivors of violence and use drugs, and their children. The publication contains operational recommendations in relation to the topics addressed in the analysis;
- *We are warriors – Women who use drugs reflect on parental drug use, their paths of consumption and access to services* is based on the participation of 110 women who use substances from nine countries,[5] and who are or have been in treatment. It includes their insights and recommendations on the impact of parental drug use during childhood on their life and subsequent drug use. It also explores the barriers and facilitators to accessing services and how to improve the response of services both to women who use drugs, and to children with parents who use drugs;
- *Listen to the silence of the child – Children share their experiences and proposals on the impact of drug use in the family* is based on 33 interviews with children and young adults from five countries.[6] They share how their parents' substance use has affected their life in terms of exposure to violence, a chaotic lifestyle and economic instability. They also talk about their parents' love and their attempts to take good care of them.

2. Specifically, 17 Pompidou Group countries (Croatia, Cyprus, Czech Republic, Greece, Hungary, Iceland, Ireland, Italy, Liechtenstein, Malta, Mexico, Monaco, North Macedonia, Poland, Romania, Switzerland and Turkey) and Spain.
3. Available at www.coe.int/en/web/pompidou/children, accessed 17 July 2024.
4. Croatia, Cyprus, Czech Republic, Greece, Iceland, Ireland, Italy, Mexico, Poland, Switzerland and the United Kingdom.
5. Croatia, Czech Republic, Greece, Ireland, Italy, Malta, Mexico, Romania and Switzerland.
6. Greece, Malta, Mexico, Romania and Switzerland.

The children interviewed also describe their feelings, such as sadness, anger, fear, love and confusion, as well as their empathic understanding of their parents' struggles. They identify protective factors: the presence of a parent who does not use substances, loving grandparents, siblings, friends who have gone through the same situations, understanding teachers, sports, art and music. They ask to be listened to and to be provided with reliable information on their parents' condition;

- *Children and parents affected by drug use – An overview of programmes and actions for comprehensive and non-stigmatising services and care* analyses 33 programmes from 11 participating countries,[7] which include a. actions in the field of data gathering; b. parenting programmes; c. social and integrated services for children; d. multidisciplinary, holistic approaches to working with families; e. services for women victims and survivors of gender-based violence; f. protocols of co-operation; and g. drug treatment services and residential communities for women and their children.

Another concrete outcome of the project is that the new Council of Europe Strategy for the Rights of the Child (Council of Europe 2022), adopted in 2022, includes in its objective "Equal opportunities and social inclusion for all children" the following: "Mapping, analysing and providing guidance on the situation of children suffering from addictive behaviours and children of parents using drugs", thus identifying, for the first time, children living in families affected by drug dependence as a group with specific situations of vulnerability.

This guide represents years of collective learning, sharing and thinking. It brings together in a unified document the enormous wealth of knowledge, analysis and proposals developed by the project Children Whose Parents Use Drugs and the human rights legal framework that guarantees children's rights as well as those of parents who use substances.

The next section offers an overview of the challenges faced by children and families affected by substance dependence. Subsequently, the concept of "hidden harm" is presented in relation to the three sections of the guide. The theoretical analysis is followed by an explanation of the scope and purpose of the guide, along with the basic definitions of terms used in this text.

2. The effects of parental substance dependence on children

> " When I was younger, it was difficult for me because I lived with my parents and they were both addicts[8] and from the time I was 6 years old I took care of my sister: I made her dress to go to school, or I looked for food for her because we didn't have anything to eat. (Regina, Mexico City)

7. Croatia, Cyprus, Czech Republic, Greece, Ireland, Italy, Malta, Mexico, North Macedonia, Romania, Switzerland and one practice from Starlings Community, a Canadian non-profit organisation.
8. Terms such as "drug users" and "addicts" are avoided in the text, since they are discriminatory against people who use substances. However, they are left unchanged when a person or a text are quoted.

Regina, her sister Valentina and their mother Sonia participated in Volumes II and III of the Pompidou Group series on children whose parents use drugs. Regina and her sister experienced the challenges faced by children whose parents encounter difficulties in fully exercising their parenting role and responsibilities while being dependent on one or more substances. Regina, as the older sister, had to cope with the effects of neglect – for instance, they only went to school once a week – and her parents had a chaotic lifestyle, involving domestic abuse. Both Regina and her sister faced the additional challenges that having two dependent parents implies (Velleman and Templeton 2016), but at least they could rely on the protection of their grandparents (Galligan 2022).

Children living in families affected by substance dependence may experience anxiety, anger, depression, fear for their parents' well-being and shame (Advisory Council on the Misuse of Drugs 2003). They may also be required to take care of themselves, their siblings and their parents from a very young age (Tusla and HSE 2019a: 16). Children's isolation and secrecy around parental drug use are strongly associated with stigma (Meulewaeter et al. 2022; Starlings Community 2022) and uncertainty about what is happening in their family (Velleman and Templeton 2016).

Parental alcohol and drug harmful use is one of the multiple adverse childhood experiences, that is, "stressful experiences occurring during childhood that directly impact on a child or affect the family environment in which they live" (Lorenc et al. 2023: 1). The term emerged in a study in the United States in the mid-1990s (Felitti et al. 1998) that found a strong interrelationship between adverse childhood experiences and severe chronic disease and premature death in adulthood. The original study identified seven adverse childhood experiences – abuse grouped by category: psychological, physical and sexual abuse; and exposure to household dysfunction grouped by category: substance abuse, mental illness, mother treated violently and criminal behaviour in household. This established a new field of study and a model of inquiry that has continued since.

These are related to risky health behaviours, chronic health conditions, low life potential and early death (Bellis et al. 2015). As the number of adverse childhood experiences increases, so does the risk for these outcomes: a "score" of four issues or more is seen to significantly increase the likelihood of a child engaging in risky future behaviour and of experiencing poor health outcomes compared with individuals with no adverse childhood experiences (Morton and Curran 2019: 11; Hughes et al. 2017). Furthermore, some adverse childhood experiences have greater impact than others (McDonagh, De Vries and Comiskey 2023); for instance, "the factor 'feeling unloved' as a child provided the single strongest predictor and may represent an overarching risk of post-traumatic stress disorder and continued substance use in later life among adults in treatment for an opiate use disorder" (ibid.: 1).

The literature is unanimous regarding the capacity for parental substance dependence to affect child outcomes: "It has become well accepted that children of substance misusers, compared to their peers whose parents do not misuse substances, are at heightened risk of experiencing a range of health, social and psychological problems" (Horgan 2011: 14).

Compared to their peers, children of parents who have developed substance dependence show increased rates of anxiety, depression, oppositional behaviour, conduct problems and aggressive behaviour as well as lower rates of self-esteem and social competence (Solis, Hussong and Reimuller Burns 2012: 5). Furthermore, when mental health problems and substance use disorders co-occur (which is the most common situation), children are at an elevated risk of poor outcomes (Dawe, Harnett and Frye 2008: 4).

The impact of parental drug use on children will vary according to external and internal factors, such as the child's age and gender, the number and the roles of the caregivers that are affected by dependence, and the presence of protective factors. Evidence also shows that not all the children living in a family with harmful substance use are at risk of harm (Comiskey 2019).

As indicated by Velleman and Templeton's review (2016) on the impact of parents' harmful substance use on children, while each family and child are unique, the risks for children are greater if:

- there is exposure to multiple problems (the presence of domestic violence and abuse appears to be particularly potent);
- the child lives with two parents with problems;
- there is greater length and severity of the problems;
- there is significant "fall out" associated with problems, both within the family (e.g. disharmony) and outside (e.g. significant disruption, association with the criminal justice system).

On the other hand, children and families also have protective factors, that, in the authors' analysis, are divided in three categories, summarised below:

- individual factors: internal locus of control; active agency; personal qualities and social skills; having a hobby; plans for the future/yearning for a better future; a sense of humour, and so on;
- family factors: supporting and trusting relationship with a stable adult who does not use substances harmfully; close positive bond with at least one adult in a caring role; consistency and stability in everyday family life; openness and good communication within the family, including open and appropriate discussion of family problems; adequate finances and employment opportunities/income; good physical home environment; absence of domestic violence/abuse, family breakdown and associated losses, among others;
- community/environmental factors: support from an adult/adult role model (e.g. teacher, neighbour); strong friendships and relationships with peers, including those that a young person can talk to about the problems at home; living in a community where there is a sense of caring, mutual protection, community engagement and supportive social networks; strong bonds with local community/community involvement; positive school experiences and influences; opportunities through education and employment; out-of-school/community activities, and so on.

Parental substance use may be experienced and continued transgenerationally: on the one hand, people who use substances and are parents have often themselves

been children who experienced adverse childhood experiences, including harmful alcohol and drug use, domestic violence and sexual abuse (McDonagh, De Vries and Comiskey 2023). Substance dependence may function as a coping mechanism: as expressed by Khantzian (ibid.: 6), "Suffering is at the heart of addictive disorders". This was also widely reported by the mothers and fathers that participated in the Pompidou Group's studies in 2022 and 2023 (Giacomello 2023a; 2023d), as demonstrated by the following testimonies.

> " In fact, I started using at the age of 15, because I was abused and in fact afterwards it allowed me to have a sort of Band-Aid for my suffering.
>
> (Eugenie, Switzerland) (Giacomello 2023a: 27).

> " The women I have met in rehabilitation centres… they all come for the same reasons: they all come for abuse, for mistreatment, because their father is on drugs. They come for different stories of connection, but I think we all go through rape.
>
> (Elisa, Mexico) (ibid.: 34).

> " I could hear my mum crying when I was asleep.
>
> I carried these things with me for years, from 13 to 20, because I didn't understand, I could only hear my mother crying, but I couldn't go near her because I was always a bit shy, insecure… I grew up with insecurity.
>
> My life was "home, work and family"; I was afraid to go out because I knew there were always problems at home. I was always trying to protect my mum, she protected me and I protected her. I had few friends.
>
> In my twenties, during the military service, I began to understand what life was about.
>
> I started right away with cocaine, as I found it was my salvation, because... the insecurities, the fear, the anxiety... I fell in love with it right away. It made me feel like another person.
>
> (Giovanni, Italy) (Giacomello 2023d: 42).

> " With my weakness and insecurity… going out with friends, with the group, we started smoking weed at 14 and then at 16 I found heroin which was the thing that made me be with people, interact.
>
> (Pietro, Italy) (ibid.: 44).

Furthermore, harmful substance use may expose parents to other situations and risks that trigger post-traumatic stress disorder (PTSD) (McDonagh, De Vries and Comiskey 2023; Staton-Tindall et al. 2013). Therefore, the child that the parent once was and the traumas that they may have experienced have to be taken into consideration.

On the other hand, children affected by parental substance dependence face a higher risk of drug involvement as well as mental health and behavioural problems (Galligan 2022: 18), which make the cycle more difficult to break (Meulewaeter et al. 2022).

To conclude this overview, it is important to remember that substance use is often only one of many issues faced by families (Cotmore et al. 2018; Dawe, Harnett and Frye 2008): parents, children and other caregivers or family members may face other challenges, such as complex traumas, mental health conditions, eating disorders, self-harm and suicide attempts (Bao and Lu 2023; Brohan et al. 2023; Rizk et al. 2021; SAMHSA 2016).

When approaching the interrelationship between substance dependence, parenthood and children's rights it is important to also consider the environmental and community factors that might represent other sources of vulnerability and social marginalisation for children and parents, such as poverty, incarceration, unemployment, housing, racial and ethnic discrimination, social inequalities, violence and lack of family or social support. These are called "adverse community environments" and interconnect with adverse childhood experiences (Dietz and Ellis 2017).

In this regard, it is important to clarify that this guide does not directly address these complex issues, and this is not because they are not considered key for families and children. Mental health, housing, employability and working conditions, social inclusion, the right to freedom from torture and other cruel, inhuman or degrading treatment or punishment, the right to a fair trial and so on are all rights to which children and parents are entitled. They constitute states' obligations established in international human rights treaties and in the European Convention on Human Rights and the European Social Charter, as described in Section 1.

Guaranteeing parents their rights is a primary step to make sure that their children have also access to them and that families can thrive. Substance dependence often intersects with other social conditions of vulnerability, stigma and exclusion and can be part of complex and painful experiences of trauma that sometimes span a lifetime, beginning from childhood (McDonagh, De Vries and Comiskey 2023).

However, this guide is conceived as a tool that, for the purposes of scope, length and theoretical underpinning, cannot include all the topics and interventions that should be guaranteed in all realms and at every level of parents' and children's lives. Such an effort would be most likely unattainable in this kind of document, or would lack a clear orientation and practical purpose.

Therefore, the guide is complementary to the existing work of state agencies and civil organisations. It aims at fostering changes in mentalities and practices in the particular and vastly complex intersection of the suffering, ambitions and paths of parents and the questions, rights and dreams of children. It means to contribute to views and collaborative ways of working that do not address parents' and children's rights and conditions as juxtaposed and services as separated silos, but that aim at working through integral approaches that can understand and support, in non-judgmental ways, the multiple issues and unique circumstances of each person and each family.

3. Hidden harms

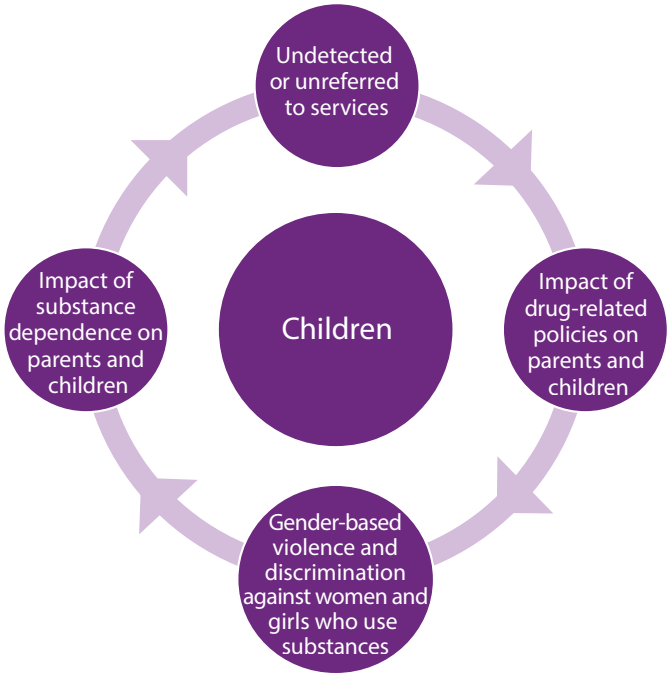
Since the publication of the ground-breaking UK report *Hidden harm – Responding to the needs of children of problem drug users* (Advisory Council on the Misuse of Drugs

2003), the experience of children affected by parental dependent substance use has become widely characterised as "hidden harm", a concept that encompasses individual and family situations as well as the response of services, and societal beliefs and stigma at large (Galligan 2022).

The concept of "hidden harm" has also been adopted in Ireland. As outlined in Ireland's "Hidden Harm Strategic Statement" (Tusla and HSE 2019a: 8): "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 present guide embodies the two elements in the above explanation and adds two new ones, in order to more fully understand, and thus address, the issues faced by children and families affected by drug dependence. These are: the impacts of drug-related policies on parents and gender-based violence and discrimination against women and girls who use substances. The four aspects are interlinked and should be addressed in a comprehensive manner in order to guarantee the child's well-being, through the fulfilment of children's rights by also promoting and guaranteeing the well-being of their parents. The following figure outlines the four dimensions of hidden harms that underpin the development of this guide.

Components of hidden harm to children in families affected by substance dependence



Source: Advisory Council on the Misuse of Drugs (2003); Comiskey (2019); Council of Europe (2012); Mutatayi et al. (2022); Giacomello (2022, 2023a, 2023b, 2023c); Tusla and HSE (2019a, 2019b).

Children are positioned at the centre because they lie at the core of this guide. The focus on children's development and well-being (Ius 2021: 75) is not intended to be juxtaposed to their parents' well-being but as complementary and interrelated. Children are the starting point from which to look at all the other issues at stake and the caregivers, services and social structures involved in The Child's World.[9] They are also the primary beneficiaries of the guide, but in a way that takes into account and cares for the needs and strengths of the people around them: their parents, siblings, other caregivers – such as grandparents – so that while each person is listened to, supported and empowered (Dawe, Harnett and Frye 2008) according to one's circumstances, family members are understood and strengthened as individuals and in relation to each other (Staton-Tindall et al. 2013).

Putting children at the centre implies giving them visibility and ensuring that they are aware of their rights and are empowered to take action and, if they need it, seek help and know where to find it. This means that children are empowered to use their voice and that there are clear channels (helplines, schools, youth associations, non-profit organisations, religious groups, public institutions, etc.) that are capable of encouraging children's participation, as well as detecting and referring situations that require support. It also means that children are listened to in the processes and decisions that concern them individually or collectively and that their views are given due weight in accordance with their age and maturity (Council of Europe 2012), as rights holders with agency and opinions.

The elements "undetected or unreferred to services" and "impacts of substance dependence" are interlinked and imply several spheres of intervention that aim at strengthening children's well-being and that of their families. The areas of intervention that will be developed in the guide imply:

- the recognition and embodiment of children as rights holders and citizens (Council of Europe 2020a), with rights and capacities to influence decisions about their lives (Section 1);
- the conceptualisation and visibilisation of children affected by their parents' substance dependence as a group that faces a specific source of vulnerable situations, and that is entitled to specific actions and support from services, including schools, and families (Sections 1, 2 and 3);
- children's participation in the processes and decisions that concern them and in the design, implementation, monitoring and evaluation of the policies and programmes that affect them directly or indirectly (Sections 1, 2 and 3);
- the development of a national strategy that names, collects data on and listens to children and families affected by substance dependence. Such a

9. The Child's World is a multidimensional tool based on Uri Bronfenbrenner's ecological system theory and the British programme Looking After the Child. It is used with children, families and practitioners and serves as a tool to identify the strengths and needs of children and their caregivers and how the components of the world of the child (namely the child, the family and the larger environment around the child) can interact to enhance the child's well-being through actions and methodologies that increase everyone's well-being. The world of the child is considered in the Italian programme P.I.P.P.I. (Programme of Intervention for the Prevention of Institutionalisation). More information can be found in Giacomello (2022) and Ius (2021).

strategy sets out the mechanisms for collaborative and multidisciplinary actions for social services and substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services (Section 2);

- the development and consolidation of co-ordinated, multidisciplinary work methods in the fields of social services and substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services (Section 3) that aim at supporting children and families at the same time and overcome the "silo" effects that flow from the formal organisation of practice and disciplinary domains.

The third aspect of hidden harm, the "impact of drug policies", intersects with the previous two but from the perspective of parents as targets of drug-related policies and their children as affected by them. It should be kept in mind that most people do not use alcohol and other drugs in a way that compromises their self-care and the care of their children. Nevertheless, "for some parents, regular or intensive drinking or drug use can seriously affect their ability to care and respond appropriately to their child's basic needs for nutrition, intimacy, security, health and learning" (EMCDDA 2010: 5). Lack of information as well as conflicting information on drug use-related services (ICAAN 2022), social stigma, the feeling that they are being judged by services, criminalisation and the fear of losing custody of their children may keep parents away from services or dissuade them from disclosing their parental status when undergoing treatment (EMCDDA 2012). This in turn leads to children being undetected and unreferred to services and to the continuation of the harms that children may be suffering because of their parents' dependence (Advisory Council on the Misuse of Drugs 2003), as well as the suffering experienced by parents who use substances because of lack of support, guilt, shame and stigma.

The impact of drug policies is comprised of two main dimensions: on the one hand, the presence, availability, access and quality of substance use prevention, early intervention, treatment, care, recovery and social reintegration services and, on the other, the design and implementation of supply control efforts, particularly the criminalisation and incarceration of people accused of drug-related offences. Both dimensions have consequences for children and parents.

The first aspect is addressed in Sections 1 and 3 and aims at guaranteeing that children are always taken into consideration by substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services and that the well-being of parents and experiences of complex traumas are addressed and supported.

It goes beyond the scope of this guide to address the second point and provide orientation on how the criminal justice system should define and sanction drug-related offences. Nevertheless, issues related to the impact of parental incarceration on children (Jones and Wainaina-Woźna 2012; Murray et al. 2014; Nowak 2019) and non-custodial measures for women who are primary or sole caregivers of small children (UNODC 2011, 2020a) are addressed in Section 1.

Furthermore, as indicated in part 2 of this introduction, parents who use substances may have experienced post-traumatic stress. As highlighted in Ireland's "Hidden Harm Strategic Statement" (Tusla and HSE 2019a: 27):

> The collective needs of families should be addressed in a comprehensive and co-ordinated way by all services. International evidence shows that many parents presenting for treatment have experienced post-traumatic stress as a result of domestic violence and childhood sexual abuse. This may require a reframing of service provision with a whole-family focus embedded within an understanding of a wider trauma agenda.

The incorporation of a trauma-informed approach in treatment services is addressed in Sections 1, 2 and 3.

The element of "gender-based violence and discrimination against women and girls who use substances" draws on the fact that patriarchal structures (Walby 1990) in society as a whole as well as in drug use circuits and treatment settings may lead to gendered forms of hidden harms against women. Stigma, guilt and shame are particularly acute for women who use licit and illicit substances or manifest other addictive behaviours such as excessive and compulsive video gaming, gambling, online shopping, streaming or social network use (Council of Europe 2022b) and for those who are pregnant or mothers, given the gender-related social mandates that see women who use drugs as unfit for motherhood (Mutatayi et al. 2022). Structural, social and economic barriers often stand between women and services, especially if women cannot attend treatment accompanied by their children or cannot count on alternative services for their care (UNODC 2018).

Women who use substances have been found to be more likely to report experience of adverse childhood experiences or gender-based violence as adults, such as intimate partner violence (EMCDDA 2023a). Among people who use drugs, PTSDs and other mental health problems, such as anxiety and depression, are more common among women. Women and girls are also exposed to heightened health risks, including higher vulnerability to HIV and sexually transmissible infections (STIs) compared to boys and men (Arpa 2017).

Childcare responsibilities and the absence of childcare options in substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services can represent an important barrier to service access for women who use substances. Maintaining or improving relationships with children is very important and may play a central role in women's drug use and recovery (EMCDDA 2023a). However, despite the growing evidence on women's drug use and their specific vulnerabilities, drug policies in general and demand-related drug policies still maintain service patterns that are men-centred in terms of availability, structure and underpinning, leaving women who use drugs much less well served while facing higher social, cultural, personal and economic barriers to accessing services (Mutatayi et al. 2022). This is reflected in the fact that while one in every three people who use drugs is a woman, women only account for one in five or fewer in treatment (UNODC 2020b: 91).

As explained by some of the participants in the Pompidou Group publication *We are warriors* (Giacomello 2023b: 33-4):

> " Usually women face difficulties with their families, they do not have somewhere to stay because they are in drug use, so they tend to stay with a drug-using partner or with drug-using friends. They have difficulties finding money, so they engage in all sorts of activities, that they don't like (prostitution, dealing, robberies, etc.) and they cannot stand without the use of drugs. In the case of addicted mothers, things are more complicated and difficult. They have to find shelter and someone to look after their child, to find more money and psychologically it is more difficult to think and have the responsibility for two people.
>
> (Georgia, Greece)

> " Dependent girls face difficulties in such a way that they do not want to seek any professional help and, on the contrary, they also lose housing with their parents, they live on the street, they have relationships with addicts and that doesn't help them much. It is very difficult for mothers when they are watched from below or worse when the authorities take away their children.
>
> (Paula, Czech Republic)

An additional source of risk for women and children is the tendency to segregate the services for women who are victims and survivors of domestic abuse and those for people who use substances, including cases where women can attend to or live with their children. Generally speaking, women with substance use disorders are not admitted in refuges for women survivors of domestic abuse (Benoit and Jauffret-Roustide 2015). This can represent in itself a form of institutional violence and expose women and their children to heightened risks.

Regulations specific to women, gender-based violence and substance dependence are indicated in all sections of the guide, with a specific emphasis in Section 3.

4. Scope and purpose

The guide aims to intertwine children's rights and those of people who use substances and are parents under a comprehensive human rights approach. It intends to fill a void in the drug policy arena and in the children's rights agenda and to provide a concrete contribution to the implementation of the Convention on the Rights of the Child (CRC) while, at the same time, promoting the implementation of human rights-based drug policies.

As established in Article 4 of the CRC, state parties have the obligation to undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the CRC. As explained by the Committee on the Rights of the Child (2003: paragraph 9):

> The general measures of implementation identified by the Committee and described in the present general comment are intended to promote the full enjoyment of all rights in the Convention by all children, through legislation, the establishment of co-ordinating

and monitoring bodies – governmental and independent – comprehensive data collection, awareness raising and training and the development and implementation of appropriate policies, services and programmes.

This guide supports national governments in implementing such obligations by serving as:

- a call to international and national bodies to address the intersections of children's rights, parents' rights and drug policies;
- a roadmap for governments and decision makers;
- a guide for local operators;
- a tool for children and for people who use substances;
- a work in progress to be encouraged, challenged, used and transformed on the basis of new knowledge and perspectives, advances in drug policies and in the child rights agenda, and the individual and collective experiences of the multiple stakeholders they are aimed at.

The guide aims to achieve:

- the inclusion of children affected by their parents' substance dependence in the international and national drug policies agenda from a comprehensive, intersectional and human rights perspective;
- the incorporation of drug policies in the children's rights agenda, including at the international and European levels, through research, interagency co-operation, data gathering and the promotion, implementation and monitoring of specific recommendations and actions, including training;
- the promotion of policies and practices that support parents who use substances, by addressing the complex traumas and mental health issues that often underlie dependency and the multiple conditions of vulnerability that some people and groups may face, such as poverty, stigma, lack of family and community support, abuse, houselessness, racism and ethnic discrimination, criminalisation and social exclusion;
- the building of national strategies specifically focused on the intersection of the four components of hidden harm identified in this guide as well as their incorporation in current national strategies on related topics;
- in national strategies, the promotion of mechanisms of co-operation between relevant agencies to guarantee a comprehensive approach to the issues faced by children and families affected by substance dependence;
- the dissemination of the guide among relevant stakeholders, including children and families, and their subsequent adoption and adaptation by national governments, including in child-friendly formats;
- the adaptation of the recommendations of the guide to national and local contexts and their subsequent implementation.

The beneficiaries of the guide are children and parents affected by substance dependence in their own right but also as a unity, in ways that do not jeopardise, juxtapose or compromise their well-being. The target audiences of the guide are:

- national governments, which should consider adapting, adopting, disseminating and implementing the guide at all relevant levels;

- the international community, to further promote the principles described in the guide and to support their member states in implementing them, specifically:
  - the Council of Europe, in particular the Children's Rights Division, the Gender Equality Division and the Group of Experts on Action against Violence against Women and Domestic Violence, with which the Pompidou Group has established transversal co-operation;
  - the European Union Drugs Agency;
  - the Inter-American Drug Abuse Control Commission of the Organization of American States (CICAD/OAS);
  - the United Nations (UN) and, within it, the Committee on the Rights of the Child; the Human Rights Council; the United Nations Children's Fund (UNICEF); the United Nations Office on Drugs and Crime (UNODC) and the Commission on Narcotic Drugs (CND).
- national and local state and non-governmental agencies and organisations in the field of children's rights, child protection, social services for families and children, schools, health services, mental health and drug dependence-related services, including harm reduction and service providers in prisons;
- ombudsperson institutions, including the ombudspersons for children,[10] independent monitoring mechanisms and national human rights institutions;
- individual practitioners in related fields.

While the guide refers to "substances" and "drugs" interchangeably (see part 6, "Definitions", of this introduction) and to "substance dependence" and "drug dependence", these terms are also used for other addictions, such as internet gambling and gaming.

5. Working method and contents

The preparation of the guide was commissioned by the Pompidou Group to Corina Giacomello, consultant, and prepared with the support of an advisory group of six experts from five countries and the Pompidou Group Secretariat (see biographies).

Katia Bolelli, University of Padua, Italy

Karel Chodil, Therapeutic Community Karlov, Czech Republic

Leda Christodoulou, National Addictions Authority, Cyprus

Catherine Comiskey, Trinity College Dublin, Ireland

Louise McCulloch, Preparing for Life, Ireland

Helmut Sax, Ludwig Boltzmann Institute of Fundamental and Human Rights, Austria

Florence Mabileau, Pompidou Group Secretariat

10. See, for instance, the European Network of Ombudspersons for Children (ENOC), available at https://enoc.eu, accessed 17 July 2024.

The final draft was completed in March 2024 and shared with the advisory group and two external readers: Dr. Eleanor Hollywood, Associate Professor in Children's Nursing at the School of Nursing and Midwifery, Trinity College Dublin, and Kateřina Horáčková, Head of the Co-ordination and Funding Unit at the Drug Policy Department of the Government of the Czech Republic, and Permanent Correspondent of the Czech Republic to the Pompidou Group.

The guide is organised into three sections and comprises 108 recommendations, which start in Section 2 under the part "mandate".

Section 1 presents the legal framework and the overarching principles that underpin the operational proposals of the guide and the recommendations outlined in Sections 2 and 3.

Section 2 invites states to develop a national strategy focused on children living in families affected by substance dependence and outlines concrete recommendations on how to develop it. The inspiration for this component is Ireland's "Hidden Harm Strategic Statement" (Tusla and HSE 2019a), which is described in three of the Pompidou Group's publications (Pompidou Group 2021b; Giacomello 2022, 2023c).

Section 3 comprises recommendations for social services, including schools, refuges for women victims and survivors of domestic abuse as well as substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services.

Each recommendation and guideline is numbered continuously across Sections 2 and 3.

6. Definitions

Child: "[E]very human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier" (UN General Assembly 1989).

Drugs/substances: "Psychoactive drugs are substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions. Psychoactive drugs belong to a broader category of psychoactive substances that include also alcohol and nicotine."[11]

In this document, the terms "drugs", "substances" and "psychoactive substances" are used to refer to alcohol, nicotine, prescription medicines, controlled substances under the United Nations international conventions,[12] new psychoactive substances as well as substances used for their psychoactive effects, such as solvents.

Drug/substance dependence: "[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);

11. *Drugs (psychoactive)*, available at www.who.int/health-topics/drugs-psychoactive#tab=tab_1, accessed 17 July 2024.
12. 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; UNODC (2013).

(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 features 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" (WHO and UNODC 2020: 4).

As explained above, when referring to dependence in this text, other forms of addiction are also included even if not mentioned explicitly. These may include excessive and compulsive video gaming, gambling, online shopping, streaming or social network use (Council of Europe 2022b).

Drug/substance use: In the guide, the term "drug use" is not used to describe all forms of drug use but as a synonym of drug/substance dependence.

Gender-based violence: The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, also known as the "Istanbul Convention", defines gender-based violence as that which is directed against a woman because she is a woman or that affects women disproportionately (Council of Europe 2011a).

This definition is taken up in this text, too; however, it is important to clarify that gender-based violence and patterns of hegemonic masculinity[13] (Connell and Messerschmidt 2005) also affect men, lesbian, gay, bisexual, transgender, intersex, queer, non-cis gender and non-binary (LGBTIQ+) individuals.

Man/male: Persons who identify their gender as male.

Non-binary: Persons whose gender is not male or female.

Parent: Persons with parental responsibilities (Council of Europe 2006).

Parenting: All the roles falling to parents that have to be fulfilled to care for and bring up children (ibid.).

Positive parenting: Parental behaviour based on the best interests of the child, which is nurturing, empowering, non-violent and provides recognition and guidance that involves setting of boundaries to enable the full development of the child (Council of Europe 2006).

13. Hegemonic masculinity is not necessarily the kind of masculinity most performed by men in actual terms, but it stands as an ideal that men may compare each other and their peers with, like an ambition and an internal and external source of approval or stigma. Hegemonic masculinity is a construction of gender norms that weighs as a mandate on men. It is part of patriarchal masculinity, which sees men as superior to women and to other men. It is also termed "traditional masculinity" and since the 1990s it has been reframed as a risk factor to men's health, according to which men who are socialised within traditional masculinity are conceived of as a socially vulnerable group that suffers the consequences of the internalisation of gender norms (Martínez-Redondo and Luján-Acevedo 2020: 27).

Social services: An inclusive range of services meeting general social needs as well as personal social services provided either by public or private bodies. While the former refers to standardised, universal services provided to people as members of a category, the latter are "needs specific" and are addressed to the particular needs of beneficiaries (Council of Europe 2011b: 6).

General social services for children and families include, *inter alia* healthcare; education; financial assistance; subsidised housing; support systems for children in vulnerable situations such as migrant children, children victims of trafficking, children with mental health problems, children without parental care and children whose parents are deprived of their liberty or other rights; integrated policies and effective early intervention in situations of child abuse and neglect; effective prevention programmes against criminality, substance abuse and other risk-taking behaviour as well as measures to overcome toxic elements in the child's social environment (ibid.: 9).

Specialised social services "should be in place to ensure immediate emergency interventions and address negative impacts of adverse childhood experiences, and provide social and psychological support to children and their families" (ibid.: 10).

Services for families and children affected by substance dependence belong to both categories.

Woman/female: Persons who identify their gender as female.

Key messages concerning this guide and its use

- Each section of the guide is independent and can be consulted separately, depending on the audience's particular interests or area of work. However, they all respond to the legal framework and the overarching principles outlined in Section 1, which should be consulted and mainstreamed in policies and actions targeted at children and families affected by substance dependence.
- Each individual section includes concrete points that can be embodied into existing actions and policies at the national and local level as well as prompt the creation of new interventions. For the development of a comprehensive model, it is advisable that national governments adopt the recommendations of the guide as a national roadmap.
- The guide is not intended as a substitute to existing regulations and practices concerning children and people who use substances. Rather, it constitutes an additional outlook on families affected by substance dependence and aims at offering policy makers, services and practitioners new perspectives and indicated actions to be incorporated in their daily tasks.
- The main elements that are required for effective implementation of the recommendations are the participation of children and families, legal harmonisation, training, capacity building, and expansion and co-ordination among services, within a multidisciplinary perspective.
- The recommendations of the guide do not focus directly on other conditions of vulnerability that families might face, such as mental health conditions,

social inequality, poverty, gentrification, racism, criminalisation and other practices and policies of social discrimination that affect parents and children, and particularly people who use substances. This is a practical decision aimed at defining the scope of the guide. However, the Pompidou Group's project is aware that these issues intersect with substance dependence and with the willingness, motivation and availability of services providing the necessary care, and that they may increase the conditions of vulnerability, social exclusion, stress, guilt and self-loathing of parents.

Section 1

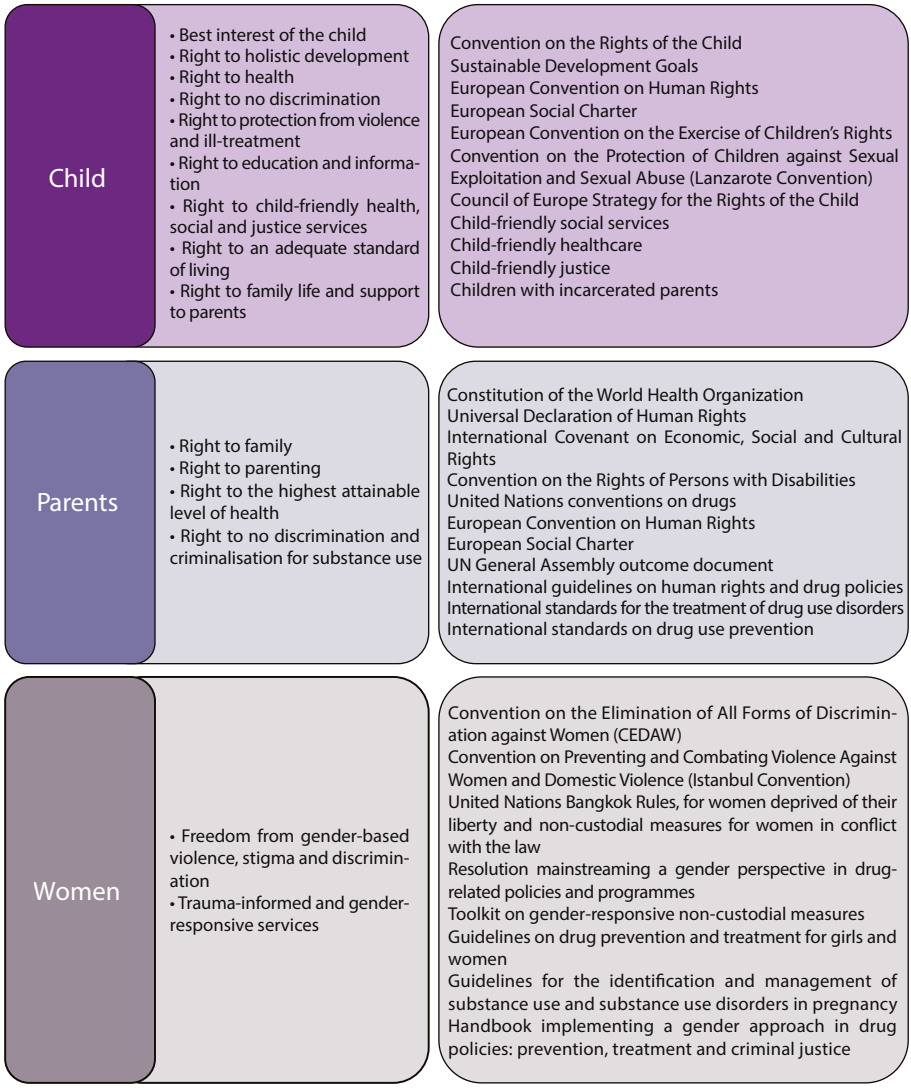
Legal framework and overarching principles

This section outlines the fundamental human rights principles and instruments to be taken into account when addressing families affected by substance dependence.

The guide and its recommendations are based on both legally binding international laws and "soft law" resources, such as international resolutions, recommendations, guidelines and handbooks. The body of documents analysed in this section is not meant to be exhaustive or limitative, but delineates the horizons within which the guide was put together. The contents of this section are organised as follows: the first part refers to standards regarding children's rights, approaching them from a global perspective, through an in-depth analysis of the CRC. Subsequently, the same exercise is replicated for the 2030 Agenda for Sustainable Development. The second section looks at the regional intergovernmental level, by presenting conventions, recommendations and guidelines developed by the Council of Europe, the guardian of human rights in Europe. The third section presents those regulations in the field of drug policies, particularly in the area of treatment, that concern parents who have developed substance dependence. Since the children's rights framework already includes parents' responsibilities and underlies the state's obligation to support parents, this section specifically focuses on the rights to health and the right to family life for people who use substances. Thereafter, the document shares inputs from the Council of Europe and the Pompidou Group that support the consolidation of positive parenting, gender equity and the child–parent relationship. The fourth part presents international and Council of Europe tools that address the intersection of gender-based violence against women and the situations of vulnerability faced by women who use substances.

The presentation of the legal framework in four parts and by target population is to allow specific audiences to identify and become familiar with the conventions, recommendations, and other international and regional tools that are most pertinent to their work. It is also aligned to the conceptualisation of hidden harms that underpin this document. However, human rights are universal, inalienable, interdependent and indivisible and, as will be explained later, children's rights and parents' rights are intimately interlinked.

The following figure synthesises the core rights addressed for each population and the tools described or named in this section of the guide. Parents' rights are intrinsically linked to the well-being of children. Women who are mothers are included in the section on the wider category of parents and addressed separately, given the specific forms of gender-based violence, stigma and barriers that women who use substances face in terms of service provision and accessibility.



This first section of the guide concludes with a list of the overarching principles that should be taken into consideration when working with children and families affected by substance dependence. These specified principles will provide direction to all subsequent sections and sub-sections.

1.1. Universal standards for the protection and enhancement of children's rights

At global level, there are nine core human rights treaties,[14] some of which are supplemented by optional protocols dealing with specific concerns. They are all of relevance to children, who are entitled to all human rights. The CRC is the landmark legal instrument on the human rights of children. It is the most widely ratified treaty worldwide and covers civil, political, economic, social and cultural rights (Vandenhole 2015).

1.1.1. Convention on the Rights of the Child

The CRC brought about a paradigm shift in the way children are perceived by society, breaking the vertical relationship that has traditionally seen children as people with no autonomy or dignity, whose condition is that of "adults in the making" (González Contró 2008). The CRC recognises children as subjects of rights entitled to special protection by their parents, the state and society, under the framework of the three Ps: protection, provision and participation (Vandenhole 2015). In the CRC paradigm, children are recognised as citizens and agents with progressive autonomy and with the capacity to form their own views on the matters that concern them directly and indirectly, including the situations of their caregivers and the world around them.

Whereas the convention itself does not refer to general principles, its monitoring body, the Committee on the Rights of the Child, has identified four overarching general principles (Committee on the Rights of the Child 2009): the best interest of the child (Article 3, paragraph 1 of the convention), the right to non-discrimination (Article 2), the right to life, survival and development (Article 6) and the right to be heard (Article 12). These are not only rights in themselves but should also be considered in the interpretation and implementation of all other rights.

The convention outlines rights that apply to all children without discrimination and children living in families affected by substance dependence are entitled to all human rights of the UN system and to all the rights included in the CRC.

The following table summarises those articles, the contents of which refer to emerging issues in the lives of children living in families affected by substance dependence.

14. The International Convention on the Elimination of All Forms of Racial Discrimination (1965); International Covenant on Civil and Political Rights (1966); International Covenant on Economic, Social and Cultural Rights (1966); Convention on the Elimination of All Forms of Discrimination against Women (1979); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984); Convention on the Rights of the Child (1989); International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990); International Convention for the Protection of All Persons from Enforced Disappearance (2006); Convention on the Rights of Persons with Disabilities (2006). Available at www.ohchr.org/en/core-international-human-rights-instruments-and-their-monitoring-bodies, accessed 17 July 2024.

Table 1. CRC measures that address the circumstances of children living in families affected by drug dependence

Article	Contents
2	Ensure the rights of the convention to each child. Protect children against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions or beliefs of the child's parents, legal guardians or family members.
3	In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration. The Committee on the Rights of the Child's General Comment on the right of the child to have his or her best interest taken as a primary consideration (Committee on the Rights of the Child 2013a: paragraph 37) explains the three-fold nature of the concept "best interest of the child" as a principle, a right and a rule of procedures. It outlines the steps to be followed to determine a child's or children's best interest in a specific situation through a case-by-case approach. It requires that the assessment be carried out by the decision maker and his or her staff – if possible a multidisciplinary team – and requires the participation of the child.
5	States parties shall respect the responsibilities, rights and duties of parents to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the convention.
6	The right to life, development and survival. The Committee on the Rights of the Child expects states parties to interpret "development" in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development. Implementation measures should be aimed at achieving optimal development for all children (Committee on the Rights of the Child 2003: 4).
9	The right of the child not to be separated from his or her parents against his or her will, unless such separation is necessary for the best interest of the child. Such determination may be necessary in a particular case, such as one involving abuse or neglect of the child by the parents. In any proceedings regarding separation, all interested parties shall be given an opportunity to participate in the proceedings and make their views known. The right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interest. Where such separation results from any action initiated by a state party, such as the detention or imprisonment of one or both parents or of the child, that state party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member.
12	The right of the child to be heard and for his/her opinion to be taken into account in all matters affecting the child.

18	Both parents – or legal guardians – have the primary responsibility for the upbringing and development of the child. States parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.
19	Protection of the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
20	State parties shall ensure special protection and alternative care for children temporarily or permanently deprived of his or her family environment.
24	The right to the enjoyment of the highest attainable standard of health. The Committee on the Rights of the Child interprets the right to health as "an inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health. A holistic approach to health places the realisation of children's right to health within the broader framework of international human rights obligations" (Committee on the Rights of the Child 2013b: paragraph 3).
27	The right to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Parents have the primary responsibility to secure the conditions of living necessary for the child's development. States parties shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly regarding nutrition, clothing and housing.
28 and 29	The right to education.
31	The right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child, and to participate freely in cultural life and the arts.
33	States parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.
34	The right to protection from all forms of sexual exploitation and abuse.
39	States parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts.

As may be observed in Table 1, the CRC recognises the primary responsibility and role of parents (Articles 5 and 18) in the upbringing and development of the child in a manner that is consistent with the evolving capacities of the child. This implies obligations for parents to provide the child with the physical, mental, spiritual, moral and social tools to develop their full potential. However, it also means that the child will be recognised in their dignity and that the child's view will be listened to and taken into account. Under these principles, between children and parents, a relationship is established that is dynamic and that envisages children's protection as well as their participation. Parents are primarily responsible for the care and development of the child; nevertheless, they are not to be left unsupported in this task: the CRC foresees the state's support to families, so parents can guarantee the child's development in all its dimensions and ensure that children have access to an adequate standard of living, as outlined in Article 27 of the convention.

The convention also sets limits to the parent–child relationships, such as in case of violence or other situations that require the separation of the child from their family. Separation can be due to conditions related to the parents or as a consequence of the state's decision, such as in the case of incarceration. In both cases, the child is entitled to the preservation of contact with parents, unless it is against their best interest.

Separation from the family should not be determined based on the parents' lack of financial means to provide for their children nor solely – in the object of this guide – on the basis of parental substance use. As indicated in the UN Guidelines for the alternative care of children (UN General Assembly 2010):

> 3. The family being the fundamental group of society and the natural environment for the growth, well-being and protection of children, efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members. The State should ensure that families have access to forms of support in the caregiving role.
>
> 9. As part of efforts to prevent the separation of children from their parents, States should seek to ensure appropriate and culturally sensitive measures:
>
> (a) To support family caregiving environments whose capacities are limited by factors such as disability, drug and alcohol misuse, discrimination against families with indigenous or minority backgrounds, and living in armed conflict regions or under foreign occupation.
>
> 15. Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family.

1.1.2. The 2030 Agenda for Sustainable Development

The 2030 Agenda for Sustainable Development (UN General Assembly 2015) was adopted in 2015 and contains 17 Sustainable Development Goals (SDGs) that aim at ensuring that by 2030 all people enjoy peace and prosperity. The agenda's goals

and its 169 targets "aim at eradicating poverty in all forms and 'seek to realise the human rights of all and achieve gender equality'".[15]

The agenda does not include a specific goal for children. However, all the agenda's goals and targets apply to children as well, as citizens of the present and of the future who "have the right to directly engage in achieving the Global Goal targets, in terms of claiming their rights now, as children, as well as preparing themselves to take on more complex responsibilities as they grow older" (UNICEF (n.d.)a: 2). Table 2 includes the goals and targets that directly address children.

Table 2. Sustainable Development Goals that explicitly reference children

Goals and targets	Contents
1.2	By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions.
2.1	By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.
2.2	By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.
Goal 3	Ensure healthy lives and promote well-being for all at all ages.
3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births [implies babies as well].
3.2	By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality to at least as low as 25 per 1 000 live births.
4.1	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.
4.5	By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations.
4.a	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all.

15. Available at www.coe.int/en/web/programmes/un-2030-agenda#:~:text=The%202030%20Agenda%20for%20Sustainable,equality%20and%20non%2Ddiscrimination%E2%80%9D, accessed 18 July 2024.

Goal 5	Achieve gender equality and empower all women and girls.
5.1	End all forms of discrimination against all women and girls everywhere.
5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.
5.c	Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.
6.2	By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.
8.7	Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms.
11.2	By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons.
11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities.
16.2	End abuse, exploitation, trafficking and all forms of violence against and torture of children.

Source: UNICEF (n.d.)a: 62.

The SDGs touch upon several issues that are relevant for this guide.

- Goal 2 – End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
- Goal 3, Target 5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- Goal 4, Target c – Increase the supply of qualified teachers.
- Goal 5, Target 4 – Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.
- Goal 5, Target 5 – Ensure women's full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life.
- Goal 8 – Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

1.2. Council of Europe standards for the protection and enhancement of children's rights

The Council of Europe is the guardian of human rights in Europe. It comprises 46 states, 27 of which are members of the European Union. The Council of Europe has a broad base of standard-setting texts whose purpose is to promote and protect children's rights, including protection from all forms of violence[16] and numerous publications and tools[17] to promote and protect the rights of children. This section presents the most relevant tools for the protection of the rights of children living in families affected by substance dependence.

1.2.1. Convention for the Protection of Human Rights and Fundamental Freedoms

The Convention for the Protection of Human Rights and Fundamental Freedoms, better known as the European Convention on Human Rights (Council of Europe 1950), came into force on 3 September 1953. It was the first instrument to give effect to certain rights stated in the Universal Declaration of Human Rights and make them binding.[18] All children are entitled to the protection of the human rights included in the Convention. For the purposes of the guide, Article 8 is particularly relevant and is often applied in cases where children are concerned:

> **Article 8. Right to respect for private and family life**
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

1.2.2. European Social Charter

The European Social Charter (revised) (Council of Europe 1996a):

> is a Council of Europe treaty that guarantees fundamental social and economic rights as a counterpart to the European Convention on Human Rights, which refers to civil and political rights. It guarantees a broad range of everyday human rights related to employment, housing, health, education, social protection and welfare.
>
> The Charter lays specific emphasis on the protection of vulnerable persons such as elderly people, children, people with disabilities and migrants. It requires that enjoyment of the above-mentioned rights be guaranteed without discrimination.[19]

16. Available at www.coe.int/en/web/children/legal-standards, accessed 18 July 2024.
17. Available at www.coe.int/en/web/children/publications, accessed 18 July 2024.
18. Available at www.echr.coe.int/Pages/home.aspx?p=basictexts&c=, accessed 18 July 2024.
19. Available at www.coe.int/en/web/european-social-charter, accessed 18 July 2024.

Seen as the "social constitution" of Europe, it was approved in 1961 and subsequently revised. Table 3 outlines those measures relevant to children living in families affected by substance dependence as included in the European Social Charter (revised).

Table 3. European Social Charter (revised) measures that address the circumstances of children living in families affected by substance dependence

Article	Contents
7	The right of children and young persons to protection
8	The right of employed women to protection of maternity
11	The right to the protection of health
12	The right to social security
13	The right to social and medical assistance
14	The right to benefit from social welfare services
15	The right of persons with disabilities to independence, social integration and participation in the life of the community
16	The right of the family to social, legal and economic protection
17	The right of children and young persons to social, legal and economic protection
17.1	a. to ensure that children and young persons, taking account of the rights and duties of their parents, have the care, the assistance, the education and the training they need, in particular by providing for the establishment or maintenance of institutions and services sufficient and adequate for this purpose; b. to protect children and young persons against negligence, violence or exploitation; c. to provide protection and special aid from the state for children and young persons temporarily or definitively deprived of their family's support
20	The right to equal opportunities and equal treatment in matters of employment and occupation without discrimination on the grounds of sex
23	The right of elderly persons to social protection
27	The right of workers with family responsibilities to equal opportunities and equal treatment
30	The right to protection against poverty and social exclusion
31	The right to housing

1.2.3. European Convention on the Exercise of Children's Rights

The European Convention on the Exercise of Children's Rights (Council of Europe 1996b) is relevant for the purpose of these guidelines insofar as it aims at ensuring that children are informed and allowed to participate in proceedings affecting them before a judicial authority – meaning a court or an administrative authority having

equivalent powers – in particular, in those cases involving the exercise of parental responsibilities such as residence and access to children.

The convention establishes the procedural measures to promote the exercise of children's rights, among them the "Right to be informed and to express his or her views in proceedings" (Article 3):

> A child considered by internal law as having sufficient understanding, in the case of proceedings before a judicial authority affecting him or her, shall be granted, and shall be entitled to request, the following rights:
>
> a to receive all relevant information;
>
> b to be consulted and express his or her views;
>
> c to be informed of the possible consequences of compliance with these views and the possible consequences of any decision.

At the same time, the judicial authority has the following duties (Article 6).

> In proceedings affecting a child, the judicial authority, before taking a decision, shall:
>
> a consider whether it has sufficient information at its disposal in order to take a decision in the best interest of the child and, where necessary, it shall obtain further information, in particular from the holders of parental responsibilities;
>
> b in a case where the child is considered by internal law as having sufficient understanding:
>
> – ensure that the child has received all relevant information;
>
> – consult the child in person in appropriate cases, if necessary privately, itself or through other persons or bodies, in a manner appropriate to his or her understanding, unless this would be manifestly contrary to the best interests of the child;
>
> – allow the child to express his or her views;
>
> c give due weight to the views expressed by the child.

These regulations are particularly relevant in the case of decisions concerning the separation of children from parents who have developed substance dependence.

1.2.4. Lanzarote Convention

The Council of Europe's Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, also known as the Lanzarote Convention (Council of Europe 2007), sets out that states shall adopt specific legislation and take measures to prevent sexual violence, to protect child victims and to prosecute perpetrators, and requires the criminalisation of all kinds of sexual offences against children.

1.2.5. Council of Europe Strategy for the Rights of the Child

The Council of Europe Strategy for the Rights of the Child (2022-2027), "Children's Rights in Action: from continuous implementation to joint innovation" comprises six strategic objectives:

- freedom from violence for all children;
- equal opportunities and social inclusion for all children;
- access to safe use of technologies for all children;

- child-friendly justice for all children;
- giving a voice to every child;
- children's rights in crisis and emergency situations.

Objective 2, "Equal opportunities and social inclusion for all children", states "the issue of children whose parents use drugs is still undetected and under-referred, despite its link to child neglect situations" and identifies as an innovating action "2.2.6 Mapping, analyzing and providing guidance on the situation of children suffering from addictive behaviours and children of parents using drugs".

1.2.6. Council of Europe recommendations and guidelines

1.2.6.1. Participation

In 2012, the Council of Europe Committee of Ministers adopted Recommendation CM/Rec(2012)2 on the participation of children and young people under the age of 18, in which participation is defined as follows (Council of Europe 2012: 6).

> "Participation" is about individuals and groups of individuals having the right, the means, the space, the opportunity and, where necessary, the support to freely express their views, to be heard and to contribute to decision making on matters affecting them, their views being given due weight in accordance with their age and maturity.

In 2020, the Council of Europe published "Listen – Act – Change – Council of Europe Handbook on children's participation". For professionals working for and with children, this is a tool to assist professionals in making participation a reality. The handbook explains the multiple dimensions of participation – universal, multiple and power and responsibility (Council of Europe 2020a: 14-15) and reproduces the conceptualisation of meaningful participation as developed by the Lundy model,[20] including aspects of space, voice, audience and influence.

Space: In order to become increasingly active in influencing matters affecting them, children need to be able to form and express views and they must be afforded the space and time to do so. They must be given the opportunity to gain the confidence, the time and a "safe and inclusive space" to contribute their views.	**Voice:** Appropriate and accessible information is an important prerequisite for the ability to speak out and express views and negotiate decisions. Adults have a responsibility to find ways in which to enable children to communicate their views, concerns or ideas.
Audience: Central to the right to participate is that adults listen respectfully to what children have to say. The right to express views and have them given due weight can only be realised if children's views are heard by those people with the power and authority to act on those views.	**Influence:** The right to participate does not automatically lead to children's views being followed, in all circumstances and in every respect. However, it requires that their views are given proper consideration and that any subsequent decision is reported back to children with an explanation of how their views had an influence, and why the decision was made.

Source: Council of Europe (2020a: 16).

20. Available at https://eu-for-children.europa.eu/about/lundy-model, accessed 18 July 2024.

The Council of Europe has also developed a Child Participation Assessment Tool (Council of Europe 2016), which provides 10 basic indicators enabling states to:[21]

- undertake a baseline assessment of the current implementation of the recommendation;
- help identify measures needed to achieve further compliance by states;
- measure progress over time.

1.2.6.2. Protection from violence

The Committee of Ministers Recommendation CM/Rec(2009)10 on integrated national strategies for the protection of children from violence (Council of Europe 2009a) prompts member states to integrate, implement and disseminate the Council of Europe Policy guidelines on integrated national strategies for the protection of children from violence (Council of Europe 2009b). The guidelines call for the development of an integrated national strategy for the protection of children from violence and encourage the setting up of child-friendly services and mechanisms.

1.2.6.3. Child-friendly social services

The Committee of Ministers Recommendation CM/Rec(2011)12 on children's rights and social services friendly to children and families (Council of Europe 2011b) underlies the development of Section 3 of this guide. It defines child-friendly social services as "social services that respect, protect and fulfil the rights of every child, including the right to provision, participation and protection and the principle of the best interest of the child" (ibid.: 6). It aims "to ensure that social services are delivered upon individual assessment of the child's needs and circumstances and take into account the child's own views, considering his or her age, level of maturity and capacity" (ibid.: 5).

The recommendation takes into account the views of families and children, as well as their needs, and outlines to member states and service providers the general elements and the key strategies that child-friendly social services design and delivery should include.

1.2.6.4. Child-friendly healthcare

The Guidelines of the Committee of Ministers of the Council of Europe on child-friendly healthcare propose an integrated approach to the development of the full range of child healthcare activities (Council of Europe 2011c: paragraph 1.1):

> 2. This approach places children's rights, needs and resources at the centre of health care activities, taking into account their family and social environment. It promotes policies to deliver child-oriented services based on child-specific developmental needs and evolving capacities, ensuring children's participation at every level of decision making, in accordance with their age and degree of maturity.

21. Available at www.coe.int/en/web/children/child-participation-assessment-tool, accessed 18 July 2024.

As explained in the introduction, children affected by parental substance use may face challenges related to their physical and mental health because of neglect and the strain that their parents' situation may imply for them, including depression, anxiety, fear, exposure to violence, and so on. The effects of parental substance dependence on children may occur in the children's present life as well as affect their development and outcomes later in life. It can also lead to substance use and dependence. A child-friendly approach to health should take these dimensions into account and develop holistic strategies for children and parents. In this regard, the guidelines include the following regulations:

> 33. The child-friendly health care approach recognises that interventions should focus not only on managing the child's health condition, but also on their physical or social environment, thus avoiding the medicalisation of social problems. It includes addressing environmental issues (air and water quality, sanitation), socio-economic problems (poverty, social exclusion, poor housing and nutrition), access to education, or parental issues (parenting skills, parents' mental health, domestic violence or substance abuse).
>
> 34. It is important to stress the need to support children in cases where parents suffer from severe physical or psychiatric conditions, drug abuse or when parents suddenly die.

1.2.6.5. Child-friendly justice

The principles and procedures of child-friendly justice address all sorts of procedures (criminal, civil, administrative) and authorities, including social and health services, and are therefore relevant for the target populations, in particular the indications expressed in the above-mentioned Council of Europe European Convention on the Exercise of Children's Rights (Council of Europe 1996b), the Resolution on child-friendly justice and the Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice (Council of Europe 2010).

Children whose parents have developed substance dependence may be temporarily or permanently separated from their parents by a court order. Such separation may happen right at birth, if the child is born with withdrawal syndrome, for instance, and while the parent undergoes treatment. However, it may also happen later in the child's life, in relation to their parents' neglect or due to the birth of a younger sibling and a subsequent court order for the parent to undertake residential treatment – usually the mother. It can also be a consequence of incarceration. With this in mind, it is important that courts and children's legal representatives are informed of the effects of drug dependence as well as of its nature and related behaviours, as well as of the effects of parental incarceration on children (Council of Europe 2019) and that such information is reflected in the arguments and decisions regarding separation.

1.2.6.6. Children with incarcerated parents

The effects of drug policies on children because of the incarceration of their parents have two dimensions: one is related to the deprivation of liberty as punishment for drug offences, whereas the other concerns access to treatment and harm reduction in prison settings.

Incarceration for drug-related offences may occur depending on a country's criminal justice system and on the circumstances of the offence and lead to the separation of children from their parents and to a whole range of effects that may negatively impact the well-being of the child and the relationship with the parent (Jones and Wainaina-Woźna 2012; Nowak 2019).

Children affected by parental incarceration share many situations of vulnerability with children affected by parental substance use, including stigma, discrimination because of their parents' situation, secrecy, anxiety, depression, a feeling of uncertainty, and a higher risk of developing substance use or other internalising and externalising behaviours (Jones and Wainaina-Woźna 2012; Murray et al. 2014).

In 2019, the Committee of Ministers adopted Recommendation CM/Rec(2018)5 concerning children with imprisoned parents, which addresses the implications of incarceration for the more than two million children who face parental incarceration in Europe (Council of Europe 2019). The text includes recommendations on positive parenting and the importance of including programmes and other interventions that support and develop a positive child–parent relationship (ibid.: paragraphs 27, 37 and 41). Other instruments address the issue of access for treatment in prison settings and are presented in section 3.1 of this guide.

1.3. Standards for supporting parents with substance dependence

The international framework of children's rights recognises parents' primary responsibilities and obligations for the upbringing and holistic development of the child's full potential. It establishes a dynamic relationship in which children are not mere passive subjects of their parents' decisions but rights holders with the capacity to form their own views and act upon their circumstances. It also points out the role of the state in supporting families that may face difficulties in providing for their children's physical, psychological, emotional, social, spiritual and moral social development. Substance use in the family is identified as a condition of vulnerability for parents and, therefore, for children, that requires attention. The instruments analysed prompt states to ensure appropriate and culturally sensitive measures to support family environments affected by harmful alcohol and drug use, in order to prevent the separation of children from their parents.

Such support should encompass housing, employment, economic well-being, mental health, complex traumas, formal and informal community and family networks, non-stigmatising attitudes, social inclusion and so on.

Because of the purpose and scope of the guide, this section addresses two areas: access to substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services and interventions that support people who use substances and are parents. Both issues are addressed in the following pages. In contrast to the previous section, the approach is rights-based, specifically: the right to the highest attainable standard of health and the right to family. Both rights are addressed by presenting international and regional conventions, as well as other instruments – resolutions, recommendations, guidelines, handbooks and

so on – that help identify the concrete measures that should be implemented in order to guarantee people's effective exercise of these rights.

1.3.1. The right to the highest attainable standard of health

The right to the highest attainable standard of health was first articulated in the 1946 Constitution of the World Health Organization and is conceived of as a condition of well-being that is arrived at by the satisfaction of multiple needs, rights and expectations. The constitution's preamble defines health as (WHO 2020: 1):

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity … The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The 1948 Universal Declaration of Human Rights also mentions health as part of the right to an adequate standard of living (Article 25). The right to health is also recognised as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Since then, other international human rights treaties have recognised or referred to the right to health or to elements of it (OHCHR and WHO (n.d.): 1).

The right to health has a number of essential elements: the Committee on Economic, Social and Cultural Rights outlines in General Comment 14 (CESCR 2000: paragraph 12) the AAAQ model, which comprises the following elements:

- availability: functioning public health and healthcare facilities, goods, services and programmes available in sufficient quantity;
- accessibility: non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility;
- acceptability: respectful of medical ethics and culturally appropriate, sensitive to age and gender;
- quality: scientifically and medically appropriate (WHO and OHCHR, (n.d.)).

The AAAQ model, while developed for the health sector, is a useful tool for assessing other services (UNICEF (n.d.)b).

The United Nations' Special Rapporteur on the right to health also recognises people who use drugs as people in vulnerable situations.[22]

1.3.1.1. Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities (United Nations (n.d.)) was approved in 2006 and marks a paradigmatic shift from a medical model of disability towards a social one, which defines disability as the result of interaction between individual impairments and existing attitudinal and environmental barriers (Council of Europe 2017: paragraph 35).

22. Available at www.ohchr.org/en/special-procedures/sr-health, accessed 18 July 2024.

> Disability may hinder the full enjoyment of human rights and fundamental freedoms and persons with disabilities from participating effectively and equally in the society. Persons with multiple, complex and intersecting impairments face additional barriers and are at higher risk of institutionalisation, exclusion and poverty. Measures to prevent or remove existing barriers are necessary investments for sustainable development and improved accessibility.

The convention is relevant to guaranteeing the right to the highest attainable standard of health for persons with substance dependence and disabilities. On the one hand, people with disabilities may use substances more than people without disabilities (SAMHSA 2016). On the other hand, substance dependence may lead to disabilities or to the worsening of mental health conditions and intellectual disabilities.[23] People with disabilities may face higher barriers to access treatment due to heightened stigma and social exclusion (ibid.). Barriers for persons with disabilities may exist in drug treatment-related services: for example, lack of access to services due to inaccessible parking, entrances and interior spaces, lack of material in Braille or other alternative formats in treatment facilities, insufficient funding and low availability of appropriately trained mental health workers, and so on (ibid.; Patel et al. 2016). Another important aspect is linked to the organisation and functioning of the health system. As explained in *The Lancet*'s systematic analysis of the Global Burden of Disease 2019 Study (GBD 2019 Mental Disorders Collaborators 2022: 138):

> Mental and substance use disorders are a heterogeneous group of disorders. Health systems in many countries organise their services for these disorder groups separately, whereas in resource-poor settings, these disorders are often grouped within essential health care packages and delivery platforms.

As explained in the Council of the European Union (2023: 3) "Conclusions on people having drug use disorders that co-occur with other mental health disorders", people who use drugs and have drug use disorders (DUDs) often also have other mental health disorders. Thus, the association between the two should be assumed as standard rather than deemed an exception. These individuals, also termed as people with DUDs and other co-occurring mental health disorders, or people with DUDs and other psychiatric comorbidities, or people with dual disorders, constitute a group with special needs.

In some regions, over 50% of all those with a serious mental illness (these include schizophrenia, bipolar disorders and major depression) have problems with drugs or alcohol that have negative and damaging effects on the illness and the way their medication works (Hunt et al. 2019).

Mental disorders are a leading cause of disease burden, with depressive and anxiety disorders having prevalence estimates and disability weights comparatively higher than many other diseases (GBD 2019 Mental Disorders Collaborators 2022). The last comprehensive review of the global burden of mental disorders was published on the basis of GBD 2010 findings, in which the combined burden of mental and substance use disorders was presented (Patel et al. 2016). The review indicates that the burden of mental, neurological and substance use (MNS) disorders increased by

23. Available at www.addictioncenter.com/addiction/disability, accessed 18 July 2024.

41% between 1990 and 2010. It also provides an analysis of the social determinants of MNS disorders, which include (ibid.: 1673):

- demographic factors such as age, sex and ethnicity;
- socio-economic status: low income, unemployment, income inequality, low education, low social support;
- neighbourhood factors: inadequate housing, overcrowding, neighbourhood violence;
- environmental events: natural disasters, war, conflict, climate change, migration;
- social change associated with changes in income, urbanisation, environmental degradation.

It also points out that a very relevant aspect of these disorders is their propensity to strike early in life. The review provides evidence of effective treatment and prevention interventions that are feasible to implement across diverse socio-economic and cultural settings for a range of priority MNS disorders. The study also identifies the barriers that stand between people with MNS disorders and the health system and provides strategies necessary for health system strengthening. Such proposals are in line with the Convention on the Rights of Persons with Disabilities and include, among others (ibid.: 1682-2683):

- the mainstreaming of a rights-based perspective throughout the health system;
- ensuring health policies, plans and laws are updated to be consistent with international human rights standards and conventions;
- implementation of multicomponent initiatives to address stigma;
- enhancement of mental health literacy and demand for care;
- mobilisation of people with MNS disorders to support each other and advocate for better services and awareness;
- engagement of other key sectors that work to improve services for people with MNS disorders, notably the social care, non-profit, private sector, criminal justice, education and indigenous medical sectors, as they may have complementary roles;
- the embedding of health indicators for MNS disorders within national health information and surveillance systems.

The Council of the European Union (2023: 5) stresses the need to develop, provide and implement evidence-based prevention and interventions that are effective in dual disorders and explains that these interventions must be integrated, multidisciplinary, comprehensive and non-discriminatory. It also acknowledges the need to improve and develop further efforts to support people with dual disorders in special and vulnerable situations, such as children (ibid.: 6).

1.3.1.2. United Nations conventions on drugs

The United Nations' three conventions on drugs (UNODC 2013) give the health of humankind as their main concern and include measures regarding four main areas: a) prevention and treatment of DUDs; b) prevention and punishment of actions related to the non-medical production, manufacture and sale of plant-based

substances and chemical precursors through the criminal justice system; c) access for all people to essential medicines; and d) alternative development for plant-producing communities.

The conventions establish the foundations of the international system of drug control. Their interpretation and implementation has been expanded by numerous declarations, plans, resolutions, recommendations, standards, guidelines and handbooks. Of particular relevance for this guide and its recommendations are:

- the United Nations General Assembly Special Session on drugs (known as UNGASS 2016) outcome document "Our joint commitment to effectively addressing and countering the world drug problem" (UNODC 2016a). The document includes specific references to women and children (see Section 4, "Operational recommendations on cross-cutting issues: drugs and human rights, youth, children, women and communities", UNODC 2016a: 14-16);
- the International Guidelines on Human Rights and Drug Policies (OHCHR et al. 2019);
- the Commission of Narcotic Drugs Resolution 61/11, Promoting non-stigmatising attitudes to ensure the availability of, access to and delivery of health, care and social services for drug users (2018);
- the Commission on Narcotic Drugs Resolution 67/4, Preventing and responding to drug overdose through prevention, treatment, care and recovery measures, as well as other public health interventions, to address the harms associated with illicit drug use as part of a balanced, comprehensive, scientific evidence-based approach (2024);
- the UNODC and WHO International Standards on Drug Use Prevention (UNODC and WHO 2018);
- WHO and UNODC International Standards for the Treatment of Drug Use Disorders (WHO and UNODC 2020);
- UNODC and Treatnet – International network of drug dependence treatment and rehabilitation resource centres (2008) document, "Drug dependence treatment: interventions for drug users in prison";
- UNODC, UNAIDS and WHO document (2006) "HIV/Aids prevention, care, treatment and support in prison settings. A framework for an effective national response".

The above list is by no means exhaustive, given the continuous and abundant production of drug policy-related documents at the international level. However, the documents included provide the framework to guarantee that parents who use substances have access to substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services that are evidence-based and non-discriminatory. Access to services should be available, affordable, adaptable and of good quality, and based on voluntary, informed consent.

These policy documents guarantee the provision of services in prison settings and recognise the intersection of substance use with the transmission of HIV/Aids, viral hepatitis and other blood-borne diseases. Furthermore, they take into account the situations of vulnerability that certain groups face in the context of drug-related

policies, particularly women, children who are or may become involved with substance use, Indigenous peoples and people in prison.

Other United Nations agencies and bodies have produced critical knowledge and recommendations in relation to the negative effects of implementing punitive drug policies that rely on criminalisation, stigma against people who use substances, arbitrary detention and, in some countries, the death penalty. A non-exhaustive list of recommended reading includes:

- the Report of the Office of the High Commissioner for Human Rights (2023) "Human rights challenges in addressing and countering all aspects of the world drug problem";
- the Human Rights Council Resolution (2023) "Contribution of the Human Rights Council with regard to the human rights implications of drug policy";
- the Working Group on Arbitrary Detention study (2021) "Arbitrary detention relating to drug policies";
- the Office of the High Commissioner for Human Rights report (2015), "Study on the impact of the world drug problem on the enjoyment of human rights".

1.3.1.3. Council of Europe approach to the right to health and people who use substances

The European Social Charter (Council of Europe 1996a) recognises the right to the protection of health in Articles 11 and 13 and includes the rights of pregnant women, women who have recently given birth and women nursing their infants in Article 8, "The right of employed women to protection of maternity".

The Council of Europe has consistently put forward the importance of a public health-oriented drug policy based on prevention, treatment and harm reduction, and on numerous occasions has encouraged member states and the international community to shift from a criminal justice approach to a public health vision of drugs and drug policy (Pompidou Group 2021a). The Council of Europe has supported the implementation of harm reduction measures as cost-effective methods to prevent the life-threatening and damaging consequences of ongoing drug use (such as deaths by overdose, blood-borne infectious diseases, misuse of new substances), and ultimately promoting the right to health (Council of Europe 2020b: 12).

Resolution 1576 (2007) of the Parliamentary Assembly of the Council of Europe, "For a European convention on promoting public health policy in drug control" (Parliamentary Assembly 2007), advocates for a public health-oriented response to problem drug use.

> 8. The Council of Europe convention should be predicated on the following three interdependent objectives:
>
> 8.1 to promote, as a fundamental human right, the right to health in the context of problem drug use;
>
> 8.2 to clarify the scope of the right to health as it applies to problem drug use;
>
> 8.3 to help identify good practices for the exercise of the right to health as it applies to problem drug use at community, national and international levels.

In 2020, the Council of Europe published the report "Drug policy and human rights in Europe: a baseline study" (Council of Europe 2020b). The report and its draft resolution advocate for, among other points:

- drug-related prevention measures that are evidence-based, proportionate and adapted to different social contexts, age groups and levels of risk;
- a public health approach with non-stigmatising attitudes and language, protecting people who use drugs from suffering discrimination, exclusion or prejudice;
- prioritising honest information and education on the risks of drugs for the health and safety of people who use drugs (in particular children and young people) and to others;
- using risk and harm reduction as well as treatment and rehabilitation services as a means to reduce the adverse health and social effects of drugs;
- providing equivalence and continuity of care for people who use drugs in prisons or other custodial settings, and safeguard the health of drug-dependent prisoners.

In 2022, at the 18th Ministerial Conference of the Council of Europe, the Pompidou Group adopted the Lisbon Declaration, which recalls "the obligations of States under the United Nations and the Council of Europe Conventions to protect human rights and fundamental freedoms, in particular the right to life and human dignity, the right to enjoy the highest attainable standards of health, the prohibition of any type of discrimination as well as the protection of all people, in particular children, from drugs and addictions" (Council of Europe 2022b: 1) and supports addressing human rights, gender and civil society participation as transversal aspects in all the activities of the Pompidou Group (ibid.: 3).

1.3.1.4. The work of the Pompidou Group

The core mission of the Council of Europe International Co-operation Group on Drugs and Addictions, known as the Pompidou Group, is providing knowledge, support and solutions for effective, evidence-based drug policies, which fully respect human rights.[24] It develops numerous activities in the fields of international co-operation, training and research in the fields of drug use, prevention, international trafficking as well as criminal justice and prisons. It has a pioneering role in the promotion of human rights and mainstreaming a gender perspective in drug policies.

Among the relevant tools[25] published by the Pompidou Group that concern the right to health of people who use substances are Volumes I, II, III and IV of the series *Children and families affected by parental drug use* (Giacomello 2022, 2023b, 2023a, 2023c):

- *Children whose parents use drugs – Promising practices and recommendations*;
- *We are warriors – Women who use drugs reflect on parental drug use, their paths of consumption and access to services*;

24. Available at www.coe.int/en/web/pompidou/about/pompidou-group-introduction, accessed 18 July 2024.
25. Available at www.coe.int/en/web/pompidou/publications, accessed 18 July 2024.

- *Listen to the silence of the child – Children share their experiences and proposals on the impacts of drug use in the family*;
- *Children and parents affected by drug use – An overview of programmes and actions for comprehensive and non-stigmatising services and care.*

In addition to this series, the following tools have been published:

- "Human rights in drug policy: a self-assessment tool" (Pompidou Group 2021c);
- "Intercultural responses to drug-related challenges for refugees, migrants and IDPs. Handbook for professionals working in the field of addictions with refugees, migrants, and internally displaced persons" (Pompidou Group 2022b);
- "Standards for treatment of people with drug use disorders in custodial settings" (Pompidou Group 2022c);
- "Prison-based therapeutic communities (TCs): a handbook for prison administrators, treatment professionals and trainers" (Pompidou Group 2021d);
- *Implementing a gender approach in drug policies: prevention, treatment, and criminal justice. A handbook for practitioners and decision makers* (Mutatayi et al. 2022);
- "Guidance Paper. Psychosocial support to tackle trauma-related symptoms and related substance use disorders" (Pompidou Group 2018b).

1.3.2. The right to family

Article 16.3 of the Universal Declaration on Human Rights and Article 23.1 of the International Covenant on Civil and Political Rights states that "the family is the natural and fundamental group unit of society and is entitled to protection by the society and the State". A similar recognition of the family as the fundamental unit of society is found in Article 10.1 of the International Covenant on Economic, Social and Cultural Rights, the CRC (Preamble, paragraph 5), the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Article 44.1) and the Convention on the Rights of Persons with Disabilities (Preamble, paragraph x). These instruments further highlight the role of families in protecting the human rights of its members and in providing them with an enabling environment for the enjoyment of those rights (Human Rights Council 2016).

The right to form a family is expressly linked to the principle of non-discrimination, which is restated in the Convention on the Elimination of All Forms of Discrimination against Women (Article 16.1.*a*) and in the Convention on the Rights of Persons with Disabilities (Article 23.1.*a*) (ibid.), and has to be guaranteed for people who use substances as well.

Article 8 of the European Convention on Human Rights recognises the right to respect for private family life and is evoked in numerous cases in which children's rights are at stake (European Court of Human Rights 2023). The Pompidou Group's publication "Human rights in drug policy: a self-assessment tool" (2021c) presents cases before the European Court of Human Rights in which parents were separated from their children for drug-related activities. The cases refer mostly to people found responsible for trafficking or possessing important quantities of substances and

not for substance dependence per se. However, the case *Y.I. v. Russia*, Application No. 68868/14, concerns the applicant's complaint about being deprived of her parental authority in respect of her three children because she had addiction problems. The Court found that:

> While drug addiction and unemployment are of relevance for considerations, these do not suffice alone to remove parental authority. Firstly, it must be considered if the parent intends to and has taken steps to resolve the drug addiction. Secondly, unemployment and financial difficulties cannot in themselves be enough grounds for severing a parent–child bond. The court decisions had not explained how her being unemployed had affected her ability to take care of her children. Furthermore, real defects in the family's living conditions must be demonstrated and established. Due consideration must also be given to the parent's expressed attachment to the children, where evidence shows that the parent has taken care of the children prior to their removal and had made efforts to maintain contact afterwards. At the same time the attachment of the children to the parent and the consequences of a separation must be considered (Pompidou Group 2021c: 50).

The decision of removing custody from parents solely on the basis of drug use is also advised against in the Guidelines for the Alternative Care of Children (UN General Assembly 2010: paragraph 9), the International Guidelines on Human Rights and Drug Policy (OHCHR et al. 2019: 17) and the Council of Europe's report "Drug policy and human rights in Europe: a baseline study" (Council of Europe 2020b: paragraph 53).

1.3.2.1. The right to family as the right to parenting

The obligations of parents towards their children are recognised in the CRC, just as it is a state obligation to support parents in fulfilling their role and responsibilities.

The Committee of Ministers Recommendation Rec(2006)19 on policy to support positive parenting defines positive parenting as "parental behaviour based on the best interests of the child that is nurturing, empowering, non-violent and provides recognition and guidance which involves setting of boundaries to enable the full development of the child". It provides countries with a framework to promote positive parenting, "by ensuring that all those rearing children have access to an appropriate level and diversity of resources (material, psychological, social and cultural) and that broad social attitudes and patterns of prevailing life are receptive to the needs of families with children and also those of parents". It includes provisions for incorporating children's views in public policies and encourages fathers to assume their share of responsibilities in caring for and rearing their children. Parenting responsibilities, therefore, are to be carried out under the principle of gender equality and the best interest of the child.

As has been pointed out on several occasions in this document, parents who use substances often have been subject to adverse childhood experiences and may have experienced poor parenting in their families. The development of substance dependence, often in concurrence with other health conditions, PTSD and other sources of economic and social vulnerabilities, may hinder parents' attempts to break the transgenerational cycle. Therefore, parents with substance dependence may need support to fully exercise and practice their parenthood.

Parenting programmes are included in the International Standards on Drug Use Prevention (UNODC and WHO 2018), the International Standards for the Treatment of Drug Use Disorders (WHO and UNODC 2020), and the Committee of Ministers Recommendation CM/Rec(2018)5 on children with imprisoned parents (Council of Europe 2019). Several partners of the Pompidou Group project Children Whose Parents Use Drugs implement programmes with parents who use substances in order to enhance their parenting skills (Giacomello 2022, 2023c).

These guidelines want to contribute to the recognition of parenting and parenting care as a children's right and an obligation for parents, but also as a right for parents. Positive parenting is thus conceived of as a composite of attitudes, tools, skills and behaviours as well as a right of both children and parents. The right to parenting implies providing parents with the spaces and tools to connect and create bonding and attachment with their children but also, or primarily, with themselves and to open for people the possibility – which cannot be forced upon them but has to be voluntarily chosen and adhered to – of exploring and embodying parenthood as one of their multiple identities.

Approaching parenthood as a right implies recognising parenthood not as a given fact for which a person has to be naturally ready and equipped, but as a personal, social and gendered process of learning, empowering and developing trust in oneself and others. It does not aim at making parents fit for parenthood but rather to create and sustain the conditions for people to live an identity that they objectively have but that they may subjectively feel inadequate to comply with, because of their own traumas and because of the pervasive social messages that see substance dependence and parenthood as incompatible. The right to parenting, therefore, is indeed interwoven with children's rights, but also with trauma-informed practice. Addressing parenthood and the right to parenting with people affected by substance dependence should be a consistent practice in research with mothers and fathers, as well as a key principle in social services and prevention, early intervention, treatment, harm reduction, recovery and social reintegration measures, including in prisons.

1.4. Standards to address gender-based violence and trauma

The final element of the hidden harm approach adopted in these guidelines is gender-based violence and discrimination against women with substance dependence, which is addressed in more in detail in Section 3. Women who use drugs are more likely than men to have experienced traumatic events, such as sexual and physical abuse as children and/or adults and intimate partner violence, which can lead to the development of PTSD or other mental health problems, as well as increase the risk of substance use (Arpa 2017). Women who are using substances may also be engaging in sex work, either through financial need or as a result of coercion, trafficking or exploitation (Mutatayi et al. 2022: 72). They face a double stigma for using drugs and for being women who break the social norms of temperance and exemplary behaviour that are traditionally assigned to their gender (ibid.).

Because of the above, an approach that is child-centred must also take into consideration the impact of gender-based violence and discrimination against women and

girls who use substances and the particular risks of stigma, abuse, guilt, violence and judgmental attitudes in their families, the community and drug-using circuits, not to mention social and health services.

Women and girls who use substances are entitled to all human rights. Nevertheless, considering the persistence of gender inequality and gender-based violence, specific international recognition has been given to women's rights. This also applies in the field of drug policies: most of the tools presented in Section 3.1, "The right to the highest attainable standard of health", identify women as a group with specific needs and vulnerabilities as a consequence of unequal social structures and gender-based violence and discrimination. In the area of prevention and treatment services, as in the case of the criminal justice system, particular attention has been given to women who are pregnant or mothers of infants (Comiskey 2019; UNODC 2011; WHO and UNODC 2020; UNODC and WHO 2018).

The following international and regional conventions provide a further framework for the recognition, enhancement and protection of women's rights and apply to women who use substances:

- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UN General Assembly 1979), which protects women who use substances from discrimination;
- the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) promotes and protects the rights of women to live free from violence in both the public and the private sphere (Council of Europe 2011a).

Furthermore, at the international and regional level, other tools address the situation of women who use substances as well as that of women incarcerated for drug offences, and provide recommendations on how to guarantee gender-responsive services, prison conditions and non-custodial measures for women in conflict with the law:

- the Commission on Narcotic Drugs Resolution "Mainstreaming a gender perspective in drug-related policies and programmes" (CND 2016), which encourages the participation of women and girls in the development and implementation of national drug-related policies and programmes and refers to women who use substances as well as those in conflict with the law;
- the Bangkok Rules (UNODC 2011), for women deprived of their liberty and non-custodial measures for women in conflict with the law;
- the "Toolkit on gender-responsive non-custodial measures" (UNODC 2020a);
- the "Guidelines on drug prevention and treatment for girls and women" (UNODC 2016b);
- the *Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (WHO 2014).

Finally, the Pompidou Group's handbook *Implementing a gender approach in drug policies: prevention, treatment and criminal justice* (Mutatayi et al. 2022) provides clear guidance to policy makers and practitioners on how to guarantee gender mainstreaming in drug responses. The document analyses in detail the barriers that women face to access treatment and develops specific recommendations, based on

an extensive literature review and good practices. The following list presents some of the gender-specific interventions highlighted in the document:

- gender-focused drug stabilisation day services that provide childcare and education options;
- domestic violence services that support and/or accommodate women who are actively using substances;
- gender-specific, low-threshold services that provide needle exchange, healthcare services (such as within sexual health services) or brief interventions;
- the introduction of specific days where women-only services are provided, in addition to expansion of designated women-only areas or creation of more women-focused facilities;
- speedy access to affordable housing and appropriate services to ensure safe pathways out of treatment and care settings;
- addressing waiting lists for detoxification services and treatment for gender-specific services.

1.4.1. Trauma-informed services

The abundant literature available at international and regional levels on prevention, treatment, and harm reduction services and programmes for people who use substances, including in confined settings, explains that these should be age, gender and culturally appropriate and sensitive, evidence-based, voluntary and consent-based. They should be compliant with human rights and with the essential elements of health services outlined in the AAAQ model mentioned above: Availability, Accessibility, Acceptability and Quality. Furthermore, they should enhance participation and accountability. Continuity of care should be guaranteed during and after incarceration as well as after treatment completion.

Trauma should also be included as a key aspect in prevention, early intervention, treatment, harm reduction, recovery and social reintegration measures, including in prisons. Trauma refers to "the effects of experiences that overwhelm a person's capacity to cope. These experiences may be early life events of abuse, neglect, and witnessing violence, or later live events such as sexual assault, partner violence, natural disaster, war, accidents, sudden unexpected loss, forced disconnection from home or culture, etc." (Schmidt et al. 2018).

Approximately 60% to 70% of the general population will experience a traumatic event at some point in their lifetime. PTSD and substance use disorders (SUD) are often concurrent. In clinical populations (focusing on either disorder), about 25% to 50% have a lifetime dual diagnosis of PTSD and SUD. Patients with this dual diagnosis have a more severe clinical profile and are more difficult to treat than patients with just one of the conditions (Pompidou Group 2018b: 5). Given the concurrence of PTSD and substance harmful use, treatment should also be trauma-informed (McDonagh, De Vries and Comiskey 2023; Mutatayi et al. 2022; Pompidou Group 2018b; Staton-Tindall et al. 2013).

A trauma-informed practice means "integrating an understanding of past and current experiences of violence and trauma into all aspects of service delivery. The goal of trauma-informed services and systems is to avoid re-traumatising individuals and support safety, choice, and control in order to promote healing" (Schmidt et al. 2018). The five core elements of a trauma-informed approach, also known as the "Rs" of trauma-informed practice, are (COSLA et al. (n.d.): 10):

- realising how common the experience of trauma and adversity is;
- recognising the different ways that trauma can affect people;
- responding by taking account of the ways that people can be affected by trauma to support recovery and recognising and supporting people's resilience;
- looking for opportunities to resist re-traumatisation and offer a greater sense of choice and control, empowerment, collaboration and safety with everyone you have contact with;
- recognising the central importance of relationships.

Trauma-informed practice is based on trauma awareness; it places emphasis on safety and trustworthiness. It opens the opportunity for choice, collaboration and connection; it is strengths-based and skill building (Canadian Centre on Substance Abuse 2014).

For a trauma-informed practice to be put into practice, it is crucial that service providers and the professionals supporting people and their families affected by substance dependence have access to high-quality trauma training (COSLA et al. (n.d.)). Furthermore, "the needs of service providers are also considered within a trauma-informed service approach. Education and support related to vicarious trauma experienced by service providers themselves is a key component" (Canadian Centre on Substance Abuse 2014: 2).

Finally, it is vital that people with lived experience have the opportunity to contribute meaningfully to how services are designed (COSLA et al. (n.d.)).

As outlined before, women who use substances are likely to have experienced traumatic events and to have lived adverse childhood experiences. However, the preliminary work on fathers who use substances carried out by the Pompidou Group (Giacomello 2023d) shows that they also might have lived experiences of trauma, harmful substance use in the family (particularly their fathers') and domestic violence. As in the case of women, substance use might be a coping strategy to deal with trauma (Salonen et al. 2023: 12). Men who use substances and are fathers may experience the desire to break with the intergenerational cycle of substance use and child neglect that perhaps they lived in their own childhood (McDonagh, De Vries and Comiskey 2023), but might not be equipped with the community support, their own role models, confidence, self-efficacy and skills (Bell et al. 2020).

Therefore, trauma-informed practice should be available for all people who use substances and should also be gender sensitive, taking into consideration how gender beliefs and gender roles intersect with the relationship of women, men and non-binary people with substances, parenting and access to services.

However, despite the evidence of the concurrence of substance dependence and PTSD, "at present, most services in Europe and worldwide are far from being 'trauma-informed' and trauma remains undetected in a majority of traumatised clients" (Pompidou Group 2018b: 31).

1.5. Overarching principles

The following overarching principles are based on the legal framework and aim at orienting the implementation of the guidelines. They can also function as a checklist that could be implemented by policy makers and practitioners to ensure that the policies, programmes and actions fully comply with the spirit and recommendations of the guidelines. Section 2 describes the process of creating a national strategy and its contents and presents two examples of how the overarching principles could be used to frame an action plan based on a national strategy on children and families affected by substance dependence.

In the principles, the word "parents" refers to parents with substance dependence, whereas "children" means children living in families affected by substance dependence. The term "family" incorporates children, parents as well as family members or close persons who help parents exercise their parental responsibilities:

- name children affected by parental substance dependence and give visibility to the specific impacts of substance dependence on children and families, and their connection with children-related policies, women's rights and drug policies, including its implications for the criminal justice system;
- recognise the hidden stigmas and harms that affect children and their families and work towards the use of stigma-free language, attitudes and approaches in services;
- tackle the negative consequences of imprisonment and separation of children from their parents and the effects that may negatively impact the well-being of the child and their relationship with parents;
- ensure that the child's best interest is a primary consideration when assessing the implications and treatment of parental substance use and guarantee that individual assessment takes into account the child's own views, considering his or her age, level of maturity and capacity;
- ensure that parents and other caregivers – for example, but not exclusively, grandparents, siblings and foster families – are actively involved as well as regularly informed and consulted on the processes and decisions that concern them and their children;
- provide age-appropriate, gender-sensitive and evidence-based information on substances and substance dependence to children;
- inform children on their rights, motivate them to ask for support and provide them with the means to do so, in online or in-person settings that guarantee trust, continuity and respect for the children's views and their parents' situation;
- guarantee that ongoing and accountable processes of participation for children are set up and that children are informed and empowered to use them;

- ensure that children are consulted on, informed of and receive explanations for decisions or judgments that concern them directly or indirectly in language adapted to their level of understanding;
- ensure that the right to the attainment of the highest standard of health, the right to family and the right to parenting are guaranteed for parents with substance dependence, including those in custodial settings;
- provide parents with exhaustive, accurate and reliable information on the services available as well as on the implications of accessing them;
- ensure access to and availability of services and other forms of support for parents who use drugs in order to ensure that they can fulfil their caregiving role to their children;
- ensure that mechanisms of participation and accountability are set up for parents who access services;
- mainstream a gender perspective in policies and services and implement actions for the achievement of gender equality and gender equity;
- guarantee that women who face substance dependence and gender-based violence have access to services that are capable of addressing both situations simultaneously;
- ensure that trauma-informed practice is available for children and families as well as for service providers and practitioners in the area of social and health services, custodial settings and schools;
- guarantee the establishment of a relationship of trust and continuity of care between services and children and their families;
- promote and regulate multidisciplinary, multisectoral, collaborative and co-ordinated work methods between services, in order to guarantee, under a case management approach, that children and their families are supported in their own needs and according to their strengths and aspirations, while guaranteeing the preservation and advancement of the family as a nurturing and safe environment for all its members;
- ensure that the working conditions for professionals and practitioners working with children and families affected by substance dependence are respectful of their rights to health and the right to family.

Key messages on the legal framework

- Children living in families affected by substance dependence and their parents are entitled to all human rights, which are inalienable, interdependent and indivisible.
- Children are rights holders and subject to special protection in a dynamic relation with their caregivers, society and the state, in which their agency, voice and opinions are to be empowered and taken into account in the decisions that affect them directly or indirectly, individually or collectively.
- Children have the right to be informed on how their opinion has been included and to participate in the processes and decisions that concern their lives.
- Children should be free from any form of stigma, discrimination or violence due to the substance dependence of their parents, caregivers or legal tutors or any other situation affecting their family environment.
- Parents have a primary responsibility in guaranteeing a child's holistic development and well-being. However, the state has the obligation to support families in their task.
- Substance dependence or economic hardship are not reasons to separate a child from his or her family per se.
- Parents affected by substance dependence face a particular situation of vulnerability and are entitled to support in order to fully exercise their rights and their responsibilities as caregivers.
- Parents who suffer from substance dependence are entitled to the rights of family life, the highest attainable standard of health, freedom from discrimination, stigma-free and trauma-informed practice, and gender-responsive services for men, women and non-binary people.
- Women who use substances tend to share a history of gender-based violence and trauma, face heightened risks and stigma, and have less access to substance use prevention, treatment, harm reduction, recovery and social reintegration measures that take into account their situations and, in the case of those who are mothers, their children. Numerous interventions can be put in place in order to guarantee women a violence-free life and gender equity.
- Services working with children, families and people who use substances should be accessible and available and adopt a holistic approach that looks into the strengths, traumas and needs of the individuals while ensuring the right to family and preventing separation or institutionalisation of children.
- Such considerations are always to be weighed against the best interest of the child as a primary consideration, the protection from violence of children and family members and the rights of all the people involved.

Section 2

National strategy

The creation of a national strategy (hereinafter "the strategy" or "the national strategy") specifically centred on children and families affected by substance use is crucial to identify, tackle and reduce the hidden harms generated by the intersection of substance dependence, drug policies and gender-based violence and discrimination. It promotes awareness raising, capacity building, cross-sectoral co-operation and children's participation. It lays the basis for an action plan that implements concrete actions, the progress of which can be monitored and evaluated through nationally applicable indicators. Finally, it is consistent with states' obligations in fulfilment of the CRC.

As enshrined in Article 4 of the CRC – reproduced in the introduction – states parties have the obligation to undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the convention. General Comment 5 of the Committee on the Rights of the Child (2003) outlines states parties' obligation in this respect. Among other aspects, the committee emphasises the importance of carrying out a comprehensive review and harmonisation, in accordance with the convention, of all domestic legislation and administrative guidance. It encourages states parties to ensure the full enjoyment of children's rights through "legislation, the establishment of coordinating and monitoring bodies – governmental and independent – comprehensive data collection, awareness-raising and training and the development and implementation of appropriate policies, services and programmes" (ibid.: paragraph 9). The committee calls for cross-sectoral co-ordination between different levels of government and with civil society and promotes the development of a national strategy that is based on consultation, children's participation, independent monitoring and evaluation, and adequate budgeting.

Based on the CRC and its obligations for states parties, and on the hidden harms conceptualisation and the overarching principles that underpin these guidelines, this section presents the elements that could constitute the development of a national strategy for comprehensive and integrated services for children and families affected by substance dependence. National governments are invited to take inspiration from this section and craft a national strategy that best suits their needs and organisational structure and that is aligned to the country's existing policies and action plans related to children, social welfare and drug policies. The points indicated in the following pages are for indicative purposes and by no means intend to be limitative or mandatory. The design of the strategy should be

part of a national process that sets its own paths, while using the guidelines as a primary source. Indications on legislative review and harmonisation, data gathering, the consultation process as well as other components of the strategy need to be adapted to the national conditions and each state's political and administrative organisation.

Before presenting the steps for the creation of a national strategy, as well as its main components, the case of Ireland, already mentioned in the introduction and which serves as the inspiration for this component of the guide, is illustrated in the box below.

The Hidden Harm Strategy, Ireland[26]

"Hidden Harm Strategic Statement: seeing through hidden harm to brighter futures" (Tusla and HSE 2019a) was produced by Tusla, the Child and Family Agency, and the Health Service Executive (HSE), and 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 (ibid.: 18).

The Strategic Statement applies to all voluntary and community groups funded by Tusla and the HSE, including the Drug and Alcohol Task Force 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 (ibid.: 28-9):

- 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 the 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;
- a coherent continuum of support for children and families affected by parental problem alcohol and other drug use and improved timely access to local support;

26. This section is based on Pompidou Group 2021b and Giacomello 2023c.

- support of national screening and brief interventions, including screening for maternal alcohol consumption;
- identification of tools in screening and assessing parenting capacity when problematic alcohol and other drug use is an issue in the home;
- utilising existing models of evidence-based practice developed by Tusla and the HSE to address hidden harm;
- recognising and implementing role clarity, supporting complementary practice and mutual understanding of each other's roles.

The overarching principles of the Hidden Harm Strategy include listening to children and families in planning, design, development, delivery and evaluation of services. Joint working with key partners and external stakeholders is deemed necessary to advance actions on hidden harm across the lifespan of the child and across levels of need.

The Strategic Statement is completed by the "Hidden harm practice guide" (Tusla and HSE 2019b). The guide is meant to be used in the training of practitioners and to support the development of joint working between the HSE, drug and alcohol services, and Tusla child welfare and protection services on hidden harm (ibid.: 15), and is concerned with developing practice to enhance children's safety and well-being by:

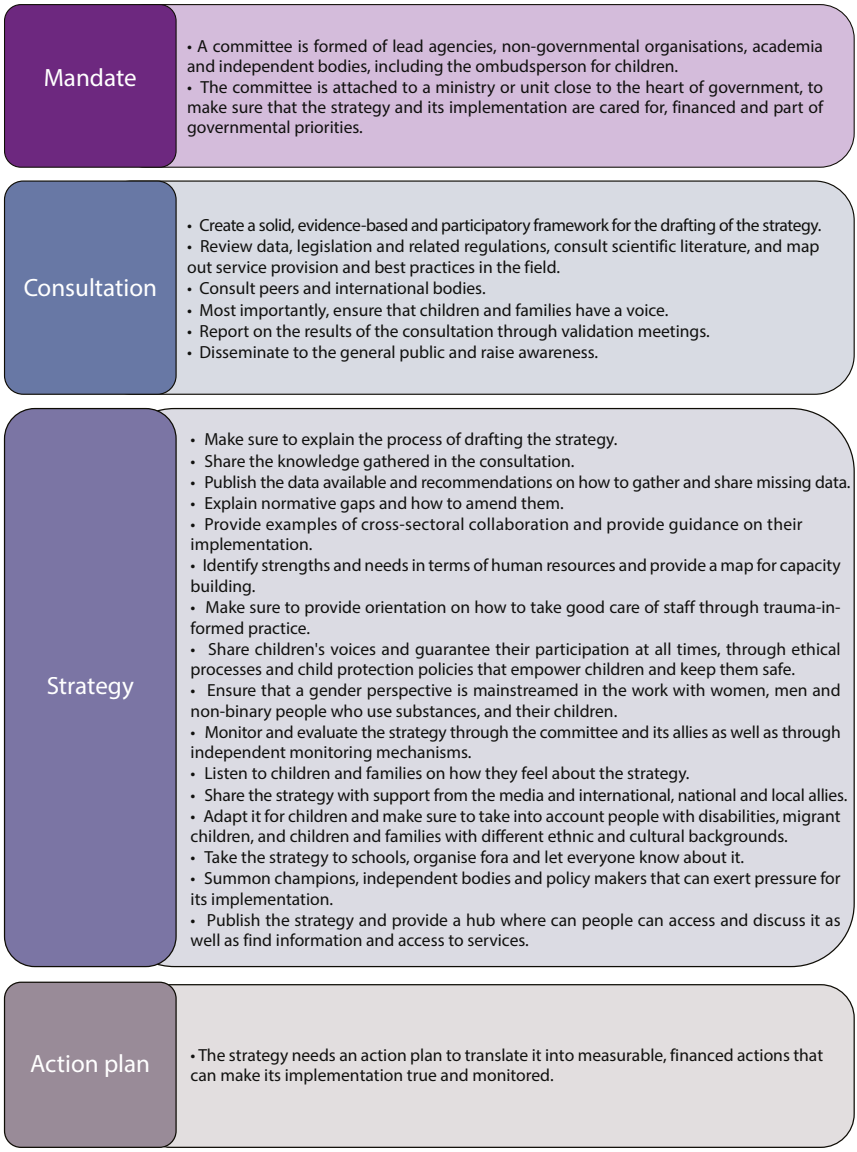
- promoting early identification and intervention at every level by all relevant agencies in order to reduce risk to a child or young person;
- promoting a "whole-family" approach to care and provision of services;
- focusing on the care of children and families who have unmet needs, where there are concerns about the health or well-being 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 should be 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 among professionals involved in the support and care of children and families affected by parental problem alcohol and other drug use.

The HSE and Tusla have also developed hidden harm eLearning with input from the community and voluntary sector, which is described in Section 3.

2.1. Creating a national strategy

This section presents the basic preliminary steps that are recommended before the draft of a national strategy, in order to guarantee the appropriateness and inclusiveness of its contents through the participation of multiple stakeholders.

Basic steps for crafting a national strategy



2.1.1. Mandate[27]

1. The drafting, implementation and monitoring of the national strategy is assigned to representatives of ministries or agencies, depending on national set-up and preference, and non-governmental organisations. The suggested lead agencies are the ministry of internal affairs, the ministry of foreign affairs, the ministry for children and

27. The following are the 108 practical recommendations of the guide. Each recommendation is numbered continuously across Sections 2 and 3.

families, the ministry of health, the national drug agency, the ministry of justice, the ministry of education, the ministry of social protection and the ministry of women. The national human rights ombudsperson or similar independent mechanisms should also be involved in the entire process, including the ombudsperson for children. Members of academia should also be included. Other ministries as well as independent and non-governmental stakeholders can be included depending on each country's preferences and political and administrative set-up.

2. The selected stakeholders lead the consultation, the drafting of the strategy, and its dissemination, implementation and monitoring through periodic reviews.

3. The lead agencies form a steering committee chaired by one of their representatives. This appointment will rotate periodically from one agency to the other. If a consensus is achieved, the chair can be chosen from outside the agencies.

4. The committee is attached to the office of the president or prime minister or other ministry, department or unit close to the head of government.

5. The lead agencies rely on ad hoc support from other ministries and agencies, including from the regional and local levels as appropriate, as well as on expert inputs, in order to carry out the specific tasks necessary for the elaboration, execution and monitoring of the strategy. The committee participates in the identification, selection and appointment of these experts and professionals.

6. Appropriate financial resources are allocated for the development, implementation and monitoring of the strategy.

2.1.2. Process of consultation

7. The drafting of the national strategy is preceded by a multilevel process of consultation, the aim of which is to:

- listen to children's opinions regarding the impact of substance dependence on their well-being as well as their recommendations on what they consider could guarantee, maintain or increase their well-being and that of their families and peers;
- incorporate the experience of parents with substance use and their opinions and recommendations on how to ensure that services recognise and contribute to the well-being of families and their role and right as parents;
- identify the gaps and strengths in the current approaches to substance dependence in social services, and its impact on children's rights and the well-being of parents and families;
- gather information regarding the elements that policy makers, service providers and professionals in the fields of social services consider to be barriers or facilitators for multidisciplinary, co-ordinated work with families;
- identify practices that adopt a participatory, trauma-informed, strength-based approach with families and children in the pursuit of comprehensively supporting families while maintaining the rights and perspectives of their individual members;
- identify the current advances and gaps in mainstreaming a gender perspective and guaranteeing the rights of women who use substances.

8. The multilevel consultation process could include:

- international organisations, particularly the Pompidou Group, the EMCDDA and the Council of Europe's Children's Rights Division and Gender Equality Division;
- national ministries and agencies;
- non-governmental organisations;
- members of academia;
- children;
- parents with substance dependence;
- other caregivers and family members.

9. After the drafting of the strategy is completed, the lead agencies engage the stakeholders involved in the consultation in a validation process of the strategy through meetings with their representatives.

10. The consultation and the upcoming strategy are announced to the general public and specialised sectors through the support of media campaigns and the dissemination of digital contents.

11. National and local media are provided with inputs containing adequate information, suggested messages and appropriate language.

12. Digital contents are developed and shared by the lead agencies and the stakeholders involved in the consultation process.

2.1.3. Mapping of services and programmes and analysis of scientific evidence

13. Where possible, the strategy includes a mapping of statutory and non-statutory services that work with children and families affected by substance dependence as well as women victims of domestic abuse.

14. The mapping also includes a list of evidence-based programmes and provides families and children with the information to access them.

15. The mapping is available in digital and hard copy format and is constantly updated on the strategy web page (see section "Dissemination and awareness raising").

16. Qualitative and quantitative academic studies, as well as analysis of best practices, are included in the preparatory work of the strategy, through the participation of experts from academia.

2.1.4. Data gathering

17. The drafting of the strategy includes the gathering of quantitative data to provide a picture of the number of children living in families affected by substance dependence as well as of parents with substance dependence and caregiving responsibilities. The lead agencies should collect the following data, if available and in respect of ethical considerations:

- number of people with substance dependence, disaggregated by gender, age range, type of substance, type and setting of treatment (including in custodial

settings), and number of children and gender, age range and arrangements of care for them;

- number of people incarcerated for drug-related offences, disaggregated by gender, age range, type of offence, judicial status (on remand or convicted), and number of children and gender, age range and arrangements of care for them;
- number of children affected by parental neglect, disaggregated by gender, age range, cause(s) of the neglect, parents or caregivers involved, and arrangements of care for the children;
- number of children surveyed in schools that report parental substance use. This data can be collected through an anonymous survey, such as the European School Survey Project on Alcohol and Other Drugs (ESPAD);
- number of women victims and survivors of domestic abuse and percentage of women with substance dependence; for the second group, the number of children and gender, age range and arrangements of care for them.

18. The data-gathering component highlights the current mechanisms and, if present, the obstacles to data gathering and sharing encountered by the participating agencies.

19. Based on the above, proposals are developed to guarantee that data can be collected, shared and used to develop public policies, in respect of privacy laws. These proposals are included in Section 2.2.2 on data collection and sharing.

2.1.5. Legislative review

20. To guarantee policy integration and coherence in the national strategy, regulations must be reviewed, and modifications may be necessary. The lead agencies conduct a review of laws, acts, plans of action and programmes that incorporate children's rights, women's rights and drug-related policies in order to identify gaps and inconsistencies in terms of the strategy's objectives. Such analysis is included in the strategy as part of its rationale.

21. The legal review is subsequently used to provide inputs for legal harmonisation (Section 2.2.3).

2.2. Contents of the strategy

2.2.1. Background and presentation

22. The introduction of the strategy presents the issues at stake, the purpose of the strategy and the process adopted for its drafting. The introduction may also include the following components:

- presentation:
  - foreword by the national government representative;
  - foreword by the Pompidou Group representative;
  - statement of the committee;
  - statement of children and parents involved in the consultation;

- explanation of the core issue, children and families affected by substance dependence:
  - description of the problem using the conceptualisation of hidden harm;
  - review of relevant research;
  - presentation of quantitative data;
- description of the methodology adopted for the drafting of the strategy:
  - description of the consultation process;
  - description of the data-gathering process;
  - legal analysis and its outcomes;
  - scope and purpose of the strategy;
  - beneficiaries of the guidelines:
    - children living in families affected by substance dependence;
    - parents with substance dependence;
    - other caregivers, including foster families;
    - service providers and professionals;
- stakeholders involved in the implementation and monitoring of the strategy;
- overarching principles and goals of the strategy.

2.2.2. Data collection and sharing

23. Data are essential for developing policies and programmes that are evidence-based and that respond to the needs and conditions of specific groups and local and national territories. Standardised data collection methods help reduce inconsistencies and inaccurate information and allow for comparisons among different groups, settings and periods.

The national strategy identifies, based on the process carried out before its drafting, which data are not currently collected, and provides recommendations to the corresponding agencies for the development of specific questions in the existing tools to address these gaps. Examples of such tools are drug treatment surveys, school surveys on drug use, child protection agencies' collection of data on families and prison population surveys.

Ireland's National Drug Treatment Reporting System (NDTRS)[28]

The National Drug Treatment Reporting System (NDTRS) was included in the Pompidou Group project and in the series of associated publications as a practice that could inspire other countries and the EMCDDA.

Ireland has been implementing the NDTRS at the national level since 1995. The data have been extensively used to inform public policies on a wide set of issues.

28. This box is based on Giacomello 2022 and 2023c. More information can be found at www.hrb.ie, www.hiqa.ie/areas-we-work/health-information/data-collections/national-drug-treatment-reporting-system-ndtrs and www.drugsandalcohol.ie/26858/, accessed 19 July 2024.

In recent years, the database has moved from a mainly paper-based system to an online data entry portal. This online database has the potential to report data in real time. The questionnaire includes an item that gathers relevant information on children whose parent(s) are in treatment, and is reproduced below.

NDTRS question 7 – Number of children[29]

Total number of children

	Under 5 years	5-17 years	18 years and over	Unknown
Living with service user				
Living with other parent				
Number in care				
Living elsewhere				
Living status not known				

Results for question 7 were published for the first time for 2020 data. The preliminary findings report that in 2020 there was an estimated number of 0.73 children for each case entering treatment for drugs and 0.79 children for each case entering treatment for alcohol, with an overall rate of 0.75.

24. The strategy also points out existing inconsistencies in data collection (e.g. ways of referring to substance dependence or substances, age ranges of children, definitions of neglect) and indicates how to harmonise them across the different tools.

25. Data on parents and children are to be collected and processed in compliance with the Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (Council of Europe 2018).

26. Data sharing between agencies and ministries, as well as between national and local services, increases the effectiveness of rapid responses and limits duplication of services and research. Collaboration between and across national, local and municipal government is key to transform data into actions. Subject to the obligations of Article 8 of the European Convention on Human Rights, the Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data, the European General Data Protection Regulation (European Parliament and the Council 2016) – particularly Article 9 for the subject of these guidelines – as well as national data protection legislation, and taking into account the best interest of

29. See www.drugsandalcohol.ie/26858/, accessed 19 July 2024.

the child, the national strategy explains the mechanisms in place and, if necessary, indicates ad hoc reforms, in order to guarantee that information is collected and shared through standardised and homogenous procedures. The purpose of data processing and sharing is to guarantee that informed public policies and services can be developed to address the family as well as the individual needs of children and parents living in a context of substance dependence.

27. Monitoring tools are established to map the number of children living with parents who use drugs.

2.2.3. Legislative harmonisation and development of co-operation protocols

28. Based on the process of consultation and ongoing activities for the development of the strategy, the lead agencies organise meetings, seminars and similar activities to collate international and local practices that contribute to the contents and implementation of the strategy, as well as to reach its goals.

29. The strategy indicates gaps or needs for reform, harmonisation or updates that have been identified in national strategies, programmes, action or implementation plans, or similar regulations, to guarantee that children living in families with substance dependence and the interconnection of dependence with other situations of vulnerability that parents may experience are acknowledged and addressed. The harmonisation process may include regulations on the following topics. The following list is not meant to be exhaustive:

- drug prevention, treatment, harm reduction and supply control;
- mental health;
- children and youth;
- families;
- schools;
- alternative care;
- women and children victims of domestic violence;
- prisons;
- social welfare;
- data collection and sharing, as referred to in the relevant section above.

30. Based on the country's needs and existing resources, as identified by the steering committee and the statutory and non-statutory agencies and persons who contribute to its drafting, the strategy presents a list of recommended protocols of co-operation among services as well as amendments to existing protocols, if necessary. The protocols may include the examples in the following list, which is not meant to be exhaustive or obligatory:

- protocols of co-operation and referral between relevant services providing care for children and parents who use drugs, in order to guarantee a holistic and multidisciplinary approach in the work with a family;

- protocols of co-operation between schools and relevant services providing care for children and parents who use drugs;
- protocols of co-operation and referral between services for women victims of domestic abuse, social services, and treatment and harm reduction services, as well as mental health services;
- protocols of co-operation between child care services and treatment, harm reduction, recovery and social reintegration services to provide parents with access to childcare facilities while accessing a service;
- protocols of co-operation and referral between antenatal and neonatal units and drug treatment and harm reduction services;
- protocols of co-operation between prisons and treatment, rehabilitation, harm reduction, recovery and social reintegration services, as well as mental health and social services for people who are in prison or who have been released.

2.2.4. Human resources

31. The presence of an adequate number of trained professionals represents a key element and a long-term investment in service delivery and families' well-being. Investment in human resources is intended to guarantee continuity of care and reduce personnel rotation and also ensure that staff working with families are not put under strain. Investment in human resources is promoted in the strategy based on services' needs and the outcomes of the consultation process with service providers and practitioners.

32. All the professionals from social and health services should be familiar with the strategy, including its theoretical and conceptual underpinning.

33. Joint training within a multidisciplinary framework is implemented online and in person.

2.3. Participation of children and families

34. Patient and Public Involvement (PPI) (Arumugam et al. 2023) in every aspect of the strategy development will add valuable insights and help to explore barriers and facilitators as well as aspirations and goals.

35. Children, parents and other significant caregivers and family members are encouraged and empowered to participate in all activities concerning the development, dissemination and implementation of the strategy, through participatory processes that are co-ordinated and guided by the appropriate authority in co-ordination with non-statutory organisations and schools.

36. Children's participation is a right and not an obligation for them and must always be based on ethical standards and the assent of the participating child, according to their evolving capacities.

37. In the context of the strategy's development and dissemination, the committee fosters the organisation of forums with the participation of children of different

developmental ages using age-appropriate participatory techniques, in order to openly discuss children's views on drug-related issues, and recommendations for families, services and their peers.

38. Children are informed on how their contributions are used to inspire policies, narratives and actions at the national and local service levels.

2.4. Evaluation and monitoring

39. The national strategy includes a set of actions and indicators related to its implementation in the different realms that comprise it, such as:

- consultation process and validation of the strategy with multiple stakeholders;
- data gathering and data-gathering review and sharing;
- normative review and harmonisation;
- development of protocols and routes of implementation;
- participation of children and families in accordance with ethical standards and the Lundy model of children's participation;
- training and capacity building;
- publication and adaptation of the strategy for multiple audiences;
- dissemination and training on the strategy with all the stakeholders involved, including schools, children and families;
- children's evaluation of the strategy through quantitative and qualitative studies.

40. The steering committee establishes a monitoring body that follows up with the implementation of the strategy within the timeline indicated.

41. The monitoring body will gather quantitative and qualitative information to evaluate implementation and indicate the interventions needed to fulfil the strategy's goals and make the necessary arrangements accordingly.

42. Independent human rights and children's rights institutions, non-governmental organisations, parliamentary commissions, youth groups, academic institutions and professional associations will be included in the monitoring process and encouraged to develop independent evaluations.

43. Children, parents and other significant caregivers and family members are also part of the monitoring body.

2.5. Dissemination and awareness raising

44. A guide for children and a guide for parents and other significant caregivers are drafted as part of the implementation and awareness-raising process. These are available in both online and hard copy formats.

45. The strategy is disseminated through different channels and presented in multiple settings, such as schools, social services and substance use prevention, early intervention, treatment, harm reduction, recovery and social reintegration services.

46. Information on the strategy's implementation is widely disseminated.

47. The media are involved in the dissemination of the strategy, as well as in the subsequent monitoring and evaluation.

48. Public events and fora are organised, with the participation of children, parents, champions and leading figures that can prompt the strategy's implementation.

49. The strategy is presented and discussed in schools with students, teachers and staff.

50. The strategy is shared on existing websites and an ad hoc website is set up. The strategy is published online and in print. The website contains a version of the strategy adapted for children as well as additional materials, such as the international and national good practices gathered during the drafting of the document, children's recommendations, and a mapping of services and programmes.

51. The website works as a reference point for professionals, families and children and is kept constantly updated.

52. The website includes online support for children and families, which is delivered by people and not tools powered by artificial intelligence.

53. Research and training on the impacts of parental substance use on children are promoted.

2.6. Action plan

54. The steering committee outlines the path for the development of an action or implementation plan that translates the strategy's contents and recommendations into financed and measurable activities.

55. An example of specific items of the action plan is included in the following table. The goals are drafted on the basis of the overarching principles of the guidelines and they only serve as examples of how the action plan might look. Given that each country differs in its organisational and institutional structure and budgetary allocations, only examples for the items "Objectives", "Actions" and "Deliverables/indicators" are provided.

Example: Goal 1. Name children affected by parental substance dependence and give visibility to the specific impacts of substance dependence on children and families, their connection with children-related policies, women's rights and drug policies, including its implications for the criminal justice system.

OBJECTIVES	ACTIONS	INVOLVED BODIES	DELIVERABLES/ INDICATORS	COSTING
1. Guarantee that actions targeting children living in families affected by substance dependence are mainstreamed in relevant national and local regulations	1. Legal review of national and local tools on substance use prevention, early intervention, treatment, harm reduction, recovery and social reintegration, as well as mental health, women victims and survivors of domestic abuse, children's rights, children's participation, alternative care and the prison system		Legal reforms that lead to the inclusion of children living in families affected by substance dependence in the relevant national and local regulations on drug prevention, treatment and harm reduction, mental health, women victims and survivors of domestic abuse, children's rights, children's participation, alternative care and the prison system	
2. Raise awareness in society and with services, including courts	1. Carry out awareness-raising campaigns and public debates, and ad hoc children's TV programmes and online publications to sensitise the general public on substance dependence and families		Alcohol Awareness Week Multidisciplinary seminars in schools Ad hoc programmes for children Seminars including public officers from multiple institutions, non-statutory organisations, families and courts	
	2. Promote anti-stigma campaigns and public debates on people who use substances and are parents		Anti-stigma campaigns in universally accessible media Consultations with people with lived experience and experts in order to develop and validate the contents of the campaigns	

OBJECTIVES	ACTIONS	INVOLVED BODIES	DELIVERABLES/ INDICATORS	COSTING
	3. International exchange of best practices		National and local seminars with international experts and national and local public officers from multiple institutions, non-statutory organisations, families and courts Publication of the results and recommendations Implementation of internationally validated best practices adapted to the national and local context	
	4. Generate awareness and synergies among substance use prevention, early intervention, treatment, harm reduction, recovery and social reintegration services, and services for women and child protection-related services		National and local seminars with the participation of services in the fields of prevention and eradication of gender-based violence, substance use prevention, early intervention, treatment, harm reduction, recovery and social reintegration services, and child protection-related services, as well as people with lived experience Public events on the intersection of substance dependence and gender-based violence	

Example: Goal 2. Ensure that the child's best interest is a primary consideration when assessing the implications and treatment of parental substance use and guarantee that individual assessments take into account the child's own views, considering his or her age, level of maturity and capacity.

OBJECTIVES	ACTIONS	INVOLVED BODIES	DELIVERABLES/ INDICATORS	COSTING
1. Guarantee that children's views are listened to and incorporated in the decisions that affect them	1. Train practitioners and family and criminal courts on the legal and practical framework for children's participation		Number of trainings and of people trained	
	2. Carry out multidisciplinary round tables for the exchange of experiences on children's participation and the drafting of resolutions, plans and texts that take children's views into account		Number of meetings Examples of resolutions, plans and texts that take children's views into account	
	3. Provide training for professionals in the judiciary system so as to make informed decisions with regard to families and child welfare		Number of trainings and of people trained	
	4. Include children in the activities		Number of meetings with children's participation Number of children involved	
	5. Publish and update examples of good practices on children's participation on the strategy website and distribute hard copy material to relevant bodies and operators		Online publication Hard copy materials distributed to relevant bodies and operators	

Key messages on the national strategy

- The creation of a national strategy centred on children and families affected by substance use is crucial to identify, tackle and reduce the hidden harms generated by the intersection of substance dependence, drug policies, and gender-based violence and discrimination.
- It promotes awareness raising, capacity building, cross-sectoral co-operation and children's participation.
- It is consistent with states' obligations in fulfilment of the CRC.
- The steering committee is attached to a ministry or unit close to the heart of government, to make sure that the strategy and its implementation are cared for, financed and part of government priorities.
- Children, parents and other significant caregivers and family members are actively involved in the preparation, drafting, validation, dissemination, monitoring and evaluation of the strategy.
- The strategy provides a solid review of data, scientific literature, and international, national and local practices, while also mapping existing services, including in custodial settings.
- It offers clear direction on legal harmonisation, protocols of co-operation and referral, data gathering, human resources and the participation of children and families.
- The strategy is disseminated through different channels and presented in multiple settings, such as schools, treatment and harm reduction services, and social services. The media are involved in the dissemination, along with children, champions and leading figures that can prompt its implementation.
- It is the basis for an action plan that triggers concrete actions, the progress of which can be monitored and evaluated through nationally applicable indicators.

Section 3

Social services

In these guidelines, social services are defined as "an inclusive range of services meeting general social needs as well as personal social services provided either by public or private bodies" (Council of Europe 2011b: 6).

This section is intended for a) service providers and practitioners in social and health services working with children and families who face conditions of vulnerability; b) schools; c) services for people who use drugs; and d) services for women victims and survivors of gender-based violence.

The purpose of this section is not to outline all the actions and services that social services should implement or provide, but to highlight only those items and procedures that could complement their work by including the four dimensions of hidden harm in it.

The proposals alternate with examples of specific practices, the majority of which are taken from the Pompidou Group's publications on children and families affected by substance dependence (Giacomello 2022, 2023a, 2023b, 2023c).

3.1. Service provision

56. Social services respond to the AAAQ framework outlined by the Committee on Economic, Social and Cultural Rights in General Comment 14 (CESCR 2000: paragraph 12) and guarantee:

- availability: functioning public health and healthcare facilities, goods, services and programmes in sufficient quantity;
- accessibility: non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility;
- acceptability: respectful of medical ethics and culturally appropriate, sensitive to age and gender;
- quality: scientifically and medically appropriate (WHO and OHCHR, (n.d.)).

57. Equivalent care and service provision is guaranteed in rural and isolated settings, excluded localities and prisons, and in other custodial settings or closed institutions for adults and/or children.

58. Sustainable funding is provided, to guarantee that programmes and services for families are not interrupted.

59. Online services are available to support families, and they are delivered by persons and not tools powered by artificial intelligence.

3.2. Staff capacity and joint training

60. Investment in human resources is required to guarantee continuity of care and reduce personnel rotation while ensuring that staff working with families are not put under strain.

61. Given the delicate and often difficult circumstances and cases that staff working in the fields of substance dependence, children and other conditions of vulnerability deal with, adequate support is provided to service personnel in terms of counselling, supervision and trauma-informed practice.

62. Vicarious trauma possibly affecting staff working closely with people affected by substance dependence (Canadian Centre on Substance Abuse 2014), other conditions of vulnerabilities and complex traumas are acknowledged. Effective ways of measuring this and strategies to address it are implemented. These include "self-care practices, mindfulness, adopting a healthy lifestyle, pursuing education, seeking social and peer support, establishing boundaries, and engaging in supervision" (Annunziata, Comiskey and Curtis forthcoming: 15).

63. Identification of people who may require support is crucial and some agents can play a key role: schools, primary health services, helplines, services for women who are victims of gender-based violence, youth clubs, religious organisations, and social and child protection services engaged with families in situations of vulnerabilities. For adequate identification and swift referral (if needed), social services should be equipped with evidence-based and stigma-free information on the processes of dependence on legal and illegal substances, along with other behaviours and forms of addictions, such as excessive and compulsive video gaming, gambling, online shopping, streaming or social network use (Council of Europe 2022b). They should also have information on the services available for people with substance dependence.

64. All professionals from social and health services – including substance use prevention, early intervention, treatment, harm reduction, recovery and social reintegration services – should be familiar with the legal framework and the methodologies and approaches for the participation of children and families, substance dependence, gender-based violence prevention and elimination, as well as conflict prevention, management and resolution in relation to substance dependence. That does not imply that social workers should be experts on substance dependence or that addictologists become experts on children's rights but that each group has a basic knowledge of both and know how to refer the children.

65. Stigma and stigmatising attitudes and language affect the way people see themselves and how they are seen by society and services (Canadian Centre on Substance Use and Addiction 2019; CND 2018). Stigma can defeat the purpose of service providers, delay recovery and lead to relapse (Comiskey et al. 2021: 25). The conscious or unconscious reproduction of stigmatising beliefs and practices can happen through language and the words we use to refer to people who use substances and their behaviours, conditions and needs, including their roles as parents. Therefore, service personnel should receive anti-stigma training (Comiskey et al. 2021; OHCHR 2019: 9), which includes development and training on standardised

language (Cafferkey, Kelly and Comiskey forthcoming 2024) and involves people who use substances in its design, implementation and evaluation (CND 2018; Comiskey et al. 2021).

66. Joint multidisciplinary training allows for staff from different fields to receive enough information, training and exchange of knowledge, practice and experiences to be able to develop multidisciplinary methodologies and approaches and to reduce existing barriers – such as ignorance on drugs and dependence or a purely clinical, individual approach to the treatment of a client – that hinder joint working and a holistic approach to families affected by substance dependence.

67. Joint training within a multidisciplinary framework is implemented online and in person.

Hidden Harm Training, Ireland

The National Hidden Harm Project was established by the HSE and Tusla to inform service planning and improve services for children in relation to hidden harm. The HSE and Tusla collaboratively developed and published the "Hidden Harm Strategic Statement" and "Hidden Harm Practice Guide" in January 2019.

Based on the latter, the HSE, Tusla and community/voluntary sector partners developed training on hidden harm using a blended learning approach.

An eLearning module was developed with the aim of supporting staff to increase their awareness of and response to hidden harm by:

- recognising the impact of hidden harm on children and young people;
- supporting parents to limit the impact of their alcohol problem and other drug use on the child or young person;
- working in partnership with parents and other services to meet the needs of the child or young person.

The eLearning module was developed in partnership with colleagues working in frontline services in maternity hospitals, treatment services, social work services, family support services and therapeutic community services. It included supported consultation with a parent using a residential treatment programme for parents, who contributed to both the content and directly via a video for the eLearning module in order to ensure the voice of the parent was present in the learning.

The eLearning is a stand-alone module. It also serves as a prerequisite to the one-day skills-based training on hidden harm. The aim of the one-day skills-based training is to provide an environment to colleagues from the HSE, Tusla, the community, and voluntary sector and partner agencies to:

- provide an environment to colleagues from the HSE, Tusla, and the community and voluntary sector to consider the impact of the issues of hidden harm on their practice;

- consider how, by working together, they can increase their assistance and support to each other;
- and in turn, clarify the benefit to the child, parent and family of effective working together.

The training facilitates staff from across the services to come together and meet in person, discuss working together, and facilitate developing referral pathways to support families and implement practices to address hidden harm. The co-facilitation of the training by both the HSE and Tusla has allowed participants to observe and be part of the collaborative and partnership approach referred to in the Hidden Harm Strategic Statement and practice guide.

The skills training was piloted in three locations (city suburb, rural region, rural city). The implementation of the pilot training was facilitated by local HSE and Tusla colleagues, who were instrumental in recruiting participants in each location representing HSE, HSE-funded, Tusla or Tusla-funded staff who work with the children of parents who use drugs or with parents who use drugs. A balance of statutory and community and voluntary sectors was essential at each pilot training. Online meetings between the working group and the local areas were held in advance of the training to support the pilot areas on the recruitment of participants and troubleshoot any issues.

Post-training evaluation with the participants, trainers and observers highlighted the following:

- a balance of participants from the HSE, Tusla and community and voluntary sector is essential to successful training. Making connections and identifying referrals pathways was a key takeaway from the training;
- the opportunity to understand roles and responsibilities for the participants and their peers in other sectors was beneficial.

All three trainers who delivered the pilot were highly skilled, with extensive experience of both training delivery and frontline work. Given the oft-complex nature of the queries that arose during training, future hidden harm trainers must have a working knowledge of the services their agency provides and the issues facing the people using their services as well as the issues facing their peers as they address hidden harm.

A hidden harm training implementation plan and recruitment of trainers nationally is currently ongoing.

3.3. Identification and referral

68. The protocols outlined in point 30) are drafted and ongoing training for its successful implementation is provided.

69. Subject to international and national regulations on data protection, an identification mechanism is used to identify and trace parents and children and guarantee that social and health services are provided with continuity of care nationwide, even in case of geographical mobility and changes of service providers.

70. People with substance dependence who are in prison or other closed settings and their families are identified and connected with social services and treatment, harm reduction, recovery and social reintegration services.

71. Given the interrogational dimension of substance dependence and parents' possible history of adverse childhood experiences, it is recommended that social and health services implement the Adverse Childhood Experiences International Questionnaire (ACE-IQ), adapted to the national and local context. As outlined by WHO:

> When the ACE-IQ is administered as part of broader health surveys it should be included in the middle of the instrument to ensure that an adequate level of rapport between the interviewer and respondent can be established before asking the sensitive questions it contains. As some of the questions in the ACE-IQ may cause upset for a participant it is strongly recommended that wherever the ACE-IQ is implemented a list of reputable, reliable and responsible local services should be available, so that the interviewer can direct the participant to the appropriate source of help or support.[30]

72. In the case of joint working between different services that attend to more than one family member, individual files can be connected through an online platform, in order to develop, report and monitor complex cases through a holistic, multidisciplinary approach. As highlighted in Section 2, data profiling and sharing is subject to the international and national legal framework in place and to the reforms adopted as a consequence of the national strategy's recommendations on legal harmonisation, if any.

P.I.P.P.I's RPMonline, Italy[31]

P.I.P.P.I.[32] is a national Italian programme and was included in the Pompidou Group 2021 project and in the 2022 and 2023 publications. The programme began in 2011 and in July 2021, the National Plan of Interventions and Social Services (*Piano Nazionale di Interventi e Servisi Sociali*) recognised P.I.P.P.I. as an essential service of social intervention (*Livello Essenziale delle Prestaziono Sociali*, or LEPS) to be implemented nationally. This section focuses on one component of the methodology: RPMonline.

RPMonline – Detect, Plan and Monitor – is an online tool accessible to all the practitioners involved in P.I.P.P.I. Every child's profile is uploaded anonymously through a code and the work with the child and their family is divided into three moments: the first is the assessment (T0), where needs are identified, discussed and analysed with children and families, through the assessment framework The Child's World and other tools.

Together with the family and the child, an educational pact is defined, identifying the priorities and actions necessary to achieve the expected outcomes.

30. More information on the ACE-IQ, its format and the implementation guide can be found at www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq), accessed 19 July 2024.
31. This section is based on Giacomello 2022.
32. Available at https://pippi.unipd.it, accessed 19 July 2024.

The work on micro-projects (T1), such as "the father will read books to the child before bedtime" or "the mother will take the child to the park and other social activities with other children" is carried out through the activation of "specific interventions" such as home-based family support work and informal social support, such as family–school–services partnerships and parents' groups. The ecosystem approach adopted takes into account the family system, the social network, the nursery and/or the school attended by children/young people, the environment in general and the dimensions of each member of the family.

At the end of the intervention (T2), practitioners and families focus on evaluating the effects of the programme on children and their parents, particularly through the measurement of changes that have occurred in the families between T0 (beginning of the care plan) and T2 (end of the care plan).

Such steps are clear, defined and lead to results that can be seen in actual transformations and outcomes. The planning is not the product of a top-down approach by which practitioners tell the family what they need and how to get there: it is families and children who, through the programme's multiple tools during the assessment phase, identify their needs and desired outcomes.

The steps are reproduced meticulously in the online format, because this allows for a post-evaluation and update up to the point that the expected outcomes are realised (T2). The tools implemented are evaluated and are either considered to have fulfilled their function or lead into updated plans, across a 12- to 18-month span.

Assessment, planning and evaluation are carried out at regular intervals by the multidisciplinary team together with the family, in a participatory and complementary process of learning, decision making, follow-up and next steps, according to the principles of PTE (participative and transformative evaluation) (Serbati and Milani 2013; Serbati 2020).

At the local level, the municipalities involved in the programme collect data on families, subsequently collected in an annual report that, in turn, provides quantitative information on the needs of the families in the area, including drug dependence.

3.4. Multidisciplinary and participatory work with families and children

73. Social workers, child protection officers, nurses and medical staff and courts work together with substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services as well as service providers in other fields of relevance (e.g. schools, housing, employment and poverty) through a multidisciplinary team model, to guarantee comprehensive and co-ordinated attention to families and each family member.

74. Staff from social services understand the multiple challenges that some parents may face, because of their relationships with substances and other situations

(e.g. economic deprivation, abusive relationships, homelessness, mental health issues or disabilities, complex traumas). They are capable, willing and informed on how to better orientate people to navigate the system, provide them with accountable information and support, and swiftly liaise them with other services. They are flexible and able to adapt, proposing realistic actions and involving service users in the planning and decision-making process.

75. Trauma-informed care and practice is implemented in social and health services, including substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services, with both families and staff.

Project Davina, SAOL project, Ireland

The SAOL project is the first women-specific, feminist, drug rehabilitation day project in Ireland and states as its mission improving the lives of women affected by addiction and poverty. Based in Dublin, it has a range of person-centred community programmes for women in recovery. One of them is Project Davina, which stands for domestic abuse/violence is never acceptable.[33] As explained on Davina's page:

> The Davina Project was set up in response to an increased need among women who were presenting to SAOL for support around domestic violence. We estimate that well over 90% of women who attend our project have experienced domestic abuse and violence at some point in their lives. However, it can be difficult if using alcohol or drugs to access mainstream domestic violence services. Davina aims to bridge the gap between addiction and domestic violence services so that women can not only access support earlier but can also explore the impact of domestic abuse on her decisions around drugs and alcohol.

Trauma-informed practice is entrenched in SAOL and in Project Davina and is, actually, rather than a "practice", that is the application of a sequential number of pre-determined steps – a cultural change, a mentality and a way of being with women. As explained by Rachel Fayne, co-ordinator of the project, the way in which SAOL works is ingrained in trauma-informed practice. The SAOL building is covered in art, there is music and a non-institutional approach prevails. The staff is understanding and non-confrontational. It is not only traumas from childhood or the past that are acknowledged, but also traumas that women may be experiencing as adults, for instance in having their children taken by the child protection system.

The existence of Project Davina itself is an example of trauma-informed practice: usually women's needs and the situations they may be facing are not addressed in one, integrated place; women are referred from one service to another and have to attend multiple appointments. That can be difficult to cope with and can lead to a lack of attendance that, in turn, puts them in situations of strain and may lead to stigma from services that believe that the women do not want to recover.

33. Available at www.saolproject.ie/project-davina-sub-page, accessed 19 July 2024.

As outlined at several points in these guidelines, services for women who experience domestic abuse and violence and services for women who use drugs are usually separated. But gender-based violence and abuse are an almost constant part of women's lives and, according to Fayne, both have to be embraced:

> If you have been in abusive relationships, your voice is taken from you, your power is taken from you. Trauma informed can be a little thing or a big thing, but it really is everything. A lot of women would come to substance use through trauma but also, once you are in the trauma, you need to continue drug abuse to cope with the trauma, in a never-ending cycle, almost, so if the trauma is ignored, how do you expect the woman to end the drug abuse? It's not always in their power to control the drug abuse if the drug abuse is controlled by an abuser. If you separate the two experiences, you are missing the unique experience of abuse. The idea that you would, as a drug service, work with women and not accept that most of your women come affected, you are not responsive, and you are not gender responsive.

Project Davina addresses the concomitance of these two aspects of women's lives, which are present and profoundly interwoven in most cases.

A key feature of Davina is the role of peers, that is women who have a lived experience of addiction and domestic violence. The peers not only inform the direction of the project, but also develop materials that can be used by professionals to work with women who experience dual issues of addiction and domestic violence. Davina was itself co-designed by women attending SAOL, and the SAOL team and the women interviewed had an input in choosing the project's co-ordinator.

The women who go to SAOL are interviewed in a non-structured way by Davina's co-ordinator. They are not asked to fill in a checklist or to prove that they are indeed victims of domestic abuse, which may be a form of re-traumatisation, but rather talked into the issue of domestic abuse, manipulation and other situations that they may be experiencing but are not aware of or not prepared to talk about yet. They can choose to attend the service, which runs individual meetings every one or two weeks and the group meetings, which take place once a week. The project runs a 10-module course, in which several salient topics are covered, such as change, risks, identifying abuse, sexual violence, gang-related violence, dynamics within abusive relationships and its impacts on addiction, mental health and children, and so on. The course also focuses on healthy relationships, boundary setting, communication skills and sexual consent.

There is no fixed period that women have to stay in Davina and women can always go back on and off across years. They can also be trained as peers and then move on to a paid position. Each path is different and respected.

Women are welcome to visit with their children and there are several options for them, including a creche for children between 1 to 3 years old, and a mother and baby group.

76. Children's participation is embodied as an ongoing practice within services and courts. Children's participation is always their choice and not an obligation. Children have their rights explained to them and they are given information on the stages, scope and purpose of the proceedings, the possibility of legal representation, what to expect from hearings or sessions, and the availability of protective measures. Furthermore, it must be explained to children how their views will be considered, on what matters, and what weight will be given to them (Durandelle, Enslen and Thomas (n.d.): paragraphs 12, 13).

Implementation of the Lundy model of children's participation, Ireland

As outlined in Section I of these guidelines, participation is one of the key pillars of the CRC and an indispensable condition for the realisation of all the other rights; children's right to participation is enshrined in the work of the Council of Europe. The Council of Europe's Strategy for the Rights of the Child (2022-2027) itself was informed by the participation of 220 children in 10 countries.

An internationally renowned model to make children's participation a reality is the Lundy model, which was developed by Laura Lundy, Professor of International Children's Rights at the School of Education at the Queen's University of Belfast. Her model provides a way of conceptualising children's right to participation, as laid down in Article 12 of the CRC.

The model consists of four elements: space, voice, audience and influence (see also page 35).

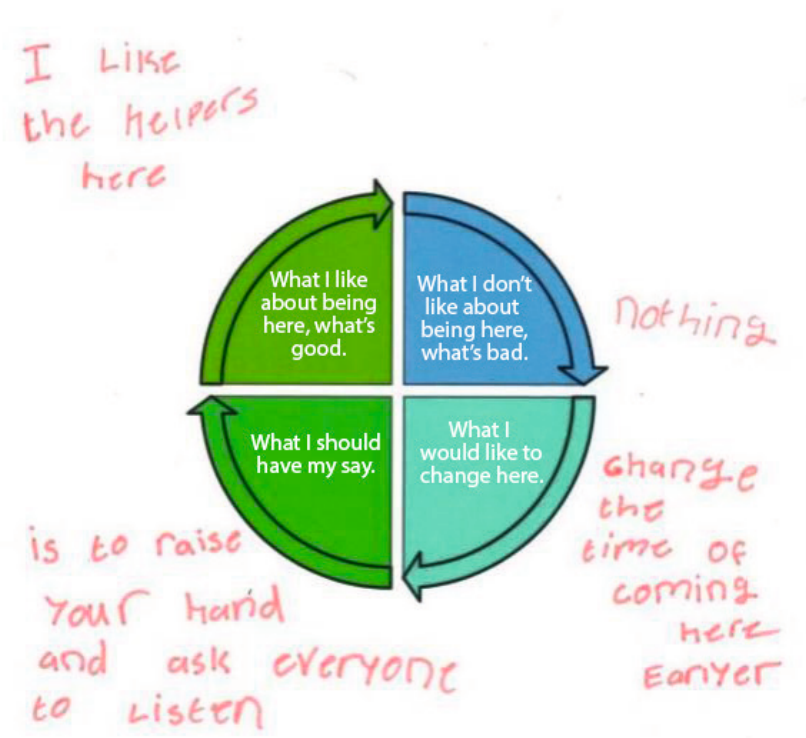
It can be used with children who go through situations of vulnerability, such as migrant children, children living in refuges, children with parents who use substances and children victims of violence.

Eleanor Hollywood – trained nurse and Associate Professor in Children's Nursing at Trinity College Dublin – implements the model with children in contexts of vulnerability by using different participatory techniques, such as drawing, collage and other art-based methods. As she explains, art-based techniques are a recognised conduit for children to express their views on a variety of topics that interest them (Hollywood 2020). Since not all children like to draw, one key element is to give children a choice on how they want to express themselves about what they are going through. Children are also given a voice not only on the situations that concern them but also on how much they want to share and what topics they prefer to leave out: through laminated red and green traffic lights, children can articulate if they want to discuss a certain topic or if they prefer the conversation to move on to other issues (Hollywood et al. 2023b: 27):

> The "traffic light" system is a set of laminated traffic lights that were presented to the children at the commencement of each interview. The objective of the "traffic light" system was to provide participating children with a non-verbal means of bringing the interview to a standstill (red light) if they wish to not answer a question and skip to the next question (green light). The working mechanism of the traffic light system was explained and demonstrated to the

children at the commencement of the interview. The inclusion of the "traffic light system" adds to the study's credibility because it ensured that children only answered the questions that they wanted to answer and wanted to talk about. Its inclusion also ensured that children were not coerced into answering questions that they did not want to answer or discuss topics that they did not want to talk about.

Another technique is The Wheel, which allows children to explain through simple questions what they like and what they do not like about a particular situation or setting and how they would want things to be. Hollywood's research includes working with children living at Meath Women's Refuge & Support Services[34] and children attending a service called Barnardos,[35] which is a referent in Ireland in terms of work with children in situations of vulnerability, including children affected by substance dependence. The figure below of The Wheel in action is taken from Hollywood's research with children attending Barnardos.



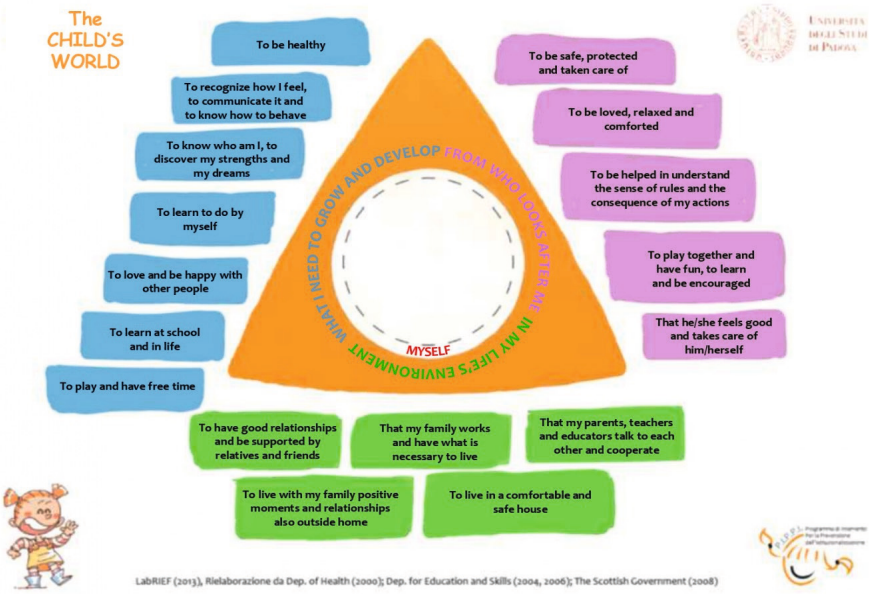
Source: (ibid.: 26).

34. Available at www.dvservicesmeath.ie, accessed 19 July 2024.
35. Available at www.barnardos.ie, accessed 19 July 2024.

The Triangle of The Child's World

The Child's World is a multidimensional tool that allows for the development of a case-by-case working plan based on children's needs and aspirations and their own understanding and verbalisation of what they acknowledge as important for their well-being.

The triangle-shaped assessment framework takes into account seven key elements of a child's development, namely health, education, emotional and behavioural development, identity, family and social relationships, social presentation and self-care. The three dimensions that constitute the three sides of the triangle are "What I need to grow up", "What I need from the people who take care of me" and "What I need in the places where I live". Each dimension has a series of sub-elements.



As explained in the "Scottish Practice Guidance – Using the National Practice Model" (Scottish Government 2022: 11-12):

> The My World Triangle examines key aspects of the child or young person's well-being across the three sides of the triangle. These enable practitioners, together with children and young people, to think about what is happening in a child or young person's whole world.
>
> …
>
> Practitioners routinely gather some of the information across the sides of the My World Triangle through their work with children, young people and families. The information gathered, alongside any assessments undertaken, should determine the need for and right to additional support. It is important to consider that what is happening on one side of the triangle may have a significant impact on another side. There may be overlap between the different sides of the triangle. Use of The My World Triangle should be proportionate to the need identified.

Some critical questions for practitioners to consider during the assessment:

- What are the views of the child, young person and their family?
- What are the strengths, talents and needs of this child or young person?
- Which aspects of family relationships promote the child or young person's development and well-being?
- How can the parent–child relationship be strengthened?
- What other factors are influencing the child or young person's well-being and development?
- What would help the parents to support the child or young person to reach their full potential?

A child or young person's age and stage of development should have a bearing on the assessment of their needs and the planning and actions taken to support them.

77. Parents who use substances and family members are actively involved in the assessment, planning and monitoring of actions that concern them and their family through methodologies that privilege collaborative and multidisciplinary processes.

78. Peer support groups for parents and for children as well as other family members are prompted and supported by services.

BRIO: peer training reintegration programme for women in contact with the law and substance dependence, Ireland

Building Recovery Inwards and Outwards (BRIO)[36] is a two-year education and training programme for women with experiences of addiction and recidivism (Woods 2020). Envisioned, proposed and designed in 2015 by the SAOL project, Dublin, it is funded by the Probation Service. As described on SAOL's web page on BRIO, the four core influences are:

- the wounded healer;
- pedagogy of the oppressed;
- the Magenta principle;
- trauma-informed care and practice (TICP).

Two of the modules are "Recover Me" (which explores emotions) and Davina (domestic violence), which is described as very hard for many of the women, particularly when discussing the impact of violence on children.

As explained by Woods in her evaluation of the programme for the period 2016-18 (2020: 192):

In its first two years, BRIO adapted to the demand from women on probation or leaving prison to participate, and while maintaining a similar modular structure, it developed a less linear, more inclusive approach, responsive to individual need and circumstance. As a result, BRIO made contacts with a total of 116 women.

36. Available at www.saolproject.ie/brio-sub-page, accessed 20 July 2024.

Referrals are taken from a range of addiction, homeless and criminal justice agencies. Some women self-referred. A committee of Probation and SAOL representatives periodically reviews the referral pathways and operation of the programme. BRIO participants do not receive remuneration and the peer work they carry out during and following training is voluntary. Progression pathways include involvement in peer work and further education.

Extracts from the evaluation report (ibid.: 202-203) state:

> The women's increased sense of self-esteem and self-worth as a result of participation in BRIO was highlighted. They assumed the identity of "wounded healer" or "peer" and believed that they were "getting a lot from the programme". Several talked about how they were received and perceived more positively in the community now and by their families and, in some cases, their children.
>
> …
>
> They have new friends, social networks and contacts, many of whom have similar aspirations. They have acquired skills and knowledge, that are transferable. They have started to plan for participation in future educational programmes. They are more aware of safeguarding their physical and mental health and are more aware of triggers and stressors. Their "eyes have been opened".
>
> Recommendations for change made by participants focused on the programme's contact hours, additional modules and remuneration for participation. A module focusing on mental health was proposed, so that peers know how to respond to and refer on individuals who are experiencing extreme distress, suicidal ideation or self-harm.

79. Besides children, other family members, such as parents, partners or siblings, may be affected by a person's substance use in different ways: emotionally, psychologically, economically, physically as well as in terms of care, neglect or abuse. They may also experience "strain on family relationships – with a potential loss of social life and an increased sense of isolation because of the stigma associated with having a relative who is using drugs" (EMCDDA 2023b: 4).

A holistic approach to assessment and intervention with families is key (Tusla and HSE 2019a), including recognition of the contribution made by family members in supporting children with parents who use substances (ibid.).

80. Adult family members of people who use drugs may benefit from services and interventions in their own right. For instance, peer support groups and specialist support services can be valuable in reducing social isolation. Other services include the provision of bereavement support and assistance for kinship carers, for example grandparents looking after the children of their drug-using child (ibid.: 6).

Services and interventions for family members should be available in substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services as well, in co-ordination with other social services.

81. Responses addressing the needs of children affected by parental substance should adopt a strength-based approach (Dawe, Harnett and Frye 2008), promote

resilience and provide support at different stages of the child's development, addressing multiple areas (EMCDDA 2023b).

82. Family programmes that focus on improving parenting skills and parent–child interactions and bonding can have positive impacts on both parents and children, improving parent–child relationships and developmental outcomes. Some examples are Incredible Years,[37] the Parent Management Training Oregon programme, the Triple P programme (ibid.), multidimensional family therapy for adolescent drug users (EMCDDA 2014) and Parents Under Pressure (Giacomello 2022, 2023c).

Prevention programmes, Cyprus

Prevention programmes (Giacomello 2022, 2023c) aim to identify and support vulnerable children – children with mental disabilities, with incarcerated parents, and so on – including children living in families with drug dependence. These programmes operate locally in the communities, articulating services and providers in order to reach children in contexts of vulnerability identified by local social services, schools, mental health services and drug treatment services. They offer educational and psychological support, free access to sport (including sport equipment) and other leisure activities, and transport, among other services that 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.

Prevention programmes are funded by the National Addictions Authority of Cyprus (NAAC) through a call for tenders.

The main objectives and tools adopted in the programmes are:

- strengthening personal skills (e.g. decision making, self-esteem);
- strengthening social skills (e.g. communication, empathy, assertiveness);
- creative activities;
- learning support;
- counselling/psychological support;
- parental/guardian counselling;
- referral to treatment.

In *Children whose parents use drugs* (Giacomello 2022), the following organisations and the prevention programmes that they implement were presented: a) TKNS and Hug of Inclusion, implemented by the European University of Cyprus; b) "You deserve an opportunity", implemented by KENTHEA: Centre for Education about Drugs and Treatment of Drug Addicted Persons; c) "It's everybody's responsibility to make sure that you are fine", by Counselling Station "Odessa"; and d) the prevention programme implemented by the Municipal Prevention Team of Geroskipou, Pafos.

37. Available at www.emcdda.europa.eu/best-practice/xchange/incredible-years-teacher-classroom-management-comprehensive-programme-parents-teachers-and-children-prevent-reduce-and-treat-behavioural-and-emotional-problems-children_en, accessed 20 July 2024.

Rialto Community Drug Team, Family Works Programme, Ireland

The Rialto Community Drug Team (RCDT) is based in St. Andrew's Community Centre, in Rialto, Dublin, and its work is included in the Pompidou Group project Children Whose Parents Use Drugs (Giacomello 2023c).

RCDT provides multiple services to people who use drugs, including women-only groups, incarcerated and formerly incarcerated people, homeless people and those using club drugs, alongside a holistic service. All services are free. It works with families and children, providing support, systemic family therapy, harm reduction and outreach and so on.

Family therapy in addiction services addresses the needs of families systemically: it views a family as a system with each family member being interconnected to each other, their wider family and their community. Its approach is different to individual counselling, where the focus is on the individual's needs. Family therapy draws on the capacity of each family member to impact and have influence in bringing about change within the family. Family Works operates through a collaborative approach with RCDT staff, particularly the family support worker of the RCDT, to ensure that the family members are supported throughout their therapeutic journey.

In the current model, the therapists meet with the referring agency to discuss the need and suitability for the clients' family. An initial introductory assessment session with therapists, key worker and family members takes place. A further exploratory session with the family is offered using creative media. Following this session, the therapists will suggest a plan for six to eight sessions, where the family will be offered a session per week. These sessions will likely include the parent(s), grandparent(s) or carer working with the family therapist and the child/children working with the child/adolescent psychotherapist. Family sessions may be facilitated, taking the place of the two concurring sessions, depending on the ongoing requirements of the family. A further six to eight sessions can be offered, depending on the needs that arise. The other key workers and in particular the family support workers continue to link in and follow up with the children, young people, parents and families who engage in this service, focusing on prevention and early intervention with an emphasis on the strengths of family members. The aim is to reinforce positive informal social networks and build on individual resilience (Giacomello 2023c: 58-9).

83. Comprehensive care is provided to parents who use substances and their children in order to empower parents who use substances and strengthen their capabilities, and prevent and reduce family separation or favour the reunion of children with their biological family (EMCDDA 2012). Families are assisted in the reunification process, taking into account the challenges this may raise for children and parents individually and collectively.

Mánaberg, Iceland

Mánaberg is a 24/7 house that provides childcare for children in difficult situations while parents are assisted in their parenting role. Children aged 0-13 years can live there with their parents. If there are older siblings, they are also accommodated in the house. The programme also has another house to accommodate children aged 14-20 years.

The service is part of the child protection services and functions as a place where families can be helped on a case-by-case basis. Monitoring takes place to evaluate if children can continue to live with their parents and to help parents keep their children with them. The main goal is to help parents get better so they can take care of their children themselves.

Mánaberg consists of four rooms and an apartment and usually accommodates a maximum of seven children and five adults. If necessary, more people can be hosted. Children are always taken in although parents may have to wait, depending on the space available.

Families usually stay in the house for two to four months, but this can be extended, depending on the case. The adults living in the house do not always have to be present, and can even go to their own homes after putting their children to bed, returning in the morning. They can also leave the house in the day for other activities, such as drug treatment at the Society of Alcoholism and other Addictions (SÁÁ), which is the leading treatment facility for alcohol and drug dependence in Iceland. Drug use disorders and mental health issues are among the most frequent difficulties faced by parents hosted at Mánaberg.

The first two to three weeks of the programme are devoted to getting to know the parents and establishing a therapeutic relationship of trust. Subsequently the adults establish, together with the multidisciplinary team, feasible goals and outline the steps to reach them. They also work on the skills required to face the difficulties they might encounter along the way.

Those living in the individual rooms are engaged in more intense and closely supervised work. However, the family living in the apartment is understood to be at an intermediate stage, and is provided with the support needed to be able to return to an autonomous life. Each family is supervised and accompanied very closely; the parents and their supervisors carry out daily assessments in the evenings, after the children go to sleep. Families, their supervisors and the multidisciplinary team also meet weekly. The working plan is assessed and adapted as needed.

The children who live at Mánaberg enjoy a normal routine and attend school and kindergarten. The children learn routines that they may not have had at home with their parents. The programme also provides art therapy. Besides school, the staff accompany children to sports activities and other social and leisure activities in order to ensure that their lives are as normal as possible.

When the parents are ready to go back home, they are followed up very closely. There are two teams that carry out home visitations, usually for one or two months, although the length depends on the needs of each case.

Mánaberg is a safe place and a place of trust. Therefore, for parents to go back to their homes, sometimes to disruptive relationships and hostile or difficult environments, can be challenging and lonely. Parents can fall back into old habits and may find it difficult to cope on their own. They are allowed to return to Mánaberg if they need to (Giacomello 2022: 24-5).

84. Multidisciplinary comprehensive care programmes are implemented, with doctors, nurses, midwives, psychologists and social workers following up with women who use substances and their children from early pregnancy into childhood to ensure the well-being and healthy development of the mother and the child (EMCDDA 2012). These include home visiting programmes for women who are pregnant and families with small children and children living in families with vulnerable situations.

85. Staff members in health, social or child protection services who have direct contact with women who use substances and are pregnant or mothers are trained and are aware about the feelings and situations that women may experience, including the risk of being victims of gender-based violence or finding themselves in violent partner relationships. They are prepared to respond appropriately and in a supportive way, avoiding stigma and shaming (WHO and UNODC 2020), while working towards creating safe conditions for mothers and children.

Home visiting programme, Preparing for Life, Ireland

Preparing for Life is an evidence-based early intervention and prevention programme whose goal is to support parents to nurture children so the child, family and community can thrive.

The home visiting programme is a manual-based programme that works alongside families from pregnancy and accompanies them until the child starts primary school. It is based on a horizontal way of working with families, through which trained home visitors create a space to deliver information to parents based on what the parents need but also on the families' strengths and capabilities.

The home visitors see the family approximately once a month or every fortnight for between 45 to 90 minutes, depending on the needs of the family and the stage they have reached. The visits can be more or less frequent, and the length will also vary.

Even if it is a manual-based, evidence-based project, one of its characteristics is that it is highly flexible, responsive and family centred. Parents are invited to engage in a process called Goals and Aspirations: this process creates space for parents to identify things they would like to achieve, and work on setting goals for themselves so they can feel a sense of accomplishment and recognise all their wins, no matter how small or big they happen to be.

The home visitors are not only trained to deliver the information while listening to the families and engaging them in the process but also to deliver parenting classes and baby massage. Midwifes are also available to facilitate prenatal education classes and provide breastfeeding support.

Parents can engage in home visits within their home, community-based settings or other venues such as local play areas. Parents and children are also offered the other programmes available at Preparing for Life – such as the Triple P parenting programme and the Circle of Security, among others – depending on their needs, and are connected to other agencies or services, including treatment services.

Data from 2020 show that approximately 11.8% of families (11 out of 93 active households engaged in Preparing for Life) self-reported addiction in the household. Feedback from home visitors clarified that this number might be an underestimate, since some families are new and might not disclose drug use until trust is established (Giacomello 2023c: 47-9).

Protocol for referral of a pregnant or breastfeeding woman in case of alcohol consumption, Cyprus

Cyprus' Protocol for the Prevention, Detection and Treatment of Alcohol Consumption in Pregnancy and Breastfeeding is presented in the two Pompidou Group publications on services and actions targeted at children and parents living with substance dependence (Giacomello 2022, 2023c). The protocol was approved in January 2021 by the Cyprus Ministry of Health, and while the main purpose is to act preventively in the case of unborn children who might be exposed to foetal alcohol syndrome (FAS), this tool serves as a means to detect all substance use disorder.

Before beginning the implementation of the protocol, and in order to implement it effectively, training was provided to the 10 midwives appointed by the services to act as the referral team for the purpose of the protocol.

The training provides the professionals with background knowledge on FAS/foetal alcohol spectrum disorders (FASD) as well as best practices in different disciplines. It also gives them a step-by-step description of the actual protocol and processes that need to be followed, including referrals to other services.

The revised clinical guidelines that incorporate the protocol as well as a handbook with all the relevant national services/professionals for referral purposes are also distributed in hard copy and digital form to all participants. These are also available online on NAAC's website and information platform for all interested professionals.

Referral protocols are accompanied by a quantitative and qualitative questionnaire to be completed by practitioners to gather more information on the patients.

Midwives thus have more tools to identify the women's needs and make the proper referral. These might span dietary issues, a brief intervention, feedback on healthy lifestyles, financial support, drug treatment services and counselling.

The women are followed up with during pregnancy and after the child is born. While the first part of the protocol focuses on the pregnant women, the second concentrates on the newborn and their needs, in physical, psychosocial or psychiatric terms, depending on each case.

86. Accurate and updated information on the programmes and services available in the territory and their contact is available for children, families and service providers, to facilitate access and referral.

87. Specialised helplines and online qualified supports are put in place for children living in families affected by substance dependence. The service is delivered by persons and not tools powered by artificial intelligence.

88. Information on these services is advertised in the media and on social media, and in schools and community settings.

Nacoa Helpline, UK

Nacoa is a charity in the United Kingdom providing information and support for everyone affected by their parent's alcohol dependence. The charity was founded in 1990, the same year a helpline was installed.

Nacoa offers different ways for people to contact them for support: the number 0800 358 3456, the email helpline@Nacoa.org.uk, the instant chat available on the charity's web page (https://nacoa.org.uk, accessed 22 July 2024) and their mailing address: Nacoa, PO Box 64, Bristol, BS16 2UH, UK.

The helpline is available Monday to Saturday, 10 a.m. to 7 p.m. and is free and confidential.

The charity's page also offers information, resources and advice for children, parents and professionals, and publishes personal experiences voluntarily shared by adults and young people (Giacomello 2022).

3.5. Training, prevention, identification and referral in school settings

89. Schools are important access points for the adolescent population and their parents (EMCDDA 2022), and it is where children and adolescents spend about a third of their time. Teachers should be trained and informed on substance dependence so that they are able to identify children who may be affected by parental substance dependence, but also so that they do not reproduce stigmatising beliefs on people who use drugs or addictive behaviours, such as excessive and compulsive video gaming, gambling, online shopping, streaming or social network use (Council of Europe 2022b).

90. As indicated in point 30) of these guidelines, protocols of swift identification and referral should include schools and multisectoral, multidisciplinary, face-to-face and online training should be implemented.

91. Children and adolescents are provided with age-appropriate and stigma-free information on substance dependence. While it has been demonstrated that the provision of information-only interventions is not effective in reducing drug use (EMCDDA 2022), children whose parents use drugs need to be provided with an

understanding of what they may be experiencing at home and what their parents may be going through, to help reduce their feelings of uncertainty.

92. Such efforts should be part of larger strategies of children's participation, aimed at empowering children, and creating ongoing processes where children know about their rights and can discuss them along with other issues that matter to them – playing, books, TV shows, music, drugs, sexuality, tattoos and so on – or that can be socially difficult to manage, such as a caregiver's substance dependence, incarceration or abuse.

93. Processes of participation are tailored to the age of children, are gender and diversity sensitive, and guarantee children's involvement in planning and development.

Children & Youth Municipal Councils, Italy

Children & Youth Municipal Councils (CYMCs) are an experience implemented in Italian schools. This box is based on the information provided by Katia Bolelli, director of the organisation Ragazzi in gioco,[38] which runs six CYMCs in the city of Pordenone, in the region of Friuli-Venezia Giulia.

The councils are enshrined in Italian legislation and the regional and international framework for children's participation, and function as a mechanism for children's participation. They are composed of children in late primary and mainly secondary schools, and they are a space where children and teenagers can express their opinions and channel recommendations to the local authorities on how to improve their city and community. They are funded by the local municipality; therefore, the extent and length of the project will depend on the funds available.

Children are elected as part of the councils – reproducing the structure of the local government – by their peers through the processes that characterise a democratic society: campaigning, elections and representation before the municipal authorities.

As part of the process of establishing a CYMC, children and young people are informed about their rights and the role of democratic rule and participation.

While these mechanisms can foster children's participation in their community, two main caveats must be mentioned: firstly, being part of a representative body, children and youth bring forward the perspectives, problems and recommendations of the majority. Therefore, issues that are less common and visible, such as substance dependence in the family, are more likely to be under the radar. Secondly, and this is not dependent on the practice, local authorities are not always an active and accountable audience.

94. While these guidelines do not focus on the substance use of children and adolescents, prevention programmes in school are also relevant for children who live in families affected by substance dependence. According to the EMCDDA (2022: 2),

38. Available at www.ragazzingioco.it, accessed 22 July 2024.

programmes that are supported by current evidence include: universal prevention programmes that focus on developing social competences, refusal skills and healthy decision-making abilities; school policies around substance use; and interventions aimed at developing a protective and nurturing educational environment that is conducive to learning and establishes clear rules about substance use. Other approaches that may be beneficial include events or interventions involving parents and the use of peer-to-peer approaches.

95. Besides the programmes described in the box below, the EMCDDA's best practices portal includes a) My Health Diary – a school-based programme to enhance subjective well-being and health by strengthening emotional and social skills and parent–child relationships[39] (rated as "additional studies recommended"); b) BE smokeFREE – enhance students' self-efficacy to help them cope with social pressure in school[40] (rated as "beneficial"); c) IPSY – life skills training with discussions on school context and learning climate[41] (rated as "likely to be beneficial"), and so on.

Unplugged, European countries

Unplugged is a comprehensive social influence programme for schools, originating in Italy, and is one of the EMCDDA's best practices.[42]

The target group is children aged 12-14 years old.

It addresses the following protective factors concerning individuals and peers: a) problem-solving skills and b) skills for social interaction.

It has been evaluated in Austria, Belgium, the Czech Republic, Germany, Greece, Italy, Spain and Sweden.

The EMCDDA Xchange page on Unplugged offers the following description of the practice:

> Unplugged is a school-based programme that incorporates components focusing on critical thinking, decision making, problem solving, creative thinking, effective communication, interpersonal relationship skills, self-awareness, empathy, coping with emotions and stress, normative beliefs, and knowledge about the harmful health effects of drugs.

Unplugged particularly emphasised correcting pupils' beliefs about the pervasiveness of substance use ("normative beliefs") by contrasting these with data from surveys of pupils of the same age which typically reveal that average use levels are lower.

39. Available at www.emcdda.europa.eu/best-practice/xchange/my-health-diary-school-based-programme-enhance-subjective-well-being-and-health-strengthening-emotional-and-social-skills-and-parent-child-relationships_en, accessed 22 July 2024.
40. Available at www.emcdda.europa.eu/best-practice/xchange/be-smokefree_en, accessed 22 July 2024.
41. Available at www.emcdda.europa.eu/best-practice/xchange/ipsy-life-skills-programme_en, accessed 22 July 2024.
42. Available at www.emcdda.europa.eu/best-practice/xchange/unplugged_en, accessed 22 July 2024.

The curriculum consists of 12 one-hour units taught once a week by class teachers who have previously attended a 2.5-day training course in the lessons and materials, and in how to teach them using methods which encourage interaction between pupils and between pupils and teachers, such as role-play and giving and receiving feedback in small groups. Based on teacher feedback and barriers identified during the first implementations of Unplugged, the revised programme's lessons are: 1. Opening Unplugged, 2. To be or not to be in a group, 3. Choices – Alcohol, Risk and Protection, 4. Your beliefs, norms and information – do they reflect reality?, 5. Smoking the cigarette drug – Inform yourself, 6. Express yourself, 7. Get up, stand up, 8. Party tiger, 9. Drugs – Get informed, 10. Coping competences, 11. Problem solving and decision making, 12. Goal setting.

The materials are available on the EMCDDA web page, as are experiences of implementation and evaluations of the programme.

Good Behaviour Game (GBG), United States and Europe

The Good Behaviour Game (GBG) – group-contingent positive reinforcement of children's prosocial behaviour, is included in the EMCDDA's best practices and rated as beneficial.[43]

Originating in the United States, it has been applied in several European countries, among them Belgium, Ireland and the Netherlands.

The target group is children aged 6-10 years old and the programme is implemented in schools.

As described on the EMCDDA's web page:

The Good Behaviour Game (GBG) is a classroom-based behaviour management strategy for elementary school that teachers use along with a school's standard instructional curriculum. GBG uses a classroom-wide game format, with teams and rewards, to socialise children to the role of student and reduce aggressive, disruptive classroom behaviour, which is a risk factor for adolescent and adult illicit drug abuse, alcohol abuse, cigarette smoking, antisocial personality disorder, and violent and criminal behaviour. In GBG classrooms, the teacher assigns all children to teams … that are balanced with regard to gender; aggressive, disruptive behaviour; and shy, socially isolated behaviour. Basic rules of student behaviour in the classroom are displayed and reviewed. When GBG is played, each team is rewarded if team members commit a total of four or fewer infractions of the classroom rules during a game period.

During the first weeks of the intervention, GBG is played three times a week for 10 minutes each time, during periods of the day when the classroom environment

43. Available at www.emcdda.europa.eu/best-practice/xchange/good-behaviour-game_en, accessed 22 July 2024.

is less structured, and the students are working independently of the teacher. Game periods are increased in length and frequency at regular intervals; by mid-year, the game may be played every day. Initially, the teacher announces the start of a game period and gives rewards at the conclusion of the game. Later, the teacher defers rewards until the end of the school day or week. Over time, GBG is played at different times of the day, during different activities and in different locations; the game evolves from being highly predictable in timing and occurrence with immediate reinforcement to being unpredictable with delayed reinforcement, so that children learn that good behaviour is expected at all times and in all places.

3.6. Services for people who use drugs and their families

96. Substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services may have an individual approach to people who use substances and thus leave out family-related issues, such as parenting responsibilities and the right to parenting, and the impacts of substance use on the clients' children, partners or parents. This is due to a number of factors, among them the importance of building trust and the time it requires, which may in turn prompt the service provider to avoid topics or situations that may generate fear or distrust on the client's side, thus pushing them away from the service and hindering the recovery process. Parents with substance dependence are not always willing to disclose their parenting status, for fear of being separated from their children. This is particularly frequent in the case of women. While the guidelines acknowledge that there are multiple ways of experiencing and exercising parenthood, which may include violent or unstable models, it is recommended that the clients' role as parents is acknowledged and taken into account and that parents who show an interest or desire to strengthen it are supported.

97. Parenting roles, models and expectations vary generationally, culturally and by gender. The work with men and women who are parents should take gender differences and needs into account and discuss how they inform, facilitate or hinder the client's relationships with themselves, their children and their role as parent.

98. Substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services offer the possibility for parents to attend services with their children, by providing caretaking services in the facility or in co-operation with other local services. In the case of residential treatment services, there should be facilities where people who are sole or primary caregivers can live with their children, with areas for mothers and fathers, as well as family units. The centres have specialised services and staff for children. Children living in the facility are involved in educational and recreational activities at the centre and in the community.

99. Children whose parents use drugs have access to services and programmes tailored specifically to their needs.

Parents Under Pressure, Coolmine, Ireland

Coolmine is a drug and alcohol centre that provides community, day and residential services. It participated in three of the Pompidou Group publications (Giacomello 2022, 2023b, 2023c) on children whose parents use drugs through interviews with women who use substances and descriptions of two of its services: the residential community for women, Ashleigh House, and the Parents under Pressure (PuP) programme.[44]

The PuP programme aims to improve family functioning and child outcomes by supporting parents who are, or have been, drug or alcohol dependent. Evaluations of the PuP programme have been carried out in other countries and the first evaluation in Ireland and in a residential setting was carried out at Ashleigh House in 2018 by Trinity College Dublin. The PuP programme is a manualised intervention, but it is individually tailored to each family as practitioners and families collaborate to develop a therapeutic family support plan with identified goals.

The following extracts are taken from the evaluation report (Ivers and Barry 2018: 10-11):

> The PuP programme is a 20-week home-based support for parents who are receiving treatment for substance use. Professor Sharon Dawe and Dr Paul Harnett in Australia specifically developed the programme for "multi-problem high-risk families" with children aged between two and eight years. The programme recognises that parents who are receiving treatment for substance use quite often experience problems across several areas, such as family life and functioning, child behaviour problems, mental health difficulties and loneliness. Thus, the PuP programme is supported by an asset-based model, which aims to address the complex and multiple problems specific to these families.
>
> …
>
> The programme combines psychological principles relating to parenting, child behaviour and parental emotion regulation within a case management model.
>
> …
>
> The PuP programme is generally run over 20-weeks and aims to enhance parenting skills and develop positive and secure relationships between parents and their children. The programme comprises of 12 core modules, which begins with a full assessment and goal setting. Working with the PuP therapist during assessment allows the parent to identify the further modules to address specific needs (view of self as a parent, managing emotions under pressure, health check for your child, connecting with your child/mindful play).
>
> The final session of PuP is dedicated to reflecting on the parents' achievements over the course of the programme. Sessions are usually confined to two hours. Any necessary supplementary case management occurs outside of the PuP sessions.
>
> The programme takes a strengths-based approach where the focus is on aspects of care that the parents do well in order to build their confidence. PuP therapists

44. Available at www.coolmine.ie/parents-under-pressure, accessed 22 July 2024.

work with parents to assist them with their understanding of their child's development while focusing and responding to the child's emotional needs and in turn improving the manner in which they interact with their child. A number of other methods are incorporated into the delivery of the programme, including video feedback, parent workbook, and mindfulness. Mindfulness is fundamental to the programme and the proposed method of change, supporting parents to recognise and regulate their emotions, while being fully "present" during daily interactions with the child.

Society of Alcoholism and other Addictions (SÁÁ), Iceland

SÁÁ is a non-governmental organisation that was founded in 1977 and is today the leading treatment service in Iceland. It operates a detoxification clinic, four inpatient and outpatient rehabilitation centres, and a centre for family services and a social centre.

SÁÁ's National Centre of Addiction Medicine has since 2008 run a programme targeting children from 8 to 18 years old with family members who use drugs, usually their parents or their siblings, but who have not started using drugs themselves. Any child can access the service and referrals come through different channels, such as parents in treatment reporting their children, child protection authorities, social welfare and schools.

SÁÁ's programme supports children in developing healthy ways to cope with the pain and difficulties caused by their parents' substance abuse and to strengthen their own self-image and their social skills. It also helps them to deal with their negative feelings, such as anxiety, anger, guilt and low self-esteem. Through the programme, children develop increased awareness of the consequences of substance use. Their potential risk of developing substance use disorders is also discussed.

The programme relies on two trained psychologists and manages to keep the waiting list short – depending on funding and, in turn, on the number of psychologists available. The psychological intervention is based on eight interviews with a trained psychologist.

SÁÁ's programme is developed to help children realise that:

- addiction is a disease, therefore the person with addiction is a sick person, not a "bad" one;
- addiction is not the children's fault or responsibility;
- they are not alone, there are other children struggling with the same situation;
- some children lack support and have no one around them whom they can trust or talk to.

It provides services with a threefold goal:

- psycho-education, aimed at understanding the children's situation better;

- psychological support, to help children deal with difficult feelings and cope with their situation;
- prevention of drug use.

The programme also includes interactive activities with computers, which makes it more dynamic and entertaining (Giacomello 2022: 44-5).

Trampoline, Germany

Trampoline[45] is a programme developed and implemented in outpatient treatment centres in Germany that targets children with parents who use substances. It is included in the EMCDDA's best practice portal[46] and rated as "additional studies recommended". As explained there:

> TRAMPOLINE is a selective prevention programme that aims to prevent substance use disorders (SUD) in children from families affected by substance use. It is a nine-session addiction-focused modular group programme for children aged 8 to 12 years with at least one substance-using parent. The main objective of the programme is to teach participants effective strategies to cope with stress; it seeks to reduce the psychological stress resulting from parental substance abuse or dependency by extending children's knowledge about alcohol and drugs, their effects on people and the consequences of substance-related disorders for affected persons and their family. Moreover, it aims to improve feelings of self-worth and self-efficacy, and to help develop a positive concept of self.

Ballyfermot STAR, Ireland

Ballyfermot STAR CLG (Support, Treatment, Aftercare, Rehabilitation)[47] is a registered charity located in Ballyfermot, Dublin. It provides a drug rehabilitation programme, early learning childcare, community employment and family support service to people who use drugs and their families. It welcomes individuals and their families in a non-judgmental, trauma-informed space and includes special services and places for children and for women. Ballyfermot STAR also runs the S.W.A.A.T project – Supporting Women to Access Appropriate Treatment – which is supported by the Tallaght and Ballyfermot drugs and alcohol task forces (Giacomello 2023c).

Ballyfermot STAR has a childcare and early learning centre, which operates 49 weeks a year and provides a full-time service for children aged 3 months to 5 years old.

The personnel are highly trained and constantly upskilling. The centre is located in the backyard and has an outdoor area, provided with natural wooden toys.

45. Available at www.projekt-trampolin.de, accessed 22 July 2024.
46. Available at www.emcdda.europa.eu/best-practice/xchange/trampoline-selective-prevention-programme-prevent-substance-use-disorders-children-vulnerable-families_en, accessed 22 July 2024.
47. Available at https://ballyfermotstar.ie, accessed 22 July 2024.

It has room for 26 children. Of the children going to the childcare service, about 80% have parents who use drugs and are in treatment, while the remaining 20% are from the general population.

The early years programme has been running for 12 years. The work with children is based on the HighScope curriculum,[48] an American programme that builds on children's abilities, strengths and choices.

The staff also help prepare the older children (aged 4 to 5 years) for primary school by encouraging independence, helping them to develop speaking and listening skills, reading books about going to school, and talking and reading about making new friends.

100. Women who use substances and are mothers may have experienced high degrees of stigma, shame and self-loathing, because they are often considered socially unfit for motherhood. In the work with women, it is important to not reproduce stereotypes or attempt to make women "fit for motherhood", by focusing uniquely or mostly on their role as caregivers.

101. Women should be given the time and space to rebuild the relationship with themselves and to heal, before being engaged in the activities and functions related to motherhood.

102. Women-only spaces or times as well as comprehensive, dedicated services should be available for women who use substances. As indicated by the Pompidou Group's handbook *Implementing a gender approach in drug policies: prevention, treatment and criminal justice* (Mutatayi et al. 2022) some of the gender-specific interventions that should be available are:

- gender-focused drug stabilisation day services that provide childcare and education options;
- gender-specific, low-threshold services that provide needle exchange, healthcare services (such as within sexual health services) or brief interventions;
- the introduction of specific days where women-only services are provided, in addition to expansion of designated women-only areas or creation of more women-focused facilities;
- speedy access to affordable housing and appropriate services to ensure safe pathways out of treatment and care settings;
- addressing waiting lists for detoxification services and treatment for gender-specific services.

San Patrignano, Italy

Founded over 40 years ago, San Patrignano is a long-term, drug-free residential therapeutic community located in the Italian region of Emilia-Romagna. It has participated in the Pompidou Group project since its first edition and guests

48. Available at www.early-years.org/highscope, accessed 22 July 2024.

of the community were interviewed for the publications on women who use substances in 2021 and 2022 (Giacomello 2022, 2023b, 2023c) and fathers who use substances in 2023 (Giacomello 2023d).

Women with their children have been admitted to the community since the very first day. If the child has been placed in a safe environment – such as with extended family or the father – it is preferable for the mother to enter the community alone and use the first months to adjust herself to the community's reality and rules. Women who enter the community with their children are sometimes mandated treatment through a judicial order and may have experienced years of a chaotic lifestyle, adverse experiences in childhood, domestic violence and poor attachment to their children. Because of the traumas and experiences they have gone through, as well the dynamics of their drug use circuits, adjusting to the strictly regulated life of the community and developing a sense of belonging and trust requires time that women should ideally have to themselves. In these early months they can come to accept their life in the community and start building links to their peers and the operators, which will reduce their desire to return to their previous lifestyle.

This time is necessary for the mothers to work on themselves and have the time to build back, or find for the first time, a relationship of trust with themselves and others, gradually recreating their self-esteem and thus preparing to undertake the laborious task of being a mother. However, if the children are not in a good or safe situation, they are brought in with their mother.

The children attend a local pre-school and school. San Patrignano personnel accompany the mothers in taking their children to school and picking them up. The community also runs summer camps and other activities in which children from the surrounding villages can also participate. Children who live outside come and visit their parents in the community, maintain constant contact with their mother, and spend summer and winter holidays in the community (Giacomello 2022: 74-5).

Coolmine, Ireland

Coolmine has two residential services for women who use substances, where they can live with their children: Ashleigh House (which for years was the only residential facility for women in Ireland) and Westbourne House (which opened in 2022). They provide holistic care to women, which includes supporting their family and friends.

Ashleigh House and Westbourne House provide a full-time childcare service for clients' children in their dedicated creches, so that women can attend the programme while feeling secure that their children are being cared for at their various stages of development.

Both residential communities include treatment and integration stages, and the PuP programme is delivered to mothers.

Ulmenhof, Switzerland

Ulmenhof[49] is a unique service in Switzerland for families affected by the addiction of one or both parents. It is described in the study "Voices of mothers with substance dependence. Stigmatisation, challenges and recommendations" (Canevascini and Kleinhage 2023) as part of the Pompidou Group's research on women who use substances.

Ulmenhof offers a full range of services for mothers, parents, families and children. The aim is to help families regain their independence through social services, counselling, inpatient therapy, supported housing and mixed forms of living (ibid.: 55-6).

The Kanu social service is responsible for reception, integration and outpatient follow-up. Sociotherapy includes a day centre offering trauma-focused therapies for parents, children up to the age of 6 years, single people and couples.

The family unit includes several allocation groups and flats for a total of 10 adults and 12 children. The Fischerhuus offers seven flats that can accommodate 10 adults and eight children.

The Tipi children's home offers supervised accommodation from birth, focusing on stabilising, encouraging and building relationships between the child and its parents. This facility can take in the children of host families, at night or at weekends, to relieve parents or in an emergency.

At Bachmoos, nine flats of different sizes are available for parents with children and single adults, encouraging independence while offering occasional support.

Admission to Ulmenhof is voluntary, but there may be legal requirements. Women can be admitted from the start of their pregnancy. If the mother is admitted after her child has been placed elsewhere, family reunification may be considered at a later date.

The average length of stay is one year, but thanks to follow-up, contact between Ulmenhof and the family can be maintained for 10 to 15 years.

103. The recovery process implies support networks and services during and after treatment. It comprises housing, insertion in the labour market, health, legal issues, counselling, ongoing support through multiple means (calls, video calls, visits, local organisations) and includes the well-being of children and other family members as well. It is developed in communication and co-ordination with social workers and courts – if applicable – and links to people who are released from prison and people who move or return to their place of origin after residential treatment.

49. Available at www.ulmenhof.ch, accessed 22 July 2024.

SANANIM, Czech Republic

The non-governmental organisation SANANIM[50] is comprised of a complex network of facilities and services for people who use drugs (Giacomello 2022).

SANANIM services are designed to form a complex network ranging from outreach services to therapeutic communities – including a therapeutic community for women and their children – and aftercare services, addressing the different needs of populations using different substances or with behavioural addictions, of different genders, economic status, ages and so on.

The wide range of services allows in-depth co-operation, internal referrals and case management on an individual basis, providing each person with the path that they need instead of aiming at a "one-size-fits-all" approach. Harm reduction services are provided, as well as social work, counselling, psychotherapy, psychiatric care, family counselling, outpatient and inpatient treatment, opioid substitution treatment and services targeting women with children.

As described on its web page, there are currently 11 facilities:

- outreach programmes;
- contact centre;
- specialised outpatient services, CADAS;
- daycare centre;
- Therapeutic Community Nemcice, a facility for long-term, in-house treatment and social rehabilitation of clients who are 21 or older;
- Therapeutic Community Karlov, a community that specialises in mid-term in-house treatment of minors and young clients. Addicted mothers with children are another target group. The capacity of the community is 15 individual clients and 10 mothers with at most two children each;
- aftercare centre;
- agency for employment and social services;
- centre for people in conflict with law;
- consulting room for parents;
- drug information centre.

3.7. Services and refuges for women victims of gender-based violence

104. While there is ongoing recognition of the intersectionality of substance use and domestic violence for women, there have been limited initiatives to provide integrated responses and care (Prakashini Banka et al. 2022; Mutatayi 2022: 152). Generally speaking, there is a siloed approach in place whereby domestic

50. Available at http://sananim.cz, accessed 22 July 2024.

violence services tend to exclude women who are actively using substances from residential services and, on the other hand, treatment services primarily or exclusively address substance use.

105. Countries and services review and expand their capacities of comprehensive services that address these concurring issues and adopt a trauma-informed approach.

106. Collaborative, comprehensive and trauma-informed care and practice should be available in services for women who use substances as well as in domestic violence services.

107. Refuges should be equipped with children's support workers (Hollywood et al. 2023a) dedicated to working exclusively with children in refuges.

108. Multidisciplinary cross-sectoral training should be implemented in order to enhance women services' collaboration and the implementation of comprehensive care.

Cuan Saor, Ireland

Cuan Saor Women's Refuge[51] (Tipperary, Ireland) is a domestic violence service that supports and provides accommodation for women who are experiencing domestic violence, including if they are actively using substances (Mutatayi et al 2022: 80).

Cuan Saor provides the following services:

- refuge accommodation;
- a 24-7 freephone helpline every day of the year;
- support and information (drop-in or by appointment);
- counselling;
- outreach to designated clinics in the south Tipperary area;
- a court accompaniment service;
- aftercare;
- training and awareness raising;
- child and family support.

In addition, a range of trauma-informed interventions are provided, including routine enquiries for adverse childhood experiences, art therapy and play therapy. Strong links and in-reach from the local substance misuse and social work services, as well as support to access substance use stabilisation and treatment services, are key to supporting services users effectively (ibid.: 80).

51. Available at https://cuansaor.org, accessed 22 July 2024.

SPAVO, Cyprus

SPAVO,[52] the Association for the Prevention and Handling of Violence in the Family, is a non-governmental, non-profit organisation active in preventing violence against women and children. It supports victims and survivors of violence through services such as helplines, individual counselling and shelters. It also provides information, support and education about domestic violence through seminars and training. A particular feature of this organisation is that SPAVO's shelters and rental apartments host women who experience domestic violence and use substances, together with their children (Giacomello 2022).

Saoirse Domestic Violence Services and Ballyfermot STAR, Ireland

The charity Saoirse Domestic Violence Services (SDVS)[53] provides a range of support services for women and their children across Dublin South-West and West Wicklow, including a 24-hour helpline, safe refuge accommodation, safe house accommodation, children's support services, community outreach support, court accompaniment, training and workshops (Giacomello 2023c).

Saoirse refuge accommodation admits women who have been assessed to be stable in their substance use and/or on a rehabilitation programme. The refuge team works in partnership with addiction services and medical support to provide a wraparound support package for victims/survivors in refuges who use substances.

The SDVS Community Outreach programme works with women through any stage of their substance use with a "crisis to recovery" model. The outreach programme focuses on supporting those women living in the community who are unable or choose not to seek refuge accommodation. The Dublin 10 Community Outreach programme delivers its services directly to Ballyfermot STAR. In this way, the outreach programme and its presence in Ballyfermot STAR provides a collaborative, wraparound package within which both domestic violence and drug use are addressed.

52. Available at https://domviolence.org.cy/en, accessed 22 July 2024.
53. Available at https://sdvs.ie, accessed 22 July 2024.

Key messages on social services

- In this guide and its recommendations, social services are defined as "an inclusive range of services meeting general social needs as well as personal social services provided either by public or private bodies" (Council of Europe 2011b: 6).
- The recommendations included in this section are meant for a) service providers and practitioners in social and health services working with children and families who face conditions of vulnerability; b) schools; c) services for people who use substances; and d) services for women victims and survivors of gender-based violence, including in prison or other custodial settings and closed institutions for adults and/or children.
- Social workers, child protection officers and courts work with substance use prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration services and service providers in other fields of relevance (schools, housing, employment, poverty, etc.) through a multidisciplinary team model, to guarantee comprehensive and co-ordinated care to families and each family member. They are capable, willing and trained on how to better orientate people to navigate the system, provide them with accountable information and support, and swiftly liaise them with other services.
- The AAAQ framework is mainstreamed in social services, guaranteeing that services are affordable, take into account disabilities, and are available across the national territory, including in rural or isolated areas, prisons and other closed settings. Information on service availability is widely disseminated.
- Universal, selective, indicated and environmental prevention programmes are implemented for children and teenagers through a participatory process that empowers children to know about their rights, recognise and discuss situations that may affect them or their peers, and know where to seek help, if they need it.
- Participation of children and parents is embodied as an ongoing practice within services and courts, addressing the needs and differences among children in terms of age, gender, ethnicity, nationality, cultural and language background, and disabilities.
- The Lundy model of participation is implemented, guaranteeing that children are not only listened to but that the decisions that concern them directly or indirectly, individually or collectively, are shared with them and rendered accountable to them.
- Responses addressing the needs of children affected by parental substance use promote resilience, adopt a strength-based approach and provide support at different stages of the child's development, addressing multiple areas.
- Children whose parents use drugs have access to services and programmes tailored specifically to their needs.

- Assessment and interventions with families adopt a holistic approach that includes the recognition of the contribution made by family members in supporting children with parents who use substances as well as the impacts of substance dependence on other family members.
- Accurate and updated information on the programmes and services available in the territory and their contact details are available to children, families and service providers, in order to facilitate access and referral.
- Staff members in health, social or child protection services who have direct contact with women who use substances and are pregnant or mothers are trained and are aware about the feelings, situations and needs that women may experience. They are prepared to respond appropriately and in a supportive way, avoiding stigma and shaming.
- Collaborative, comprehensive and trauma-informed care is available in services for women who use substances and in domestic violence services, and in services for children and families.
- A gender perspective is also adopted in the work with men who use substances.

Final remarks

This guide was prepared as part of a four-year project that, under the leadership of the Pompidou Group, has engaged participating countries in a double effort: on the one hand, to shed light on the impacts of parental substance dependence on children; on the other, to develop proposals aimed at creating integrated policies that take into account children as well as their parents and support families so they can thrive.

It is based on the contributions of multiple stakeholders, including governmental and non-governmental bodies and people with lived experiences: women and men who use substances and are parents, as well as children and young adults living in families with substance dependence.

The guide draws on an international legal framework that, through a thorough analysis of hard law and soft law tools, shows how, in order to fulfil states' duties under international treaties, measures have to be adopted to support parents who use substances while guaranteeing children's rights, including their right to family.

Articulated in three sections and 108 concrete points, the guide outlines to member states what actions could be implemented to ensure that children and parents affected by substance dependence in the family are acknowledged, supported and empowered by policies and social services. These are not recommended with the intention of substituting existing regulations and practices concerning children and people who use substances. Rather, the guide constitutes an additional outlook on families affected by substance dependence and aims at offering to policy makers, services and practitioners new perspectives and indicated actions to be incorporated in their daily tasks.

It is intended to be a practical tool with strong theoretical, evidence-based, legal grounds that can, at the same time, be adapted to each stakeholder's needs, interests and possibilities. Each section of the guide can be read and consulted independently and by specific audiences, depending on their field of competence and interest. Member states can decide to implement full sections or only specific guidelines or set of guidelines.

National governments, non-governmental organisations, schools and social services are encouraged to adopt the recommendations of the guide as a roadmap and tailor it to their national, local and specific context.

A strategy of implementation could imply a translation and adaptation of the guide, as well as the development of shorter, practical formats of dissemination. Training and sensitisation are also key in order to engage multiple stakeholders and create collaborative networks for the identification of each context's strength and gaps and the adoption of the guide's most relevant contributions.

The Pompidou Group will have a key function in providing technical assistance and guidance to those countries interested in undertaking this path. Additionally, as

demonstrated during the project Children Whose Parents Use Drugs between 2020 and 2024, the strong commitment and enthusiasm of the participating countries and the wealth of expertise shared by all the people, institutions and organisations who have contributed, will certainly help to create a critical mass of knowledge, mutual support and concrete ideas on how to move forward.

Participation of children and families will also be a fundamental factor and a means to enact children's right to be listened to and for their opinions to be taken into account in the matters that concern their lives.

To conclude, it is important to remember that this guide, as well as every product of the Pompidou Group's project on children and families affected by substance dependence, is written with the ethical purpose of enhancing human rights and children's rights, and with the conviction that, through international co-operation and concrete national and local actions, the recommendations of Alexis, the young boy from Greece whose testimony opens this document, can become a reality for the millions of children affected by substance dependence, and their parents.

Short biographies of the contributing experts

Katia Bolelli, University of Padua, Italy

Dr. Bolelli is a pedagogist and educational psychologist, member of the Scientific Group of the Programme of Intervention for the Prevention of Institutionalization (P.I.P.P.I.), and researcher at the Laboratory for Research and Intervention in Family Education (LabRIEF) at the University of Padua. She has always delved into the issues of the pedagogy of marginality and deviance, with a particular focus on programmes and interventions for vulnerable families.

Dr. Bolelli is involved in addiction care and intervention services (SerD) and teaches group management skills in the Master's degree course in Social Work at the University of Trieste and communication dynamics and developmental psychology at the Theological Faculty of Triveneto.

Karel Chodil, Therapeutic Community Karlov, Czech Republic

Director of Therapeutic Community Karlov, of the non-profit organisation SANANIM, Karel Chodil has been involved in Children Whose Parents Use Drugs since 2021, sharing information on the community and its working method. He also facilitated interviews with women who use substances for the publication *We are warriors* and participated in the working paper "Fatherhood and substance dependence: preliminary research to develop proposals".

Leda Christodoulou, National Addictions Authority of Cyprus, Cyprus

Officer of the Policy Department at the National Addictions Authority of Cyprus (NAAC), with main responsibilities on issues related to alcohol and tobacco, Leda Christodoulou currently co-ordinates the National Committee for the Treatment of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorder (FASD), and previously co-ordinated the National Co-ordinating Committee on Smoking. Within her role as a Policy Officer for alcohol-related issues, she drafted the National Clinical Guidelines for the prevention, identification and treatment of children and individuals diagnosed with FASD within the National Committee for FASD and participated in the development of a healthy lifestyle guide for women during pregnancy and breastfeeding.

Catherine Comiskey, Trinity College Dublin, Ireland

Professor at Trinity College Dublin and Chair of the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Professor

Comiskey is a leading expert on people who use substances and has been conducting research for 20 years, combining qualitative and quantitative methodologies. Together with Dr. Galligan, Professor Comiskey developed the first estimate of the number of children with parents affected by substance dependence in Ireland.

She was appointed focal point to the Pompidou Group project Children Whose Parents Use Drugs by the Government of Ireland in 2021 and has been collaborating with the project ever since, helping the consultant to contact other services and experts, participating in events related to the project, reviewing the publication *Listen to the silence of the child* as well as participating in the working paper "Fatherhood and substance dependence: a preliminary research to develop proposals". Professor Comiskey is the author of over 150 research papers and two sole-authored books: *Addiction debates*, published by SAGE UK in 2019, and *Addiction research and evaluation*, to be published by Springer in 2024.

Louise McCulloch, Preparing for Life, Ireland

Louise McCulloch is research and evaluation co-ordinator at Preparing for Life, an evidence-based early intervention and prevention programme in Ireland, where she has been working since 2019. The programme's goal is to support parents to nurture children so the child, family and community can thrive. She has been involved in the Pompidou Group project Children Whose Parents Use Drugs since 2021, sharing the work of Preparing for Life and its different programmes with children and families. She is also conducting her doctoral research on women who use substances and are mothers.

Helmut Sax, Ludwig Boltzmann Institute of Fundamental and Human Rights, Austria

Senior legal researcher at the Ludwig Boltzmann Institute of Fundamental and Human Rights in Vienna, Austria, Dr. Helmut Sax leads the institute's research activities in the fields of the human rights of children and trafficking in human beings. Recent projects addressed the impact of the Covid-19 pandemic on child protection systems, deprivation of liberty of children (including as co-lead of an international research group on child detention in the administration of justice for the UN Global Study on Children deprived of Liberty 2016-19 and a follow-up project in Austria), and rights protection of children in migration and of child victims of exploitation and trafficking. He also served as member of GRETA, the Council of Europe's Group of Experts on Action against trafficking in Human Beings, responsible for monitoring the implementation of the Council of Europe Convention on Action against Trafficking in Human Beings by the Parties (2011-18).

Florence Mabileau, Pompidou Group Secretariat

Florence Mabileau has extensive experience in working in the drug policy area and supporting Pompidou Group member states in her role as Deputy to the Executive

Secretary of the Pompidou Group and Head of the Mediterranean network for co-operation on drugs and addiction, MedNET. Among different priority areas in her portfolio, she led the Pompidou Group's work on gender, aiming at implementing a gender approach in drug policies, and was an active member of the European Group on Gender and Drugs. In November 2020, with her support, the Pompidou Group project Children Whose Parents Use Drugs was launched.

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