Children whose parents use drugs

Promising practices and recommendations

Corina Giacomello

Pompidou Group
Groupe Pompidou

COUNCIL OF EUROPE
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Her lines of research include women deprived of their liberty, adolescents in conflict with the law, children with incarcerated parents and women who use drugs. She has published extensively on these topics, in Mexico and abroad.

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Preface

The Pompidou Group provides a multidisciplinary forum at the wider European level where it is possible for policy makers, professionals and researchers to exchange experiences and information on drug use and drug trafficking. Formed at the suggestion of French President Georges Pompidou in 1971, it became a Council of Europe enlarged partial agreement in 1980 open to countries outside the Council of Europe.

On 16 June 2021, the Committee of Ministers of the Council of Europe adopted the revised Pompidou Group's statute, which extends the group's mandate to include addictive behaviours related to licit substances (such as alcohol or tobacco) and new forms of addictions (such as internet gambling and gaming). The new mandate focuses on human rights, while reaffirming the need for a multidisciplinary approach to addressing the drug challenge, which can only be tackled effectively if policy, practice and science are linked.

To better reflect both its identity as a Council of Europe entity and its broadened mandate, the group changed its official name from the Co-operation Group to Combat Drug Abuse and Illicit Drug Trafficking to the Council of Europe International Co-operation Group on Drugs and Addiction. In 2022, it encompasses 41 countries out of the 46 member states of the Council of Europe, Mexico, Morocco and Israel, as well as the European Commission.

The year 2021 marked the launch of a new project concerning children whose parents use drugs. The content, conclusions and recommendations presented in this publication aim to help increase the knowledge base and interest in the topic and to serve as a practical reference for the identification of promising practices and international partners to implement them.

This project was proposed in response to the invitation to the Pompidou Group secretariat to participate in the Council of Europe's Inter-Secretariat Task Force on Children's Rights and contribute to the discussions on the themes which should appear in the new Council of Europe Strategy on the Rights of the Child (2022-27). It started with a preliminary assessment including a literature review and quantitative data (Phase I of the project) and continued with online focus groups between the different participating countries: Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Romania, Poland, Switzerland and Turkey.

Some 29 experiences by governmental and non-governmental bodies are reported in this publication. They cover family and children-oriented services that take drug use into account; programmes and services for families and children in drug and alcohol treatment services; drug treatment services targeted at pregnant women, mothers and their children; and services for women who are victims and survivors of violence and use drugs.

Findings and recommendations conclude this research conducted for the first time on the children whose parents use drugs, and who have been "invisibilised", and offer pathways for further research and interventions.

Chapter I

Introduction

"Children blame themselves and they wonder 'why doesn't she love me?' but it's not true: the mother loves her child, but the substance is too strong."

"Kids undertake the role of the adults. They want to save their parents."

"I became my mother's mom. It is not the child who has 'to do' something, it's the grown-up who has to protect you."

"I would tell them to not feel ashamed and to look for help. They don't ask for help because they are afraid and they think they are betraying their parents."

The testimonies above are extracts of a focus group with women in the therapeutic community of San Patrignano, Italy.[1] The participants were in the process of recovering from dependence on alcohol, heroin or other drugs and generously shared their experiences and insights for this research. Some of them grew up in families with substance dependence. They saw how their parents injected heroin and died of overdoses, and as young girls they hid empty bottles in cupboards to protect their parents so that social services would not take them into foster care.

Now, these adult women are faced with the difficult job of overcoming dependence and fully exercising their motherhood, with the aim of sparing their children from experiencing the consequences of growing up in a family where drug dependence turns parenting into a complicated and, sometimes, overlooked task. It goes without saying that parenting is not an easy mission per se, and it is particularly challenging for women dependent on drugs, given the persistence of perceptions around "good mothering", from which drug use is automatically excluded.

Fathers and mothers who are dependent on drugs can be overwhelmed by the intersection of i. their personal history and history with substances; ii. social, cultural, gender-related and individual challenges in relation to parenthood; and iii. a hostile, stigmatising and not always solidary environment that does not see them as fit for parenting because of their substance use. Concomitant stressors certainly impact parents and, consequently, their children.

1. As part of the research for this report, the consultant co-organised with Monica Barzanti (San Patrignano) and Katia Bolelli (University of Padua) a focus group with six women who are undergoing recovery at San Patrignano. They shared their experiences as women who use drugs and are mothers (five of the six) but also as women from families impacted by drug dependency. The focus group took place in person in San Patrignano in August 2021, and was followed by a virtual meeting in September 2021.

Parental drug use affects children at every stage of their lives, from before birth and well into their adult lives, varying according to the children's age, gender as well as their circumstances and personal resources. The impacts of parental substance use are reflected in children's development outcomes and their daily lives. Children of drug-dependent parents often have to assume parenting responsibilities prematurely, and as a result feel confused, rejected, burdened and unable to trust their parents (Horgan 2011: 13).

These children can experience anxiety, depression, anger, guilt and shame, and have trouble concentrating at school because they are preoccupied with what might be happening to their parents. They often feel isolated, and are afraid of speaking out and looking for help because they think they would be betraying their parents or face the risk of being separated from them. Sometimes, they simply do not have anybody they trust enough. They think that they are somehow responsible for what is happening to them and that they have to save their parents. Oftentimes they have to take care of themselves and their siblings, carrying out tasks such as getting ready for school, cooking, cleaning and so on, that are their parents' responsibilities, or they are left home alone when they are too young.

Parents' drug use can lead to child neglect and maltreatment. This can be aggravated in the case of domestic violence: "[W]here domestic abuse and substance misuse co-occur the health and well-being of family members is severely impacted and the effect on children's lives compounded" (ibid.: xii). Exposure to violence not only has immediate risks and implications but, as reported in the Pompidou Group's study "Improving the management of violence experienced by women who use psychoactive substances", witnessing, "as a child, physical or psychological violence inflicted on another person, one's mother or a sibling for example, can also be a factor contributing to the start of use" (Pompidou Group, 2016: 30).

As reported in an interview for this study by one of the psychologists working with children affected by parental drug misuse at the Society of Alcoholism and other Addictions (SÁÁ), Iceland:

> Children feel ashamed of the situation at home, they have lower self-esteem. In school they face difficulties concentrating, because they are very worried about their parents. In the family we see that children take responsibilities of the adults, like cooking, cleaning, taking care of their siblings. Sometimes they don't have food at home, they face more neglect, they are left alone at home when they are not in an age of being left alone. Sometimes they are victims of physical violence and they see violence at home. They don't want to go out because they want to protect their parents or they do not want to invite friends over because they don't want to show the situation at home. There is still stigma against people with addiction, so sometimes they hear other adults saying mean things about their parents.

Childcare responsibilities often trigger the parents' wish to stop using drugs. Particularly in the case of women, pregnancy and motherhood can be strong motivating forces to help them face up to and overcome their drug problems (EMCDDA 2010: 9). The possibility of combining treatment and childrearing responsibilities is particularly crucial to foster women's entry and permanency in treatment.

Parents try to reduce the impacts of their drug use by attempting to hide it. For instance, they may avoid sleeping during the day or conceal their drugs and paraphernalia. Despite such efforts, "children are usually aware of their parents' drug taking, and at earlier ages than the parents may think. The children, however, keep this knowledge to themselves." (EMCDDA 2012a: 16)

Not all parents with dependence issues have difficulty caring for their children (ibid.), but some parents coping with substance dependence can undergo a multiplicity of feelings and situations strongly affected by their relationships with the substance in question. Some are repeating a history they lived as children, and they involuntarily reproduce dynamics of neglect on their children. The lack of information on the services available for people who use drugs or, in some cases, the fear of criminalisation or past experiences of stigma, added to the dynamic of drug use circuits and the personal paths of trauma and suffering, can impede people from seeking help and drive them deeper into isolation and lack of self-esteem and trust in oneself and others.

While the development of dependence stems from multiple situations, trauma and experiences of alcohol and drug misuse in the family of origin can be conducive factors.

Alcohol and drug abuse are two of the nine categories identified as Adverse Childhood Experiences (ACEs) that can result in long-term harm for individuals. A total of four or more issues increases, according to Morton and Curran (2019:11):

> the likelihood of a child engaging in risky future behaviour, experiencing poor health outcomes (e.g. smoking, alcohol/drug misuse, poor diet and obesity, teen pregnancy, chronic disease, violence or incarceration), and having 'difficulty in changing course' as they move through adulthood (Felliti et al., 1998; Bellis et al., 2015; Bond 2018; Edwards et al., 2019).

Focusing on children exposed to parental dependence on drugs and alcohol implies addressing an invisible population of children and helping them and their families to overcome dependence and its consequences. It also has a clear preventive aim: to avoid the transgenerational dimension of children's vulnerabilities and adults' struggles in relation to substances.

In order to protect children, it is therefore mandatory to address children's needs as rights holders, and make sure they grow up in a healthy and protected environment that ideally should coincide with the original unit of the family, avoiding separation unless living with their parents puts the child at heightened risk. Parents must be addressed as the individuals accountable for their children's development and well-being and held accountable if they do not fulfil their responsibilities.

At the same time, interventions with families, while giving voice to children, should always maintain a compassionate, non-stigmatising, trauma-informed, gender-responsive and flexible attitude towards parents.

This is particularly sensitive in the case of women: in the first place, because trauma, gender-based violence, low self-esteem, and at times sexual violence, play a role in women's development of dependence (EMCDDA 2009). This must be addressed with the same gender-responsive attitude that women victims and survivors of violence should receive. Women who use substances are also more highly stigmatised than men (UNODC 2016), and often live their motherhood in isolation, with little support

in taking care of their children when they want to access treatment. Another key aspect, particularly for women, is that the fear of having their children taken away from them is a relevant factor in not seeking treatment or disclosing their drug use. It is a well-founded one: as reported in the study by the Pompidou Group (2016), perceptions of women drug users as "bad mothers" are still very present and can encourage child protection services to remove children from women with drug use disorders. Child removal can have serious consequences for women. Research from Scotland shows that loss of child custody was closely linked to loss of motivation for recovery, feelings of hopelessness and increased risk of drug-related death.

> One potential source of trauma among women who use drugs is the loss of child custody due to child protection concerns (Broadhurst and Mason, 2013, Kenny et al., 2015). Some authors have hypothesised that the emotional impact of child removal is exacerbated by its profound stigma, in *"disenfranchised grief" that cannot be acknowledged or shared with others* (Broadhurst and Mason, 2013). There is emerging research evidence to support front-line reports that child removal often results in worsening mental health, social functioning, and substance use among mothers (e.g. Kenny et al., 2015, Wall-Wieler et al., 2017). … Loss of child custody appeared to be a time of considerable vulnerability: one woman explicitly linked this event to a relapse and another to plans for an intentional overdose. (Tweed, Miller and Matheson 2018: 18)

Services for women in this situation have the dual task of providing women with facilities where they can attend treatment with their children, as well as environments that are non-judgmental and where women feel safe and respected.

This report focuses on children growing up in families affected by drug and alcohol dependence, as well as on the services, programmes and practices that help to protect childhood and guarantee children's needs while, at the same time, addressing the needs of parents. It comprises a mosaic of interventions aimed at families and children; services for women who use substances and are mothers; dependence treatment services that take into account parental responsibilities, children's needs and particular situations; and shelters for women victims and survivors of violence who use substances.

Protecting the rights of the child is at the core of the Council of Europe's mission to safeguard human rights, uphold democracy and preserve the rule of law. As such, this publication is part of a human rights-oriented project that responds to the mission of the Pompidou Group to integrate human rights in drug policy.

The countries (listed in the next section) and practices included in this report have been included because of the commitment of national governments through their Permanent Correspondents to the Pompidou Group and their subsequent involvement in a plurality of activities. Certainly, other experiences and programmes not included here can be illustrative of promising local and national efforts to guarantee children's rights in families impacted by dependence. Also, other voices that participated in this report but are not included in the description of specific practices have nevertheless nurtured its reflections and recommendations.

This research, rather than representing a conclusion, is the beginning of an ongoing effort to give visibility to children in families affected by drug and alcohol misuse and the practices that target them and their families, and to foster co-operation and dialogue between governmental and non-governmental actors.

At the time of completing this report (October 2021), the project had already led a co-operation initiative between the governments of Croatia and Cyprus and secured the interest of the non-governmental organisation SANANIM (Czech Republic) in contacting other therapeutic communities that host women with their children.

The contents, conclusions and recommendations presented in the following pages are intended to help increase mutual knowledge and interest and to serve as a practical reference for the identification of promising practices and international partners to implement them.

Background

This project was proposed in response to the Council of Europe's invitation to the Pompidou Group secretariat to participate in the Inter-Secretariat Task Force on Children's Rights to contribute to the discussions on the themes that should appear in the new Council of Europe Strategy for the Rights of the Child (2022-27). The Pompidou Group made the following proposal to be included in the strategy: "To include actions to develop practical tools to protect children of parents who use drugs under the 'equal opportunities' pillar of the draft strategy, as they were deprived of their childhood and had been disproportionately affected by the pandemic".

Subsequently, a preliminary assessment was developed, based on 16 Pompidou Group countries'[2] responses to a questionnaire, a literature review (international legal tools and standards) and quantitative data, corresponding to the first phase of the project. The report and preliminary assessment and proposals (Pompidou Group 2021a) were shared with the 20 countries that expressed an interest in the project, as well as with the non-governmental organisations that contributed by sharing information or perspectives.

In February 2021, the Bureau of the Pompidou Group took note of the developments under this new project and entrusted the secretariat to follow it up as appropriate with the second phase of the project (February to December 2021). Some 13 countries participated in the second phase.[3] Between February and September 2021, the consultant responsible carried out three inter-country focus groups,[4] national focus groups with five countries,[5] and semi-structured interviews with a total of 61 people from 10 countries, namely the Czech Republic, Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Poland and Switzerland.[6]

2. Croatia, Cyprus, Czech Republic, Greece, Hungary, Iceland, Ireland, Italy, Lichtenstein, Mexico, Monaco, Poland, Romania, Spain, Switzerland and Turkey.
3. Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Morocco, Norway, Romania, Poland, Switzerland and Turkey.
4. The countries participating in the focus groups were Croatia, Cyprus, Greece, Iceland, Ireland, Italy, Mexico, Romania, Poland and Turkey, while Switzerland provided written responses to the questions shared with the countries' focal points.
5. Croatia, Cyprus, Iceland, Ireland and Italy.
6. The differential representation of countries in the report is not intentional but is the outcome of the referrals proposed by countries or contacts inside countries as well as the extent of responses from the people, organisations or institutions contacted for the development of the project.

The experiences shared in the focus groups between countries can be found in the report "Children whose parents use drugs. Report of focus groups held in February 2021" (Pompidou Group 2021a), while this document includes the findings of the national focus groups and the semi-structured interviews.

All the meetings were carried out virtually on Zoom and the informants had access to the recordings. During the writing of the present report, the consultant shared with each participant or group of participants the text regarding the particular programme, service or governmental or non-governmental entity they represented, to give them the opportunity to comment, make corrections or add further information. The response to the project was collaborative and enthusiastic and the research inculcated an interest in participants to learn about other countries.

Besides conversing with experts and operators, the consultant had the opportunity to draw on the voices of nine women from two therapeutic communities in Italy. While their experiences are not included directly here, they feed into the conclusions and recommendations of the report and will be subsequently analysed with the intention of promoting specific work on gender and motherhood in the context of dependence and the services' responses and attitudes.

Key concepts and contents

The term "drug use" adopted here does not refer to all forms of drug use, but only to drug use disorders, based on the definition provided by the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC) in "International standards for the treatment of drug use disorders" (WHO/UNODC 2020: 4),[7] with substance dependence as one manifestation of drug use disorders.

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7. "According to the 11th revision of the International Classification of Diseases (ICD) (WHO, 2019a) the term 'drug use disorder' comprises two major health conditions: 'harmful pattern of drug use' and 'drug dependence'. The harmful pattern of drug use is defined as a pattern of continuous, recurrent or sporadic use of a drug that has caused clinically significant damage to a person's physical (including bloodborne infection from intravenous self-administration) or mental health (such as substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others. Substance dependence is defined in ICD-11 as a pattern of repeated or continuous use of a psychoactive drug with evidence of impaired regulation of use of that drug which is manifested by two or more of the following: (a) Impaired control over substance use (including onset, frequency, intensity, duration, termination and context); (b) Increasing precedence of drug use over other aspects of life, including maintenance of health and daily activities and responsibilities, such that drug use continues or escalates despite the occurrence of harm or negative consequences (including repeated relationship disruption, occupational or scholastic consequences and negative impact on health); and (c) Physiological 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.
   'Disorders due to drug use' comprise a broader category of health conditions that include drug intoxication, withdrawal syndrome and a range of drug-induced mental disorders. Drug use disorders often go hand-in-hand with a significant urge to use psychoactive drugs, which can persist, or easily be reactivated, even after a long period of abstinence. Very often drug use disorders are associated with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence."

Drawing on the same definition, the concepts "drug use", "drug use disorders", and "substance or drug dependence" are also associated "with hazardous or harmful use of other psychoactive substances such as alcohol or nicotine, or with alcohol and nicotine dependence".

Typically, the terms "drugs", "substances" and "drug abuse" are used to include substances prohibited under the international drug control conventions and their non-medical use (UNODC 2020a: 5), alcohol and nicotine. Alcohol is indeed the most worrisome drug for the topic under study, "given that large numbers of parents with alcohol problems may generate more problems overall for children in the European Union than the smaller numbers of children affected by parents with illicit drug problems" (EMCDDA 2010: 30).

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

The report includes 28 experiences and practices from governmental or non-governmental bodies, divided by main area of intervention and country. Every practice can encompass more than one programme, service, territorial area, target group and so on. The description of every experience is based on the interviews or focus groups and is complemented by information available on the internet.

The contents are organised as follows.

Chapter II, "Family and children-oriented services that take drug use into account", looks at a wide range of practices from Cyprus, Iceland, Ireland and Italy that range from prevention programmes with children to intense interventions with parents and children in very vulnerable contexts, and situations in between. The programmes and practices aim at providing children with skills, opportunities and safe spaces, while addressing families' complex needs through systemic and holistic interventions in the attempt to maintain family unity while increasing parental skills, attachment, communication and resilience for both parents and children.

Chapter III, "Programmes and services for families and children in drug treatment settings and related services, including data gathering and advocacy", looks at those cases where children are actively addressed by treatment services, not as users but as subjects exposed to particular vulnerabilities because of parental substance use disorder. Programmes in Iceland and Ireland, as well as the latter's data gathering system, provide specific examples that can open up perspectives for other countries. Mexico's case sheds light on support for children with parents who use substances and integration into the community through treatment services. Croatia's approach confirms the need to bring families and children into a therapeutic alliance. The example from Switzerland reinforces the need to produce and disseminate materials for children (gender-sensitive and differentiated by age group), parents and professionals. This section also includes a brief review of a practice in the United Kingdom, a country that is not included in this study but that was referred to by informants from the Irish Silent Voices campaign.

Chapter IV, "Drug treatment services targeted at pregnant women, mothers and their children", covers residential communities for women who are pregnant or have

children, where they can actually live with their children, including examples from the Czech Republic, Croatia, Cyprus, Greece, Ireland, Italy and Poland. These services were created on the basis of growing evidence that the key factor for women to enter treatment is being able to take their children with them. The chapter also describes a recent protocol from Cyprus aimed at ensuring that women who are pregnant or have recently given birth are referred to the right services through a liaison midwife capable of fostering a relationship of trust. This practice is currently being looked into by Croatia as well.

Chapter V, "Services for women who are victims and survivors of violence and use drugs, and their children", highlights a much-needed yet still marginal practice, namely the admittance of women who use substances into shelters for women victims and survivors of violence and their children. Through the examples of Cyprus and Ireland, this chapter illustrates that dependence should not be a barrier to providing women and their children with protection.

Chapter VI, "Key messages and recommendations", includes an analysis of findings and recommendations that pave the way for future research and interventions, with the hope of engaging countries in pursuing the sharing and development of policies, programmes and practices. This chapter also draws on the two previous reports: the preliminary assessment and proposals (Pompidou Group 2021a) and the report of the focus groups.

Main challenges and promising practices

This section synthesises some of the findings and recommendations, further detailed in Chapter VI.

Table 1. Main challenges and promising practices

Challenges	Promising practices
Current practices of data collection and sharing between ministries and the relevant services fail to produce a national estimate of the number of children affected by parental substance dependence.	Ireland's National Drug Treatment Reporting System includes questions and features that can help overcome the limits currently implicit in the Treatment Demand Indicator. The Italian programme P.I.P.P.I. and the prevention programmes in Cyprus in connection with the National Addictions Authority of Cyprus provide examples of data gathering; however, they do not necessarily have national reach.

Challenges	Promising practices
There is insufficient integration between social services, child protection and treatment services in terms of communication, mutual knowledge and co-ordinated, holistic work. This can hinder processes of support for children. Further, the persistence of stigma, or simply a limited understanding of dependence on the part of social services and child protection, and a certain resistance or difficulty in addressing family matters and responsibilities for children on the part of treatment services, can make the development of collaborative, coherent and integrated plans more difficult. Other structural difficulties, such as lack of personnel and insufficient training, also come into play.	The Hidden Harm Strategic Statement (Ireland) provides a framework for holistic approaches and joint work between the services and agencies. This, however, must be supported by funding and national-local collaboration. The drafting and operationalisation of protocols presented in the case of Italy can provide examples of how to bring operators from different services around the same table to collectively assess and address a case (intended as a dyad of the child and parents). Further, the protocol presented in the case of Cyprus is an example of innovative mechanisms to guarantee gender-responsive referrals and support to mothers after birth that are beneficial to newborn babies. The Parents under Pressure Programme (Coolmine, Ireland) is a good practice in the field of systemic interventions that take into account parents' situations when facing the dual challenge of parenthood and dependence. The interventions carried out by Preparing for Life, Alcohol Forum Ireland and P.I.P.P.I. generate methodologies, frameworks and approaches that can improve collaboration and integrated work beneficial to families and children.
Women still face barriers and stigma in accessing treatment. They often lack access to information and there is still a scarcity of outpatient, intensive outpatient and inpatient facilities where they can take their children with them.	Intensive outpatient services should be available for people with parental responsibilities, particularly women. Child services, such as accredited crèches and day care centres, should be available for women to leave their children while they attend treatment or other services. Trauma-informed, women-only services such as the SAOL project, as well as the multiple services provided by SANANIM (Czech Republic) and the interventions implemented in San Patrignano, Mimosa, Monar and Coolmine, among others, are examples of practices where the unique needs of women and children, and as a dyad, are addressed.

Chapter II

Family and children-oriented services that take drug use into account

This chapter analyses practices from Cyprus, Iceland, Ireland and Italy aimed at children and families in situations of vulnerability. Their main aim is to strengthen children's inclusion, communicational and emotional skills, resilience, feeling of belonging, and participation in a wide range of educational, sports and group activities through the provision of safe spaces, both physical and symbolic. Parents are addressed through multiple programmes that, based on family and individual needs, reinforce their strengths and support them in their parental role.

Cyprus

The National Strategy for Addressing Dependence 2021-28[8] identifies vulnerable groups under its pillar on prevention. The National Addictions Authority of Cyprus (NAAC) is in charge of funding, through a call for tenders, several prevention programmes that aim to identify and support vulnerable children. They target children with mental disabilities, children with parents who have been deprived of their liberty, and so on, and include children living in families with drug dependence. The programmes operate locally in the communities, articulating services and providers in order to reach children in contexts of vulnerability as identified by local social services, schools, and mental health and drug treatment services. They offer educational and psychological support, free access to sports (including sports equipment) and other leisure activities, and transportation, along with other services that are tailored to the specific needs of each child. The link with drug treatment services is key in order to make referrals for the children of people in treatment.

In the following sections, four prevention programmes are described, based on the information provided by their representatives in the national focus group event held in April 2021.

8. Other vulnerable groups, according to the National Strategy, are the following: school drop-outs; students who are experimenting with the use of substances/gambling; children whose parents are imprisoned; children whose parents face mental illness; children who have faced/are facing any form of abuse; children in the custody of the state; immigrant children/teenagers; children/teenagers with delinquent behaviour; children living in poverty; children with attention deficit hyperactivity disorder (ADHD) and other learning difficulties; pregnant women who use alcohol and/or other substances; unemployed and seniors vulnerable to pathological gambling.

Counselling Station "Odysseas"

The non-governmental organisation "Odysseas" is the result of co-operation between six municipalities in Limassol, and operates under the scientific supervision of the organisation KENTHEA.[9]

"Odysseas" provides services through the framework of a prevention programme and drug treatment. Treatment is offered to adults and their families as well as to parents or young adults involved in the prevention programme who are using or misusing substances.

The prevention programme, titled "It's everyone's responsibility to make sure that you are fine", targets children aged 6 to 20. It offers a wide array of services: psychological and educational support, access to arts, sports and other leisure activities, music lessons, and so on. All services are free to locals and the programme also offers logistical support if needed, such as transport, materials and equipment.

Funds come from the six municipalities and NAAC. Given the variety of services and volume of expenses involved in providing everything free of charge, the organisation fundraises through public and private organisations that also provide school grants, sports equipment, music instruments, and so forth.

The implementation of the programme is based on an individual assessment of family needs and takes place in co-operation with parents and caregivers. Parents with addiction issues are referred to the treatment service if it is appropriate for them, thus guaranteeing a holistic approach. The successful completion of treatment is often a requirement to secure custody of the child.

At the time of the focus group event, the programme hosted approximately 55 children. The co-ordinator of the prevention programme put stress on the importance of "caring for the caregivers". While families indeed receive financial support, this is not enough. The caregivers – usually grandparents – sometimes also share other difficulties and require psychosocial support:

> It's important to support the caregivers, educate them about the problems of addiction and give them information, because they usually don't know this information or don't have this support and they are the people who need to know how to support the drug-using parent. I don't think we have services or people who are trained to support the caregivers for this specific issue of addiction.

TKNS and Hug of Inclusion, European University of Cyprus

TKNS and Hug of Inclusion are prevention programmes co-ordinated by the European University of Cyprus with funding from NAAC. The first is implemented in Nicosia, Limassol and Paralimni and the second in Nicosia and Limassol.

TKNS – the Greek acronym for "What do you do?" – has been running since 2015. It began as a pilot programme with the aim of fulfilling the psychological, educational,

9. Centre for Education about Drugs and Treatment of Drug Addicted Persons, available at www.kenthea.org.cy, accessed 16 December 2021.

social and mental health needs of children. It targets high-risk children aged 8 to 15 from families with a history of mental health disorders or substance abuse disorders or both, as well as children with incarcerated or formerly incarcerated parents. These children are likely to be overburdened, and suffering from social exclusion and stigma. The family members, extended family and the general social milieu of these children are also addressed.

The programme currently focuses more on sports and leisure activities and conducts multiple group outings such as a "week at the beach", camping, hiking, biking, and visits to the cinema, museums and the theatre. These activities are meant to enhance children's social skills and integration while targeting prevention. Since 2015, some 110 children have participated in TKNS activities at least once.

Hug of Inclusion is focused on education as well as creative and social activities. Children can take English, Greek, mathematics, painting, robotics and theatre lessons after school. The programme co-operates with the Cyprus Sports Organisation, the Department of Art and Music of the European University of Cyprus and the Grammar School of Cyprus, among other organisations.

As reported in the focus group:

The most usual problem experienced by children in families facing drug addiction is a real need to belong somewhere, to live in a place where they feel they are secure, where they fulfil their need for communication.

The innovation of this programme is the fact that we give facilities and activities to those populations that have never had the opportunity to have them.

They usually don't have the money, or the benefit of moving, so usually after the evaluation we find out that even if you give them the opportunity to participate in activities they stop because they don't have a way to travel to the activity. We use our car in order to take the kids, or volunteers, students, etc.

Mainly women from low socio-economic levels, approach the programme, mostly unemployed, receiving benefits from the government.

Another initiative of this programme is that the group of people working in this programme have strong cohesion.

We started to increase this team dynamic; we managed to get 10 bicycles from the Cyprus sports organisation and we go cycling every week. Also, every summer and during the winter we stay in houses for three or four days where they have the opportunity to collaborate with each other and create connections. This has been going since 2015, so some children have been with us for six years and they are very connected, enhancing feelings of belonging to this programme.

We move to the children's environment, we fill the gap between the services (such as mental health) and the community.

During the lockdown resulting from the Covid-19 pandemic, activities moved to the homes of the participating children.

> Now with Covid we managed to get the things to the children's houses in order not to lose their lessons and continue the activity, and also we have the possibility to intervene with the family by creating individual or team work in order to enhance and support the members of the family with the problems that they are usually facing.

Municipal Prevention Team of Geroskipou, Pafos

This prevention programme is funded by NAAC and also by the municipality of Geroskipou. However, it covers other regions in Pafos.

Its main goal is to promote and offer activities that enhance the well-being of children and parents in the early stages of children's lives, aged elementary school through to the beginning of their teenage years. The programme targets children aged 6 to 13, offering psychological support mainly through drama therapy. Besides individual work, drama therapy is also applied in small groups of between six and 10 children of a similar age range.

The programme is also available to younger children – aged 3 to 5 – using sensory play. Through work with children and their parents, it focuses on bonding and the parent–child relationship.

When working with children, a suggestion is made to parents and caregivers to also undergo psychological support, in order to improve dynamics that can be rooted in the family. Both individual counselling and group work are available for parents referred to the programme and who belong to vulnerable groups. Parental group work is intended to strengthen fulfilment of parental roles and skills.

The programme also carries out group work and seminars with teachers. This has led to a further development: since 2018, the programme has been offered to entire classrooms, mainly those characterised by cultural diversity and/or by children with difficult behaviour, usually triggered by mental health issues, drug use, life-threatening illness, unemployment or other difficulties in the family setting. The focus group informant reports that by the end of classroom work, the classroom dynamics have improved, new friendships have been forged, and there is more unity and understanding.

One of the issues raised in the meeting was that funds are often insufficient and programmes can thus be short-lived.

KENTHEA: Centre for Education about Drugs and Treatment of Drug Addicted Persons

KENTHEA is a non-governmental organisation located in Nicosia that offers programmes all over Cyprus. The prevention programme "You deserve an opportunity" targets children from vulnerable groups. At the time of the focus group meeting, 50

children were involved in the programme, of whom about 10-15% had parents who use drugs. The initial target group of children aged 8 to 15 years has been extended; at the time of the interview KENTHEA also supported a child aged 4, whose nursery school fees it paid.

KENTHEA provides educational support, and financial support in relation to educational or other needs of the child. It also provides tutoring at home, and seeks to provide the children with positive role models of healthy young adults.

The organisation's social worker assesses each case and offers guidance and counselling, the frequency depending on the severity of the case and its particular needs. Usually, parents who use drugs receive weekly services. The social worker will visit the house, have a talk with the parents, help with applications, see if they have practical issues that need to be resolved, and so forth. The focus is on helping the families so that the children can be in a better environment. Most of the families are involved with a social welfare service, which is also the main source of referrals to the organisation. Besides individual activities with children, the organisation also runs groups of cinema therapy for adolescents.

The programme is mostly funded by NAAC but, as with the other programmes, the organisation pursues other sources as well.

Reflections on the prevention programmes

The prevention programmes fulfil several roles: on the one hand, they reach vulnerable families and children and provide them with activities, support, connections and skills that they would hardly have access to otherwise. Children are at the centre of the programmes as rights holders and are given learning and social opportunities, which also mean secure spaces and spaces of belonging.

On the other hand, the programmes also constitute a source of data for NAAC on how many children live in contexts of vulnerability and which vulnerabilities affect them. These data are then used to develop more accurately targeted public policies.

The local dimension of the prevention programmes allows for a more sustained and concrete presence in specific territories. Outsourcing them to non-profit, non-governmental organisations guarantees an expertise that government institutions do not always have, given the specificities of some intersections of vulnerabilities.

The programmes can also serve as a means of referrals and cross-referrals between public institutions, such as social welfare services and mental health or drug treatment services.

Finally, throughout the Covid-19 pandemic, the programmes have demonstrated the ability to adjust to changing and unexpected circumstances, guaranteeing their presence in homes during a period in which isolation could have led to the exacerbation of vulnerabilities, including violence.

Some of the challenges indicated by the informants, including a social worker interviewed for this study, are: i. funds are not always sufficient, thus leading to the interruption or lack of continuity of some programmes; and ii. referrals from drug

treatment services are infrequent, reflecting a problem that has also been identified in the other countries participating in this project.

Iceland

In Iceland, the legal framework on children's protection provides that the separation of children from their families occurs as a last resort. It is thus the state's responsibility to undertake all measures to support all parents in their parental role. Placing children in foster families or with other family caregivers does happen but usually for a limited period of time, and is always subject to periodic revision. Only in the most severe cases, and when other means have failed to achieve the desirable outcome, are children placed outside their family nucleus.

The experiences described below, in Mánaberg and Keðjan, derive from services provided to residents in Reykjavík, both nationals and foreign nationals, and are centred on families with high degrees of vulnerability, such as dependent drug users and those facing difficult personal and family situations. Parents are accompanied and supported in their role and in their own processes of gaining self-esteem, trust and parental skills. At the same time, children are given a safe space and are assisted by multidisciplinary teams that, while working with their parents, also provide children with group and individual interventions.

Mánaberg

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.

The house 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, while 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 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. The informants from Mánaberg were emphatic about the importance of the work carried out with the parents as individuals, at the outset and while reinforcing their parenting skills and teaching them how to establish routines with their children and strengthen their bond with them.

As one interviewee described it:

You have to look at the value of the individual, where they want to be in the future, what ways they will have to walk to get there, to be that person. Also we help them to manage skills to face difficulties… bumps on the way, teach them how to get back on the right path before it goes wrong. It's a long way, so we take small steps, always looking forward.

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 work 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 visits, usually for one or two months, although the length depends on the needs of each case. The informants also noted they often work with single mothers and that it is important to take care of them to make them stronger and instil self-belief in them.

As reported during the interview for this study: "During the follow-up we check if the parents are able to keep the routine. Routine makes them more secure."

Mánaberg is a safe place and a place of trust. For parents, going 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.

Mothers then go back with their drug-using partner and everything falls apart and they come back. Some mothers have come to stay here three, four times.

Drugs are not permitted. If they bring drugs they have to leave and the children stay. The next day they can take a test, come back, and get another chance. If they don't stop using drugs, the children go to foster care for a limited time, so parents have more time to go to rehab. We try as long as we can, taking into account the process of detox.

Keðjan

"Keðjan" means "chain" or "link", and the service aims to create links around children and their families, or in other words, strengthen the chain of co-operative, inter-linked interventions around families. This is intended to make children and families stronger and better protected.

The programme is aimed at children and parents who are under the care of the Reykjavík Welfare Department. The department works closely with the five service centres located around the city, as well as the child protection services.

Keðjan is an early intervention service outsourced from the Reykjavík Welfare Department. The cases followed by the programme are referred from the case manager of a social service centre or from child protection services, depending on each case's severity.

The programme works closely with parents in parenting counselling, with children in individual or team support, and with teenagers in group work or workshops. The service is implemented through several teams. The first team works with families through counselling, carrying out home visits approximately two or three times per week or more often, depending on each individual case. This helps parents to develop skills to establish routines, set limits and improve the general upbringing of their children.

Another team works with families with more severe challenges, providing more frequent and intense accompaniment. Some parents are affected by mental health problems and social disabilities and need to be guided through incremental steps to avoid harming their children. This service is assigned for a longer period of time, sometimes until the child is 18 years old.

The Parent Management Training Oregon (PMTO) model, "an evidence-based, structured intervention program designed to help parents strengthen families at all levels.",[10] is applied by yet another team, which also runs the PMTO SPARE (Strengthening Parenting Among Refugees) programme for foreign families, adapting the programme culturally and linguistically as needed.

Keðjan also provides services to families with children who are chronically ill or disabled and gives support to parents who need a break, placing the child with another family for 24-48 hours or more as needed. One part of Keðjan's services is SkaHm, which is located in a house at Vesturbrún 17. It works with children with multiple, severe problems and some of them live there on a temporary basis. Other children visit but do not live in the house. The SkaHm team also works with the children's families at home.

Among other services provided are seminars and courses for both children and parents. Children covered by Keðjan are involved in numerous social and physical activities, individually and in groups, to enhance their social skills and welfare.

As in the case of Mánaberg, and in line with national principles and the legal framework, Keðjan is an intervention that works with families and its core objective is to reach out and help parents take care of their children.

10. Available at www.generationpmto.org, accessed 17 December 2021.

Ireland

Hidden Harm

Ireland is the only country included in this report that has a strategy specifically aimed at addressing children living in families impacted by dependent drug use, namely the Hidden Harm Strategic Statement (Tusla and HSE 2019a) on drugs and alcohol. The strategy was developed by the Child and Family Agency (Tusla), a cross-department and independent legal entity, and the Health Service Executive (HSE). As also outlined in the report "Children whose parents use drugs. Report of focus groups held in February 2021" (Pompidou Group 2021a: 16-20), the term "Hidden Harm" encompasses both the impacts of parental drug misuse on children, on the one hand, and the lack of identification of these children by the services, on the other.

The Hidden Harm Strategic Statement is intended to bridge the gap between adult and children's services in favour of a more family-focused approach that considers the needs of dependent children and other family members (Tusla and HSE 2019a: 18).

Some of the key features and objectives of the Strategic Statement are:

- naming "Hidden Harm" as a key risk factor in all the work with children and families carried out by Tusla, HSE, and statutory voluntary and community partners;
- process and practice shifts by Tusla, HSE, and voluntary and community-funded services to identify and meet the needs of children and adults in their parenting roles;
- shared training to skill all practitioners within Tusla, HSE, and voluntary and community-funded services in working within a new framework of care to identify and meet the needs of children affected by parental problem alcohol or other drug use;
- advancing a coherent continuum of support for children and families impacted by parental problem alcohol and other drug use and improving timely access to local support;
- supporting national screening and brief intervention, including screening for maternal alcohol consumption;
- identifying tools in screening and assessing parenting capacity when problem alcohol and other drug use is an issue in the home;
- utilising existing models of evidence-based practice developed by Tusla and HSE to address Hidden Harm inclusive of Meitheal, Signs of Safety and the SAOR model;[11]

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

- recognising and implementing role clarity, supporting complementary practice and mutual understanding of each other's roles.

The Strategic Statement is complemented 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 HSE Drug and Alcohol Services and Tusla Child welfare and protection services on Hidden Harm (ibid.: 15). It promotes early identification and intervention at every level by all relevant agencies in order to reduce risk to a child or young person; a "whole-family" approach to care and provision of services; focusing on the care of children and families who have unmet needs; providing information on mutual roles and responsibilities of practitioners across the services working in this area; and supporting and maintaining the focus on multi-agency and joint working between professionals involved in the support and care of children and families affected by parental problem alcohol and other drug use.

Preparing for Life

Preparing for Life[12] provides multiple services to families and children in Dublin 5 and Dublin 7.

The programme is part of the national Area Based Childhood Programme (ABC Programme), which is a national Prevention and Early Intervention Network (PEIN) programme funded by the Department of Children, Disability, Equality, Integration and Youth (DCDEIY) and delivered through the Prevention, Partnership and Family Support (PPFS) Programme within Tusla. The programme invests in effective services to improve outcomes for children and families living in areas designated as disadvantaged and that would potentially benefit from additional support. ABC sites generally operate at three levels of change:

- front-line delivery of prevention and early intervention services for children and families that support early child development;
- capacity building, facilitation and support to other service providers to implement evidence-based ways of working;
- system-level change efforts with managers and decision makers at local, regional and national level.

Preparing for Life includes the following programmes and services for children and families:

- home visiting: a Home Visitor works with parents from pregnancy until the child reaches school age via monthly visits, with the aim of improving school readiness through mentoring, coaching and providing tip sheets to support child development. Home visiting supports families to set goals and also involves interagency working;
- antenatal care and education, which includes:
  - antenatal classes;

12. Available at www.preparingforlife.ie, accessed 17 December 2021.

  - breastfeeding support;
  - baby massage;
- parenting programmes, including the evidence-based Triple P Parenting Programme and Circle of Security. Triple P offers simple, practical strategies to any parent of children aged 0 to 12 years, helping them to raise happy and confident children. Circle of Security supports parents and children in building positive, warm attachments;
- peep groups for parents/carers and their children to learn together. The groups are designed to support families with their children's learning in a simple and enjoyable way;
- play therapy and family support,[13] which comprises the following programmes:
  - play therapy, which "provides children with an opportunity to 'play out' their thoughts, feelings and problems just as, in certain types of adult therapy, an individual 'talks out' their difficulties";
  - Theraplay, "a model of play therapy that works with the parent and child to build and enhance attachment bonds, self-esteem, trust in others, and joyful engagement. The therapist guides the parent and child through a tailored series of playful, fun games, developmentally challenging activities, and tender, nurturing experiences";
  - therapeutic parenting, which consists of "a series of four interactive workshops designed to support parents to nurture their children aged 2-8 throughout big feelings and challenging experiences";
- Early Years Education Quality Support is an advocacy, support and professional development programme for community-based early years educators and services based in the catchment area. The programme is based on the understanding that children can reach their full potential if they are grounded in the community;
- infant mental health, which underpins all Preparing for Life programmes. A network is provided for other professionals in the area to support learning and the practical application of infant mental health principles.

Italy

P.I.P.P.I.

The Programme of Intervention for the Prevention of Institutionalization of Children (P.I.P.P.I.) is funded by the Italian Ministry of Labour and Social Policies and co-ordinated by the Laboratory of Research and Intervention in Family Education (Laboratorio di Ricerca e Intervento in Educazione Familiare, LabRIEF) of the University of Padua. It "is an intervention programme targeted at families with children between the age of 0 and 11 years old, who find themselves in the position of having to face challenging situations that can hinder their access to adequate conditions for their development".

13. Available at www.preparingforlife.ie/play-therapy, accessed 17 December 2021.

Since 2011, P.I.P.P.I. has been implemented in those Italian municipalities – or groups of municipalities under a territorial co-ordination led by a municipality – that have applied to be included in the programme.

P.I.P.P.I. has grown exponentially, and today it represents the largest social policy programme implemented in Italy to date, in terms of number of participants, funding, activities, outcomes, and the time it has been running.

In 10 years, and through its eight editions, the programme has reached 212 zones (municipalities or "ambiti territoriali", that is a group of municipalities) across all Italian regions, more than 3 000 families and 3 368 children in situations of vulnerability. It has also trained more than 6 000 practitioners (social workers, teachers, psychologists, educators and child neuropsychiatrists, among others).

The author of this report had the opportunity to interview and co-work with Katia Bolelli, PhD, a member of P.I.P.P.I.'s Scientific Group, and operators from two municipalities in Tuscany (Prato and Capannori), one in Emilia-Romagna (Rimini) and one in Friuli Venezia Giulia (Sacile), with a total of 14 people. Each municipality in turn co-ordinates and supervises the work carried out in surrounding smaller municipalities and villages.

The next section sums up the principles of P.I.P.P.I. and the work tools "The Child's World" and "RPMonline". Subsequently, it describes some reflections and practices shared by informants from the local territories.

The Child's World

P.I.P.P.I.'s main objective is to:

> increase children's safety and improve their developmental outcomes in order to avoid their placement in foster care as well as to provide parents with the skills to take better care of the children's physical, psychological and educational needs and/or to reduce as much as possible the allocation outside the family nucleus when this has already occurred" (Milani et al. 2018: 17).

The implementation plan with families operates through three phases: assessment, intermediate stage and final outcomes. There are four operational tools:

- home education, through an educator who is usually recruited with P.I.P.P.I. funds from a local association and assigned to the child protection area of the municipality ascribed to the programme;
- parents' groups and children groups;
- co-ordination activities between schools and the services;
- support between families in the community.

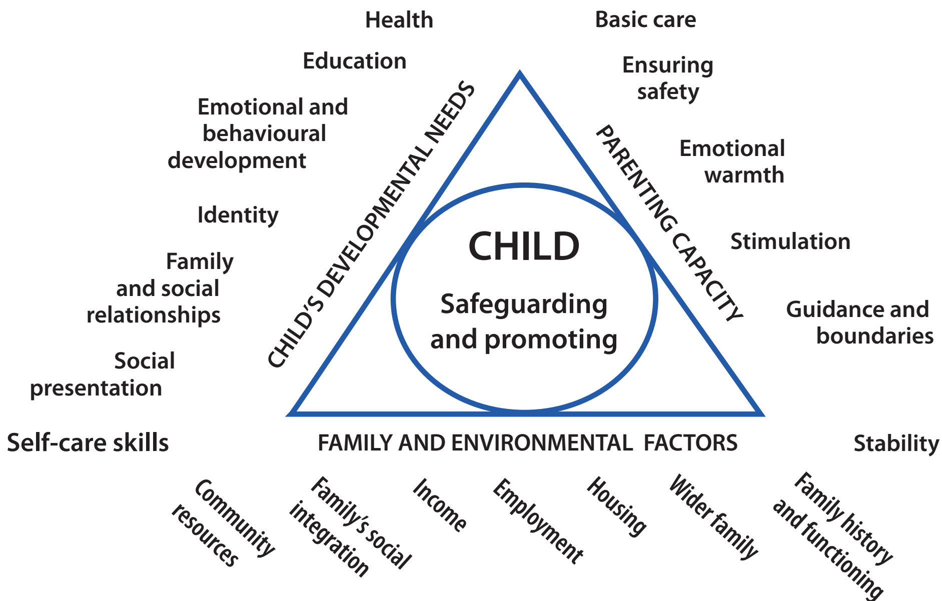
The child is put at the centre of the process and P.I.P.P.I.'s operators work with the family as a whole, taking into account and addressing the needs and the strengths of all family members. This is done to ensure that the child can live in a healthy family environment, with the whole family nucleus supported by a multidisciplinary team comprised of educators, social workers, psychologists and teachers working together. Families are part and parcel of the intervention plan and children are listened to throughout the process.

Rather than adopting a more conventional "families v. children" approach, or viewing families with drug use problems as lacking the tools to care for their children, P.I.P.P.I. is built on and trains its operators within a framework that sees children and their family as a unit whose members have different strengths and needs; these strengths must be identified and their potential realised while addressing difficulties (such as drug dependence). The entry point is asking "what families have", not "what families lack". This question is discussed with families as stakeholders and as part of the team, rather than passive recipients of top-down interventions decided on by social services and child protection agencies.

The programme thus establishes that the first stage is the analysis of the family's current situation, through an articulated process of assessment involving the services, operators, parents and, when possible, the child. This is an active, participatory process carried out co-operatively by all the actors involved.

To guarantee that children are listened to throughout the process – according to their development stage and in compliance with Article 12 of the Convention on the Rights of the Child – the operators make use of "The Child's World", a multidimensional tool that allows for the development of a case-by-case work plan based on the child's needs and their own understanding and verbalisation of their needs. This is based on the English programme "Looking after the child" (ibid.: 29), which provides operators with a triangle-shaped assessment framework that 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 skills. Figure 1 reproduces the assessment framework.[14]

Figure 1. Assessment Framework



14. Available at https://movingonfrombowlby.files.wordpress.com/2012/06/assessment-framework.jpg, accessed 17 December 2021.

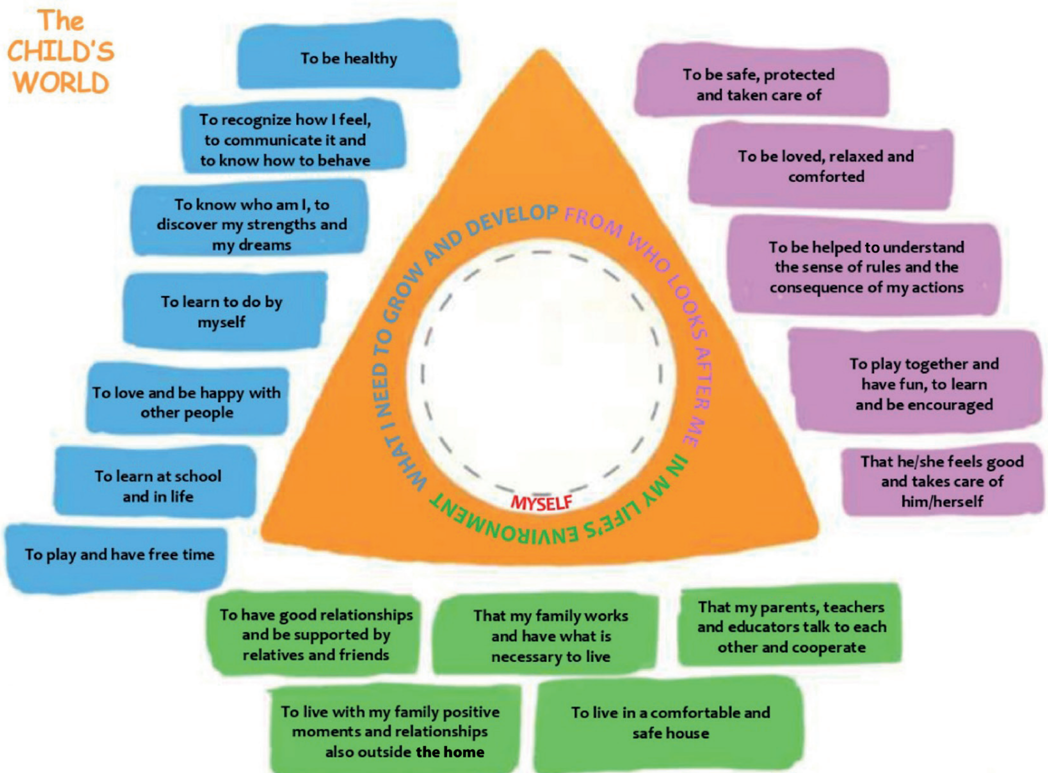
P.I.P.P.I. adopted and re-elaborated the framework based on its use in multiple countries, thereby becoming the first Italian case study for this model's implementation.

The three dimensions that constitute the three sides of the triangle are "What I need to grow and develop", "What I need from who looks after me" and "What I need in my life's environment". Each dimension has a series of sub-elements.

Figure 2[15] reproduces P.I.P.P.I.'s multidimensional model "The Child's World", at the centre of which one must imagine the child's picture. The Child's World has a "neutral version" (Milani et al. 2018: 31) and a version for the child – to be completed with him or her – and operators. Figure 2 presents the triangle that the operators use to work with children.

Figure 2. The Child's World

Children's version



15. Available at www.researchgate.net/figure/Figura-2-Il-Mondo-del-Bambino-versione-bambini_fig2_335920657, accessed 17 December 2021.

The following testimony from one of the operators interviewed for this report clearly indicates the strength of this tool and its transformative potential:

> In another of the P.I.P.P.I. families I worked with… the mother was dependent on heroin and the child was signalled to us by his school because he didn't attend. For years we discussed this with the mother but she didn't do anything about it.
>
> This child developed his triangle – The Child's World – and he wrote that he can't read and write and that he feels different to other children because of that and he explained that "to feel well I need to learn to read and write and to do that I need to go to school every day". When we gave the mother his child's voice back, she was moved, she started to cry, we planned on the child's assistance and we have seen developments, it is not perfect yet but we have seen some improvements.

RPMonline

RPMonline – Detect, Plan and Monitor – is an online tool accessible to P.I.P.P.I.'s implementers at the local level. Each "case", that is a child, is uploaded anonymously through a code, and the work with the child and their family is divided into three moments: the assessment (T0), where the needs are identified, discussed and analysed with children and families through the triangle of The Child's World; the planning of the project (T1), that is the identification and specific outline of the micro-steps that must be undertaken, such as "the father will read books to the child before putting them to bed" or "the mother will take the child to the park and other social activities with other children"; and the realisation of the desired outcome/change (T2). Such steps are clear, defined and can be seen in actual transformations and outcomes. The planning is not the product of a top-down approach by which the operators tell the family what they need and how to get there: it is the families and the children who, through the programme's multiple tools during the assessment phase, identify their needs and the desired outcomes.

The multidisciplinary team, together with the family, envisages a path to reach those outcomes. So if, for instance, the family and the child identify that the child needs to sleep in their bedroom, they will bring this need up in the assessment through the implementation of The Child's World and other tools. They will express the need and the desired outcome, for example "the child sleeps in his bedroom". The family and the team will then outline the steps. For instance, the educator who carries out the home visit will choose with the child the book they will read with their family before falling asleep. Every micro-step is conducive to the desired outcome.

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 an 18 to 24-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.

At the local level, the municipalities subscribed to the programme collect data on families, subsequently collated in an annual report that, in turn, provides quantitative information on the needs of the families in the area, including drug dependence. National reports on the programme are also published. The Ministry of Labour and Social Policies and the Scientific Group of the University of Padua have access to all the local and regional reports and thus to national data. However, even though P.I.P.P.I. has a national reach, it is not a "national" programme; therefore it is not possible to come up with estimates of how many children affected by parental drug misuse it reaches.

To conclude, P.I.P.P.I. is a programme (in organisational and financial terms), a theory and evidence-based methodology, and a new way of working with children and families that aims at strengthening families and reducing child and family separation. It is based on (ibid.: 37):

- strengths, resilience and empowerment and the capacity of people to change (strength-based);
- the family as a system, whose members – particularly children and parents – are subjects, rather than objects, of the process (family-based);
- formal and informal community resources (community-based);
- assessment, planning and evaluation, through tools that allow one to get to know the child and their family and surroundings; listen to them and understand their reality; and plan their paths and the changes that need to be undertaken;
- a guarantee that every child will be part of their own project, based on the work developed in The Child's World.

The operators work closely with families, on a case-by-case basis. In the process of "doing" with families, they also interiorise new tools and new visions. As already mentioned, for this project the consultant was able to speak with operators from the territories of Prato, Capannori, Rimini and Sacile. It was clear they have a profound, continuous and untiring commitment to their work and families – which is not always the case in other programmes. In these territories, P.I.P.P.I. landed on fertile ground and brought in new methodologies that became and remain a way of working with families (including non-P.I.P.P.I. families), even following the end of each two-year edition of the programme.

In 2017, P.I.P.P.I. contributed to the "National Guidelines. Interventions with children and families in situations of vulnerability" (Ministry of Labour and Social Policies 2017). These guidelines have been accepted by the regions and currently underpin the work with families in all the local "ambiti territoriali".

The operators report that P.I.P.P.I. "creates and changes" the services' approach and also constitutes a lens through which practitioners examine themselves. As will be shown through the practice of the "Participation Cards", it has also opened up possibilities for the services to be looked at through the lens of families and children.

This interchange is profoundly humane and personal, and while it leaves every role-player – the services, families and children – in their place, the approach is horizontal and circular, not vertical.

Of course, this does not mean that all the obstacles are overcome: not all the operators adopt and interiorise this paradigm in the same way, not all the regions or territories have the same resources, and some families have more complex needs than others. Co-operation and the building of a common language between services was identified as the biggest difficulty.

Therefore, it is particularly relevant to share how the operators viewed their work, not only because of the practices they share, but also because of their high professional and personal dedication to children and families in situations of vulnerability.

It is important to highlight that the participants in the focus groups and subsequent meetings shared an immense range of perspectives, values, practices and knowledge. What follows reflects only some of these.

It should also be pointed out that when a municipality is specifically named, this is because it is usually functioning as the co-ordinating municipality and depositary of the programme within a net of surrounding and smaller municipalities and villages – the "ambiti territoriali".

Parents' groups

Parents' groups are one of the participatory tool interventions proposed by P.I.P.P.I. They fulfil several purposes (Milani et al. 2018: 113-14), synthesised below:

- they strengthen parenting skills and develop parents' and children's social and relational abilities;
- they create spaces where families can share their experiences and histories with others in a stigma-free environment characterised by respectful listening;
- they reduce isolation and open up the space for networking between supporting families, which is another element of P.I.P.P.I.;
- they can create new competencies, strategies and alternatives to face challenging situations through mutual sharing and advice;
- they provide the operators with a deeper knowledge of families and their needs and difficulties, but also their strengths and potential.

Operators from Capannori reported the experience of *Genitori in costruzione* (Parents under construction), an annual cycle of meetings with an average of five to seven meetings per year. With the participation of three psychologists and other professionals, the cycle of meetings is open to all parents, both those in contact with the services and those who are not. Every year the programme changes and adopts new focuses, but it is always trying to promote artistic and cultural activities because, as reported by one of the informants: "Everybody needs beauty."

In the last edition, the group received all sorts of families: parents with complex needs, teachers, judges and so on, thus creating a heterogenous and autonomous group that still meets up and organises activities together through a WhatsApp group.

Genitori in costruzione creates a space for families to normalise vulnerability and feel less isolated. Opening it up to all families also leads to the identification of new families in vulnerable situations. The activity implies that, parallel to the parents' group, children also have their groups. While parents and children work separately,

there are moments where the two groups meet and share their experiences. In this way, children and parents have independent moments with peers where they can mirror their experiences with each other and interact in a non-judgmental setting, before sharing their own experiences with that of the other family members.

For those parents who only see their children during supervised visits, the groups become an occasion to both spend more time with their children and be with other families.

Women's groups

In the collective interview with social workers in charge of child protection in Sacile, the practice of a women-only group was shared. Even though it is not related directly to substances (the group was composed of migrant women from three African countries), it is included here because of the gender dimension and the importance of giving voice through a collective exercise to an experience – be it drug dependence, migration, motherhood or a combination of experiences – that is lived, usually, individually and in solitude.

The project, "Acrobat mothers, what a show!", works through a model of five meetings, in the following order: the first meeting is to get to know each other; the second approaches the topics "where I come from, what I brought with me, what I have found"; the third revolves around motherhood and cultural and identity differences between the country of origin and Italy; and the fourth meeting reflects on what answers and new strategies and competencies the women can learn and share from their own experiences.

The activity has been very powerful for the women involved and the operators, creating paths of learning, listening, opening up and sharing.

The realities of women with dependent drug use vary and perhaps not all of them can be engaged in such an activity. However, the experience can illuminate paths that could be undertaken with women who face the dual challenge of motherhood and dependence, as well as the multiple situations they face, among them histories of abuse and stigma.

Co-operation protocol with drug dependence treatment services

The municipality of Prato shared the recent approval (2020) and operationalisation (in progress) of a protocol for collaborative work between social services/child protection and the SER.D. (Servizio per le Dipendenze), the public drug treatment service available across the country through a capillary net of local services.

It is worth pointing out that the initiative of developing a framework project between services came about through a training seminar involving operators from different services. This experience – training and the protocols of collaboration – is taken up in Chapter VI of this report.

As reported by informants from other countries and discussed in other sections of this report in addition to Chapter VI, drug treatment services tend to share a certain resistance – with important exceptions (see Chapter III) – to taking into account

their patients' children. Sometimes, the attitude can be quite dismissive, leading to comments that describe the child as being a burden or a problem rather than a rights holder and a person.

Such views are not universal but reflect trends that can be addressed and moulded with the appropriate tools and methodologies.

The tool created in the municipality of Prato sets the basis for a common language and rests on three principles:

- the child is at the centre;
- the importance of the multidisciplinary team;
- valorisation of families, highlighting strengths and resources.

Another important point is that dependence is not considered an impediment to parenthood, but an aspect that must be understood together with the parent's skills and potential.

The protocol targets three populations: i. parents who use drugs; ii. children who use drugs; and iii. pregnant women who use drugs.

For each person, there is an assessment followed by planning that should be developed by all services under the same framework using common language, and in collaboration with the person and family. This does not always happen, as the process depends on the operators, their workload, their understanding of the aims and methodology of this type of work, and other structural, professional and personal factors.

If the parent gives their authorisation, their children can be referred to social services. The protocol also establishes paths of referrals and cross-referrals and engages all the services needed for each particular case, such as social services, child protection, mental health, teachers and SER.D.

According to an operator: "The effort is to include a person's project in one document compiled and shared jointly by all the participating services, maintaining the child's centrality".

Participation Cards

Developed under the framework of P.I.P.P.I. 7 (2019), the Participation Cards project was a response to the picture that emerged from the previous annual report, which indicated that while the services felt they worked well with families, P.I.P.P.I. families had a different reading of their relationship with the services.

To explore this discrepancy of perceptions, and in a collaboration between colleagues from the municipalities of Prato and Florence within the structure of the "Territorial Workshops for the innovation of practices", the operators gathered during a session of "Gare" (*Giornate di approfondimento residenziale*, or "Days of residential deepening").

Prior to the Gare session, which convened P.I.P.P.I. trainers, operators, psychologists and teachers, the voices of families were video-recorded, discussing their experiences with the services. They talked about collaboration with the services and their participation in the decision-making processes – information that was used during

the session to develop the Participation Cards. The aim was to create a tool to assist the services and families in discussing how decisions are taken in order to improve the participation of all stakeholders, including children, in the process.

The families were also invited to help the operators develop Participation Cards; they were keen to contribute, and impressed by the fact that the operators had asked them how to improve their work. Drafts of the cards were designed with the help of the University of Padua's Scientific Group and were shared with families and children in December 2019.

The project itself was implemented separately with groups of parents and children from June 2019 to 2020 in the territories of Florence and Prato. In the latter, the project's activities included a total of 16 parents and 25 children (divided by age group). For the development of the cards, parents were asked to think about a moment when decisions regarding their children were taken – in the context of the services – in order to reflect on how their participation was included, and to choose an image from a magazine that mirrored their experience.

During the interview, the operators shared examples of the cards as well as a video where one can see how the parents and children worked to create the cards, combining images and text, which made it clear that written words could never convey the emotional depth of the activity. Indeed, the Participation Cards reflect the transformative process that can be triggered when the services and families work together, when the fear of being judged and the inclination to judge are overcome, and a relationship of trust is built.

Parents and children were asked, "What helps and what does not help to foster participation?"

Some of the "it helps" sentences listed on the Participation Cards were:

- listening from our parents;
- empathy and understanding;
- clear and simple language;
- kindness, welcoming, sensitivity and smiling.

On the "it does not help" cards, the following were listed:

- shame, fear;
- prejudice;
- language barrier;
- loneliness.

The cards will be part of a kit that also includes an operational handbook and quotes from all the children, parents and operators.

Emblematic cases

The following cases were shared, respectively, by an operator from Rimini and in the collective interview with Sacile (other cases were also shared but space constraints limit us to these two). Separately and together, they exemplify the complicated

situations that some parents – mothers in these cases – face and how that affects their children. They also reflect how social workers, and the services' commitment, flexibility and endeavour to find better options for children are key to thinking and acting outside the box.

However, they are also proof that some people are likely to slip through the services, both adults and children. They reinforce the idea that work with families and children must be holistic, co-ordinated, non-linear, compassionate, creative, child-centred, adult-sensitive and gender-responsive.

Rimini

I have this case in mind of this woman who is in a violent relationship with her partner… she is an alcoholic and she drinks heavily when she tries to separate from him. They have two daughters, who are in two different foster families.

She has a high level of education and she asks us for help with such suffering… but the husband is very clever, he harms her in a way that there is never a way to prove that it was him. She asks for help and then she pulls back.

Last year we went through the whole process… she was about to enter a shelter where she could have undergone treatment as well, but at the last minute she said, "I can't".

In these cases, their strongest dependence is on the man they have this pathological relationship with.

They are extremely fragile women and they deny violence, there is underlying extreme psychological violence on the husband's side.

There have been terrible moments… I wasn't there but the social worker told me in tears about a call… he hurt their pets and she was very shocked by it, more than when he hurts her.

She tries, she is almost there… and then she can't. He doesn't go to treatment, we have the children and we can't give them back to her… the best path would be to enter the shelter. We have to work on this and if we had a better collaboration with other services it would work better. We have had a wonderful collaboration in this case, but it is not always like this.

Sacile

Dennis is a young child… only four and a half years old, but with a heavy past.

Born underweight from a long-term user mother, at the time of the interview (July 2021), Dennis had been living with his deceased father's parents for a little over a year.

His mother has been using drugs since she was a teenager and she continues to maintain a chaotic lifestyle, consuming methadone, alcohol and controlled medicines, among other substances. She has been in treatment on several occasions, including a mother-and-son residential community for women who use

drugs, from which she was expelled – together with her child – in the summer of 2019, "because she didn't follow the rules".

As a consequence of Margherita's expulsion, and her refusal to enter another mother-and-child community, little Dennis was allocated to a community for children. It was not possible to live with his mother, given her ongoing difficulty in coping with dependence and parenthood.

In the meantime Margherita went back to Dennis' father, also a long-term user, who had managed to get back on track: he had employment and had rented a house and was very keen on taking care of his child. However, he went back to using drugs with Margherita, until he died of a heart attack.

Dennis was in the community for children from August/September 2019 until the beginning of 2020. During that time, he began to see his grandparents more regularly as well as an aunt and an uncle on his father's side. The grandparents applied for legal custody of Dennis after his father's death, which was granted them by the child court after evaluating Dennis' personal circumstances and the family situation.

So in February 2020 Dennis moved in with his father's parents, whom he had met but didn't really know very well yet. During the hardest period of the Covid-19 lockdown, he found himself with this new family, his father dead and his mother not fully capable of looking after him and separated from him by a judicial order. During the first months of lockdown, Dennis and his mother could not meet, because she lived far away and mobility was restricted due to Covid-19.

The grandparents have been taking care of Dennis and are fully committed to him: they provide him with everything he needs. The critical aspect remains the relationship with Margherita, because they consider her to be the cause of their son's relapse into drug use and his subsequent death, and want her out of Dennis' life.

Here is where the child-centred approach came into play. The social workers adopted a flexible way of working with Margherita and Dennis' family, with the basic and fundamental aim of protecting him and guaranteeing him the best care from his family members.

In July 2020, the mother-and-child visits – suspended in February 2020 – started again and have been continuing since. Margherita lives about two hours away and she is allowed to see her son on a weekly basis for two hours under the supervision of an educator. When Dennis was in the child community (until February 2020), she had been coming to the visits accompanied by her own mother who, however, complicated matters because she disparaged Margherita in front of Dennis and turned the supervised visit into a moment of tension.

When the visits started again in July 2020, Sacile's social workers suggested to Margherita that she see her child alone – with only an educator present. She was relieved and grateful that she could have some moments alone with her child without the interference of other family members. She also felt recognised as a mother.

Currently, these visits take place every fortnight because Margherita finds it difficult to attend every week, both because of the distance and because she has to take a Covid test each time on account of Dennis' grandmother's fragile health. Margherita has to catch a train very early on a Monday morning, which is not necessarily compatible with drug dependence – she has a precarious living situation, with no support net and a chaotic lifestyle. But the supervised visits are moments of true affection and love, of play and unity between mother and child, something Dennis looks forward to and misses if for some reason his mother does not attend.

Following the child court's authorisation in March 2021, Dennis has also been meeting his maternal grandmother – who also lives far away – once a month, in the municipality building and under the supervision of the same educator. These meetings are also characterised by affection, closeness and play.

The supervised visits between Dennis and his mother are regarded with animosity by the grandparents, who think that the social services are biased towards Margherita. To make clear that the visits are about Dennis' well-being and that every choice and intervention is made in his best interests, while also ensuring that the grandparents feel listened to, the social services have agreed to support the cost of a therapeutic process for Dennis with a private association. This was strongly requested by the grandparents with the encouragement of Dennis' teacher.

Dennis' grandparents consider that the child needs a therapeutic process to help him review and overcome the traumas he has suffered during his first years of life, even though the child seems to be in line with his expected developmental stage and does not display any particular difficulties in his behaviour or relationships.

At the same time, the social services consider that the professional chosen by the grandparents themselves, neutral and external to the services, will help the family understand the importance of keeping the strong link between Dennis and his mother and that this process might also provide Dennis' family with tools, strategies and suggestions regarding their own delicate task as caregivers.

Gradually, the social services have begun to feel that a relationship of trust is being created with Dennis' aunt – his father's sister – who feels the services are "neutral" and not aligned with Dennis' mother, and who has also begun to comprehend that Dennis enjoys and needs his time with Margherita.

This case – one among several sensitive cases generously shared by Sacile's services – provides a glimpse not only of the complexity of some cases, but also of the delicate, tailor-made, child-centred work that social services must undertake and the important personal and professional engagement that these efforts imply.

Chapter III

Programmes and services for families and children in drug treatment settings and related services, including data gathering and advocacy

The programmes described in this chapter range cover awareness raising, dissemination of information, data gathering, interventions with children and young people living in families with dependent drug use, and include programmes aimed at the whole family, where children, parents and other caregivers are involved in order to work separately and together on the implications of drug use.

The programmes presented are from the following countries: Croatia, Iceland, Ireland, Mexico, Switzerland and the United Kingdom.

They provide a full spectrum of interventions that, implemented in combination, represent a successful path towards fully accounting for and addressing the impacts of drug use on children.

Croatia

Dr Andrija Štampar Teaching Institute of Public Health

Dr Andrija Štampar Teaching Institute of Public Health,[16] in Zagreb, provides services in the field of public health, including mental healthcare and prevention of addiction.

The Department of Mental Health and Addiction Prevention, within the institute, offers preventive and treatment activities and "provides care to persons who have problems with substance abuse, as well as families and society as a whole to overcome difficulties related to substance abuse and addictive behavior". The Unit for Prevention of Addiction "provides outpatient care to persons older than 25 who have problems with substance abuse, as well as their families".

16. Available at www.stampar.hr/en, accessed 19 December 2021.

The Unit for Child and Adolescent Mental Health Care provides outpatient mental health services that focus on the needs of children, young people and their families, and are generally associated with prevention of substance and drug abuse, behavioural addictions, and behavioural and mental health problems. Mental health services intended for adolescents are focused on helping them to achieve better self-control, assertiveness and learning techniques.

Particular attention is given to activities and counselling that focus on the mental health of children and adolescents, as well as those particularly exposed to stress, in order to help them overcome crises, adapt to new circumstances and thus prevent mental health disorders.

Preventive and treatment activities include psychiatric diagnostic assessment and treatment tailored to individual needs with drug abuse testing, individual and family counselling or psychotherapy, prescription of opiate agonists, and other pharmacological therapies.

Dr Zrinka Ćavar, addictologist and psychiatrist for children and adolescents, has worked at the institute for 15 years.

During the national focus group, she reported:

The Department annually cares on average for 1 000 persons with substance use problems, about half with opioid addiction and half with marijuana abuse, with a ratio of one woman per five men. The first goal of treatment is abstinence and psychological stabilisation, followed by psychosocial interventions that also include the development of parental skills. About 40% of patients have children. Some of my patients bring their children to me because they have mental health problems, so I give them therapy too. Very little (less than 1%) of our patients have lost their custody: since they are in treatment they could get good outcomes and have their children back.

Interventions with children and families are carried out by multidisciplinary teams consisting of a nurse, psychiatrist, social worker, psychologist and social pedagogist in coordination with social welfare services.

Iceland

Society of Alcoholism and other Addictions (SÁÁ)

In Iceland, drug use is considered a health issue. Even though stigma and discrimination against people who use drugs persist to a certain degree, there is a general recognition among professionals and society that drug-use related issues are to be seen and treated with evidence-based scientific methods:

> Treatment has thus been part of mainstream healthcare with treatment being provided by health-care professionals such as physicians, nurses, addiction counselors, psychologists alongside social workers and other health-care professions. Thus the emphasis has

been on the disease model of addiction. This view of addiction among professionals is disseminated to the mainstream, making it easier for people to address their addiction problems and this is reflected, e.g., in the lenient outlook of most employers who grant sick leave on pay for those seeking addiction treatment. Social security also provides financial support to those with substance use disorders, just as for any other medical condition further reducing barriers to treatment. (Hansdóttir, Rúnarsdóttir and Tyrfingsson 2015: 1200).

People are more likely to seek treatment if they do not risk losing their job (and salary), and continue to receive financial support from social security.

Treatment is provided by SÁÁ,[17] a non-governmental organisation that was founded in 1977 and is today the leading treatment service in the country. It operates a detoxification clinic, four inpatient and outpatient rehabilitation centres, and a centre for family services and a social centre.

Furthermore, SÁÁ's National Center 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.

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 three-fold 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.

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 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.

17. Available at https://saa.is/english, accessed 19 December 2021.

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

As reported by one of the psychologists during the focus groups:

> Children feel ashamed of the situation at home, they have lower self-esteem. In school they face difficulties concentrating, because they are very worried about their parents. In the family we see that children take on the responsibilities of adults, like cooking, cleaning, taking care of their siblings. Sometimes they don't have food at home, they face more neglect, they are left alone at home when they are not of an age to be left alone. Sometimes they are victims of physical violence and they see violence at home. They don't want to go out because they want to protect their parents or they do not want to invite friends over because they don't want to show the situation at home. There is still stigma against people with addiction, so sometimes they hear other adults saying mean things about their parents.

Another point raised in the intervention is that the adults who undergo treatment are very appreciative of the programme. They acknowledge that they did not receive such support when they were children and were struggling with their own parents' drug use.

The following testimonies from children were shared by Ingunn Hansdóttir – SÁÁ's Chief of Psychology and informant for this report – at the Youth Integration Centres' 21st International Congress on Addictions (Mexico).

Children's messages to professionals

1. We are not the problem, but we have to deal with it.
2. Education can reduce prejudice against alcoholism.
3. We live in all kinds of situations.
4. We believe that education from our peers works well for preventive purposes.
5. Be aware of the problems that come with having an alcoholic parent.
6. Alcoholism and serious mental health disorders often go together.
7. When an alcoholic wants to seek help, assistance needs to be available immediately.
8. We need help to strengthen our self-image.
9. Everyone has the right to receive services, regardless of where they live.
10. Alcoholism is a bigger problem than people think; yet, there is little discussion about it.

Children's messages to the family

1. We are children, do not put the responsibility on us.
2. Do not be in denial, it does not help anymore.

3. Do not hide the situation, talk about it.

4. Holidays and vacations often cause anxiety.

5. We feel insecure when people around us use alcohol or other drugs.

6. It does not help us when someone speaks ill of our parent.

7. We do not want to be caught between our parents.

8. It is good when the alcoholic goes to rehab but it is difficult to deal with the long absence of a parent.

9. When we want to talk about the problem you need to listen and show understanding.

10. We want a safe home.

Ireland

National Drug Treatment Reporting System

As shared by participating countries during the focus groups held in February 2021, gathering quantitative information on children living in families affected by parental drug and alcohol misuse is indispensable to develop public policies and specific interventions.

However, there is a current lack of integrated systems for the collection and analysis of information regarding how many children find themselves in such situations.

The main common indicator is the Treatment Demand Indicator (TDI) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), originally created by the Pompidou Group.

TDI is a key epidemiological indicator for drug treatment demand. It provides objective, reliable and comparable information concerning drug addiction, so it is the best source of information for drug policies. However, five caveats may be raised in relation to this study: in the first place, it only gathers information on people who actually seek and enter treatment. Depending on a country's cultural and social context, there could be a gap between people needing and wanting to enter treatment and those who actually undergo treatment. This gap depends largely on existing drug policy-related factors, namely discrimination, stigmatisation and criminalisation against people who use drugs – factors that prevent or facilitate access to treatment.

Secondly, it lists episodes of treatment for people who may enter, drop out and re-enter treatment, and who may be counted multiple times. Thirdly, people who use drugs may prefer to not reveal their parental status and caring responsibilities for fear of losing their children as a consequence of their drug use. This is a fear that is justified in some cases, depending on a country's policy and attitudes towards people who use drugs.

Fourth, even when information on people who use drugs and have children is collected, it does not provide an estimate of how many children are affected by parental drug use disorders, nor does it convey further information about what the situation of the children is and if they need to be referred to social services in order to have access to support – economic, educational, psychological, and so on. Treatment centres do not have access to personal information on the children, since this can be disclosed only through parental authorisation.

Finally, the quality of the information will also depend on the country's capacity to actually collect it and analyse it. Therefore, this indicator is a key element for drug epidemiology but remains insufficient from a children's rights perspective.

In this respect, a promising and innovative practice is Ireland's National Drug Treatment Reporting System (NDTRS). This was initiated in Dublin in 1990 and has been in place nationally since 1995. It covers Health Service Executive and voluntary addiction services – including inpatient and residential treatment – and is episode-based, reporting on all entries into treatment in a calendar year. Data is used extensively to inform drug strategy, to inform local policies and for academic research.

In fact, NDTRS is based on and fully compliant with TDI but has been modified to fit national needs; for example, in 2004, data on alcohol as a major problem given the countries' drug consumption tendencies.

In 2015/2016, the NDTRS survey was significantly changed and updated, in order to comply with reporting requirements for the EMCDDA and also in order to improve the way this data was collected nationally. More specific and detailed questions on children with parents in treatment have been included. The survey currently includes questions (e.g. question 7) on the number and age range of children as well as their situation of care. Table 2 reproduces NDTRS question number 7.

Table 2: NDTRS question 7 – Number of children

Total number of children

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

Included in the updated survey is a comprehensive data collection protocol[18] that explains the meaning of the different categories, in order to obtain the most

18. Available at www.drugsandalcohol.ie/26858/1/Master_NDTRS_2019_protocol_hard-copy_V5.pdf, accessed 19 December 2021.

standardised data possible. The information is mainly submitted online by drug treatment services.

Results for question 7 were published for the first time for 2020 data.[19] As this was a new question it required some time for coverage to improve and also to allow for data validation. The preliminary findings report that in 2020 there was an estimated number of 0.73 children for each person entering treatment for drugs and 0.79 children for each person entering treatment for alcohol, with an overall rate of 0.75. Such rates are similar to those derived by Galligan and Comiskey (2019).

The information gathered through these new questions could positively contribute to the quantitative and qualitative knowledge on children affected by parental drug misuse and be the basis for reconceptualising the TDI beyond its current limitations.

Another important element of NDTRS is the inclusion of the individual health identifier (IHI), a unique, non-transferrable number that will be assigned to all individuals using health and social care services in Ireland. This will allow for identification and follow-up of patients across services, although the measure has not been operationalised yet.

Alcohol Forum

Alcohol Forum[20] is "a registered charity that works to prevent and reduce alcohol related harms in communities". It delivers services across the counties of Donegal, Sligo, Leitrim, Cavan and Monaghan.

The interventions with families and children draw on a belief that evidence-based, systemic, holistic interventions can help families. The organisation provides a variety of services that target families and children living in contexts of vulnerability and alcohol and drug misuse. It has a single point of entry that allows for assessment and internal or external referral depending on the family situation and needs. Alcohol Forum works in co-ordination with other state agencies such as Tusla, HSE, the Drug and Alcohol Task Force and the mental health services.

The following are some of the programmes and services offered by Alcohol Forum.

Moving Parents and Children Together

The Moving Parents and Children Together (M-PACT) programme is a 10-week brief intervention to help children aged 8 to 17 years whose parents have problems with alcohol or other drugs. Children and their parents or guardians work together in a friendly, safe group environment with a team of highly skilled facilitators who help them find ways to improve family life.

Families attending M-PACT obtain a greater understanding of addiction and its impact. They learn new and improved ways to communicate about addiction. Children and

19. Available at www.hrb.ie/data-collections-evidence/alcohol-and-drug-treatment/publications/publication/drug-treatment-data-in-ireland-2014-to-2020/returnPage/1, accessed 19 December 2021.
20. Available at https://alcoholforum.org, accessed 19 December 2021.

young people learn ways in which to express themselves and be heard, and they develop coping strategies while improving their self-esteem.

About eight families participate in each session. Parents and young persons work separately then come together and discuss M-PACT – not only the issues they have regarding addiction but also how to move forward and improve communication and resilience.

Strengthening Families Programme

The Strengthening Families Programme (SFP)[21] is a 14-week, internationally recognised, evidence-based family skills programme for the whole family. Created in 1982 by Dr Kumpfer at the National Institute of Drug Abuse, it is now implemented in multiple agencies across the United States and Europe.

At Alcohol Forum, SFP is available for families with children aged 6 to 12 years and teens aged 12 to 16 years. The programme helps with childcare and transport to support families to attend if required.

Families attending the programme, which is in a group setting, improve family relationships and learn enhanced parenting and communication skills as well as skills to manage stress, anger and peer pressure. It has been found that improving parenting, protective factors, family relationships and resilience will reduce problem behaviour, improve school performance, reduce criminal behaviour, and reduce alcohol and other drug use in young people.

Have Only Positive Expectations

As a response to Covid-19 and lockdowns, new programmes were developed to work with children and families. Have Only Positive Expectations (HOPE) is an evidence-informed six-week online programme for the whole family. It is a skills-based programme for families experiencing challenges that arise from family stress, conflict, alcohol or other drug use, mental health or safety concerns. It is delivered online with individual families and skilled facilitators using the platform Zoom. Families are provided weekly with handouts and supplies that allow them to participate fully in the programme in their own home.

The programmes provide skills and knowledge to help families build and strengthen family relationships and boost family well-being. Families learn and develop skills that build family cohesion, develop resilience, and improve family communication while supporting the family's safety.

Donegal Reach

The Donegal Reach project supports young people affected by parental substance misuse. The project is for young people aged between 12 and 18 years. Skilled youth workers work with the young people through one-to-one support and group work. The project ensures an autonomous, bespoke approach and is undertaken

21. Available at https://strengtheningfamiliesprogram.org, accessed 19 December 2021.

so that members can realise their self-worth, decision making, capacities and skills for adulthood.

The aim of this project is for all young people to grow and mature in a healthy way that reduces long-term adversity and harm. The Donegal Reach project focuses on self-confidence, behavioural development, mental health support, goal setting and improvement in family and social relationships.

The team works in conjunction with the parents, adopting a systemic approach that seeks and promotes collective change.

5-Step Family Support

5-Step Family Support in Donegal is for those who are coping with or impacted by a loved one's addiction. It is a one-to-one service available for anyone 18 years or over.

The 5-Step method works with family members by supporting them in their own right, as people negatively affected by a loved one's substance use. The method is grounded in rigorous research and a clear theoretical model that underpins the intervention. The 5-Step approach is both simple and effective in filling a gap that exists for family support. It does not see family members solely as supporters of the person with the addiction but as people who need support to look after their own needs as well. In other words, the focus is on "caring for the caregivers".

Monaghan and Cavan Youth Substance Support

Monaghan and Cavan Youth Substance Support (MaCYSS) is a newly established service for young people aged 12 to 18 and their families, delivered in the counties of Cavan and Monaghan.

The purpose is to provide professional and clinical intervention targeting Youth Alcohol and Other Drug (Youth AOD 12-18yrs) individuals and their families. Using a network approach, MaCYSS has begun to bring together the services of the two counties to achieve system-level change to prevent and reduce AOD-related harm.

As explained in the evaluation report (Alcohol Forum 2021: 2):

> Monaghan and Cavan Youth Substance Support (MaCYSS) is a youth (12-18yrs) and family AOD service delivered by Alcohol Forum Ireland in partnership with, and funded by, the HSE, TUSLA and North-Eastern Regional Drug and Alcohol Task Force. Working together with service providers MaCYSS will deliver advisory, assessment, clinical intervention, and shared care coordination for Youth AOD in line with best international treatment standards. Support and intervention for youth AOD and their families delivered through MaCYSS Cavan and Monaghan Network will be holistic, trauma informed, age appropriate, family centric and culturally safe for young people with AOD concerns.

The network model approach supports AOD-affected young people and their families in accessing pathways to a combination of personalised social, emotional and other community services that enable the young people to achieve and sustain recovery (ibid.: 5).

Non-violent resistance

The non-violent resistance programme is a brief, systemic and cognitive behavioural response to child-to-parent violence. In practice, a child's or adolescent's behaviour should be considered violent and abusive if family members feel controlled, intimidated or threatened by it. The programme consists of up to 10 sessions and aims at the restoration or recovery of parental authority, supporting parents/carers in preventing and responding to the controlling and violent behaviour of children and teenagers.

Silent Voices campaign

Silent Voices[22] is an awareness-raising campaign by Alcohol Action Ireland, which is the national independent advocate for reducing alcohol harm. As stated on its webpage, "it aims to ensure the right supports are available to children today coping with parental alcohol misuse – and those adults dealing with the impact of a childhood trauma in later life." Its founders experienced parental alcohol misuse when growing up.

The campaign aims at breaking the silence on an issue that affects an estimated 400 000 people in Ireland who today are "adult children from alcohol-impacted families". In addition, it is estimated that between one in six or seven children (at least 200 000) continue to suffer the impact of alcohol-related harms and experience a life conditioned by someone else's choices.

The campaign page presents resources for adults and children, as well the voices of anonymous people who have decided to share their story. The resources for children and young people are in Ireland and the United Kingdom:

- EPIC: for children in care and care leavers, EPIC has an advocacy phone support service;
- ISPCC's Childline: Childline is a 24-hour national listening service for all children and young people (under the age of 18) in Ireland. It is private, confidential and non-judgmental and can be contacted for free from anywhere in Ireland;
- Jigsaw online: for 12-25-year-olds who need mental health support, this online service provides practical advice from Jigsaw clinicians who work with young people every day. Available at https://jigsawonline.ie (accessed 21 December 2021);
- Spun Out: young people having a tough time can talk it out (anonymously) with a trained volunteer;
- Steps to Cope: this online intervention is designed to help those affected by alcohol misuse, drug misuse or mental ill-health in their family. Visitors to https://stepstocope.co.uk (accessed 21 December 2021) can work through the toolkit at their own pace and leave at any time, picking up where they left off when they return;
- Turn2me: this webpage (www.Turn2me.ie, accessed 21 December 2021) provides online support groups facilitated by mental health professionals

22. Available at https://alcoholireland.ie/campaigns/silent-voices, accessed 20 December 2021.

and online counselling provided by professional counsellors/psychologists. It is also open to people over 18.

Mexico

Youth Integration Centres

Youth Integration Centres (YIC)[23] is a non-profit civil association whose purpose is to comprehensively address mental health and drug use with the participation of the community through two substantive programmes for prevention and treatment and two support programmes for research and training of specialised human resources. It has 120 care units distributed throughout the country:

- 106 centres for drug use prevention and treatment, which provide:
  - early intervention;
  - basic outpatient counselling;
  - drug treatment for abuse of, or dependence on, illicit drugs;
  - treatment for problem drinking;
  - treatment for tobacco use;
  - outpatient intensive treatment (day centre).
- 11 hospitalisation units for men and women, which offer:
  - detox and stabilisation related to abstinence syndrome;
  - a day centre;
  - brief inpatient treatment (one month);
  - medium inpatient treatment (three months).
- two units for people who use heroin, which provide harm reduction services, specifically:
  - detox and maintenance opioid substitution treatment with methadone;
  - distribution of sanitary packages, syringes and condoms.
- one scientific research unit on addictions.

The treatment and rehabilitation programme provides outpatient and inpatient services to drug users and their families. It serves children, adolescents, adults and elderly people. The basic focus of treatment is the person, their needs and the context, not the substance. Human rights and gender equity dimensions are incorporated throughout the services.

For this study, information was collected in the focus group between countries, with the participation of YIC's Normative Director, Dr Ricardo Sánchez Huesca, and through two semi-structured interviews with personnel from the areas of prevention and treatment as well as from the inpatient unit of Mexico City and the outpatient unit of the city of Oaxaca. The following paragraphs synthesise the information shared by the interviewees.

23. Available at www.gob.mx/salud/cij, accessed 21 December 2021.

The prevention programme integrates subprogrammes by context, age and level of risk or vulnerability for substance use. YIC outpatient units, also known as Preventive Clubs for Peace (formerly "Preventive Day Centres"), organise multiple workshops, holiday courses and daily classes. These are open to all children, regardless of whether their parents are in treatment or not. In this way, YIC promotes community integration and provides children and their families with a place where they can develop a feeling of belonging and safety, while acquiring competencies tailored for each age group: from 3 to 5; 6 to 12 (6 to 9 and 9 to 11/12); 12 to 15; and 15/16 to 17.

Children are involved in all sorts of activities – the arts, music, theatre, cooking, education, sports, cinema and recreational activities with a focus on health promotion. These seek to reinforce healthy practices, collaborative work skills, violence-free relationships and positive alternatives for the use of free time. They also provide children with tools to understand and express their emotions. The prevention strategy includes activities addressing socio-emotional competencies, safe care, healthy habits, values, cyberbullying, school violence, and tobacco and alcohol use.

The outpatient units offer daily activities on a permanent basis, such as visits to local tourist attractions, museums and fire stations, often opening up new horizons to children and their families and giving low-income families the chance to engage in cultural activities they otherwise might not be involved in.

As noted by one of the informants, the women who go to treatment often take their children with them and thus have a safe space to leave them and, at the same time, give them access to classes with other peers from the community. By bringing together children with different backgrounds and family circumstances, YIC tries to avoid the stigma that having a substance-using parent may involve. The Preventive Clubs for Peace also provide an opportunity to identify other families where there is a situation of drug misuse, or other problems in the case of children who come from the community and do not have family members in treatment.

Parents are always invited to participate in the different activities. During lockdown, which has been particularly long for children in Mexico, most activities reverted to an online format, thus requiring and promoting parents' involvement.

> As described by the Oaxaca unit's director:
>
> The work we do with them helps the children get a structure, which is something sometimes they lack at home: remembering tasks, doing homework, following a process and achieving an aim gives them structure and to their parents as well, because they are there [doing the activity] with them.
>
> It fosters a sense of belonging to YIC and also favours the therapeutic alliance in the case of parents who are in treatment with us.

Children whose parents are in treatment can also participate in the family therapy programme. Families are always invited to be part of the therapeutic process of the person who uses drugs. However, as also reported by other countries, it is not always easy for them, often because they do not want to face the issues present in the family and are sometimes behind the person's development of drug dependence. The

units carry out a programme called "New net", which is comprised of patients who are at an early stage of treatment and patients who are more advanced, as well as the patients' families.

YIC also provides early intervention to adolescents who are experimenting with drug use; often this initial therapeutic relationship brings to the surface the family issues that lie behind the adolescent's behaviour.

Finally, it is important to point out that YIC is currently (September 2021) building two inpatient units for women, where they will be admitted with their children.

Switzerland

Addiction Switzerland

Sucht Schweiz/Addiction Suisse/Dipendenze Svizzera,[24] here translated as Addiction Switzerland, is an independent foundation that was established in 1902.

Addiction Switzerland does not offer direct services to people who use drugs or their children – except for short consultations – but it works mainly on prevention, research and dissemination of knowledge, providing the general public, specific populations, relevant stakeholders, experts and professionals in the field with information about drugs, drug use and drug prevention.

Its numerous services include:[25]

- scientific and professional assistance to local dependence prevention services to learn about and implement good practices;
- sensitisation campaigns;
- training and courses;
- conferences;
- scientific research;
- prevention programme evaluations;
- pedagogic material;
- advocacy in public policy.

Addiction Switzerland covers many areas of knowledge, including children in families with dependence. As the website states:

> In Switzerland, about 100,000 children live with a parent suffering from the problematic use of alcohol or other drugs. Often, these children do not feel safe. Therefore, as loyalty to their family they do not dare to talk about this and sometimes carry this suffering for all their life.

24. Available at www.suchtschweiz.ch/; www.addictionsuisse.ch/; www.dipendenzesvizzera.ch, all accessed 21 December 2021.
25. Available at www.addictionsuisse.ch/qui-sommes-nous/nos-prestations, accessed 21 December 2021.

The specific site on this project offers materials and courses to professionals and the general public, as well as recommendations on reading materials for children with dependent parents, for dependent parents and for people working with them.

It also has a section on "Information and advice for children", which includes links to the information forum "papa drinks" and "mama drinks",[26] which reflects the emotions children feel and the situations they face and provides recommendations and guidance. The site offers videos, materials and advice to children in general and by age (8 to 12 years old and 12 years old and older). It also has a forum for public discussion on topics that are relevant to children experiencing alcohol or drug abuse in their home.

The page also informs children about where to ask for help depending on the canton where they live.

The site refers to two external projects:

- ciao.ch,[27] where children can find information and ask specific questions anonymously as well as through the forum;
- The helpline 147,[28] which is a 24/7 service, free and confidential. Children can obtain help via sms, phone or internet. It also gives guidance to children on where to look for specific services[29] in their canton, depending on their needs and the situations they are facing.

United Kingdom

Nacoa

Nacoa[30] – the National Association for Children of Alcoholics – is a UK service aimed at addressing the needs of children growing up in families where one or both parents suffer from alcoholism or a similar addictive problem.

Founded in 1990, it aims to:[31]

- offer information, advice and support to children of alcohol-dependent parents;
- reach professionals who work with them;
- raise their profile in the public consciousness;
- promote research into the problems they face and the prevention of alcoholism developing in this vulnerable group.

Nacoa offers a wide range of resources to children, young people and adults, and provides a specialised, free and confidential helpline.

26. Available at https://mamanboit.ch/petit/ou-trouver-de-laide/#stop82, accessed 21 December 2021.
27. Available at www.ciao.ch, accessed 21 December 2021.
28. Available at www.147.ch/fr, accessed 21 December 2021.
29. Available at https://services-de-conseil.147.ch/?_ga=2.225355090.998450688.1630963759-431279122.1630963759, accessed 21 December 2021.
30. This practice was referred to by Sheila Gilheany and Marion Rackard during the interview on the Irish Silent Voices Campaign, also included in this report. However, Nacoa was not contacted directly and this paragraph is purely based on information available on the internet.
31. Available at https://nacoa.org.uk/about-nacoa/about-nacoa, accessed 21 December 2021.

Chapter IV

Drug treatment services targeted at pregnant women, mothers and their children

The fieldwork and the literature review strongly demonstrated the need to target women who use drugs and are pregnant or who are mothers. It was clear that the issue should be addressed both as part of this study and also as an independent topic of analysis and policy intervention.

Women who use drugs often initiate drug use and develop dependence in relation to experiences of trauma, violence and neglect; drug use and dependency can be triggered and sustained because of romantic attachments in which the male partner also misuses drugs, and which may be further characterised by asymmetrical power relationships based on the symbolic domination of men over women (Woods, 2020: 192). The life stories of women who use drugs are often marked by cyclical gender-based violence, low self-esteem, guilt and the auto-representation of oneself as being of lesser or no value. Such feelings are reinforced by social norms and stereotypes of "proper feminine behaviour" that disproportionately burden women, and women who use drugs are seen as transgressors of the moral and social order. When women who use drugs engage in or are forced into sex work in order to sustain their dependency – and often, that of their partners – or when they become mothers, the social, family and personal judgment intensifies.

The common view is that women who use drugs are not just incapable of being mothers, they are unwilling to be mothers, and that the best place for the child of a drug-dependent woman is in foster care or with other relatives. Such a view is often shared by the women themselves who, struggling with dependency and the difficulties that motherhood entails for all women, think of themselves as not fit for the task and doomed to fail.

This is why interventions for and with women in women-only, gender-sensitive and gender-responsive settings are indispensable for women who use drugs and their children (UNODC 2016).

For pregnant women and women who are mothers, children can be a strong motivation for entering treatment. Sometimes, the concrete judicial threat of losing custody, or the conditioning of regaining it upon completing or sticking to a treatment or harm reduction programme, influences women's choice to undergo treatment. Indeed, residential inpatient units for long-time users who have often entered and dropped out of outpatient and inpatient programmes and harm reduction services often represent the last chance before indefinitely losing their children "to the system", that is to foster care, adoption or alternative custody schemes.

Nevertheless, women-only and women-centred drug treatment services are still scarce, especially for women with children who are sole or primary caregivers (UNODC 2018, 2016).

As highlighted throughout the following practices in the Czech Republic, Croatia, Cyprus, Greece, Ireland, Italy and Poland, women-only spaces are fundamental to give women the possibility to rebuild their self-esteem, to live in a place that is free of gender-based violence, and to openly speak about their experiences. These are places that are safe, non-judgmental and trauma-informed, places that help women rebuild their confidence in themselves, and where they can learn to live and relate to others without abuse, and feel trust in themselves and others, often for the first time.

Czech Republic

SANANIM

The non-governmental organisation SANANIM[32] is comprised of a complex network of facilities and services for people who use drugs. Since 1990, it has been one of the biggest organisations in the sector, bringing together drug services providers in the Czech Republic with high levels of expertise and thousands of treated clients.

The most important facilities provided are:

- outreach programmes;
- drop-in centre;
- psychiatric ambulance with opioid substitution treatment;
- a day care centre, which includes:
  - psychotherapeutic all-day treatment;
  - special treatment programme for mothers with children (and also fathers and pregnant women);
- addictology ambulance;
- gambling ambulance;

32. Available at http://sananim.cz, accessed 21 December 2021.

- Therapeutic Community Němčice;
- Therapeutic Community Karlov;
- aftercare programme;
- drug services in prison.

Additional services and facilities include:

- a work and social agency, which acts as a link between treatment and a successful transition to a drug-free lifestyle;
- a family counselling centre for parents, partners and other relatives;
- a drug information centre targeting the general public, specialists and policy makers;
- e-counselling and online treatment tools (with special programmes on THC, gambling etc.).

SANANIM services are designed to form a complex network ranging from outreach services to therapeutic communities and aftercare services, addressing the different needs of populations using different substances or with behavioural addictions, of different genders, 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.

In 2020, SANANIM admitted 12 734 clients, mostly people who inject drugs, and most of these clients (7 450) visited low-threshold services. Additionally, about 65 children whose mothers were in treatment were also hosted, along with 2 078 relatives or partners of people in treatment.

The following sections focus on the services provided to children of people who are in treatment and services for women who use drugs and have children.

Family Counselling Centre (Counselling Centre for Parents, Partners and Other Relatives)

This facility provides counselling, and psychotherapeutic and psychosocial services to families and family members, partners and the wider social environment of people who use drugs (including alcohol). It also targets people at risk of gambling. The purpose is to reduce the harm caused by drug use on families and to help families and those using drugs to cope better with their situation.

The centre is part of the Addictology Clinic Žitná. It has a multidisciplinary team formed of addictologists, psychotherapists, social workers, family therapists, psychologists and case managers. In supporting both the family and the person who uses drugs, the centre offers the following interventions:

- individual counselling for parents and other family members;
- supportive therapy for parents and other family members;
- family and couple counselling;

- family and couple psychotherapy;
- group therapy sessions for family members;
- personal growth group therapy sessions for family members;
- social work and legal counselling;
- educational and awareness activities;
- case management, including work in the client's natural environment;
- sociotherapy.

The Day Care Centre

Founded in 1996 and the first of its kind in the country, the Day Care Centre offers outpatient and intensive all-day structured outpatient treatment to people who use drugs. It targets people from the age of 16 who use non-alcoholic addictive substances, and people diagnosed with substance abuse or dependence on predominantly non-alcoholic drugs – as well as family members and persons close to the drug users.

Treatment services include:

- a daily intensive outpatient programme;
- an outpatient motivational (preparatory) programme; individual therapy and counselling; crisis intervention calls during weekends for clients;
- a programme for mothers with small children; family therapy and counselling for parents; social work and counselling;
- psychological and psychiatric examinations;
- leisure activities;
- after-treatment care for those who have successfully completed the four-month intensive treatment.

Since 2009, children with parents in treatment or pre-treatment have also been included.

Women with small children can live with them at the Children's Centre for the duration of their treatment – about four months – and attend treatment at the Day Care Centre while their children are taken care of by medical staff at the Children's Centre.

Karlov

Therapeutic Community Karlov has two main programmes: one for young people between 16 and 26 years of age and another for pregnant women and women who have children. Established in 1998, the Community began a women's programme in 2001.

Before entering Karlov, women have to undergo detoxification and arrange for legal authorisation to bring their children with them. Ideally, women should enter the Community alone and have their children brought in after an adjustment period of about two to three weeks. However, if this is not possible, the child enters the Community with their mother.

Karlov can host up to nine mothers and 12 children, which means that two to three mothers can have two children with them.

The age limit is about 6 to 7 years, not so much because of logistical issues in the Community, but because older children need to socialise with children of their age, and Karlov mainly hosts babies and toddlers.

The therapeutic programme lasts between 10 and 14 months.

Mothers and children are equally important, and both are cared for medically and educationally in an environment that is not judgmental, and where women can learn to bond with their children and recuperate – or often, find for the first time that they can trust in themselves as mothers.

As explained by one of the therapists in a documentary on SANANIM's therapeutic communities: "Treating the mother together with the child is beneficial for everyone because they establish a healthy relationship with each other. They get used to daily rituals that they did not have before the treatment."

Aftercare centre

The aftercare centre consists of a day programme; sheltered housing, with 35 beds; sheltered workshops; and a specific programme for mothers and children. Clients can stay in sheltered housing for a period of about six months. But the outpatient aftercare therapeutic programme can last several years.

Here, the clients can learn to apply what they learned in treatment, as a transitional step towards autonomous life in society. For many, "ordinary" life in society is new, since the lifestyles of drug users can be chaotic, without employment or housing and immersed in difficult relationships with parents, partners, social circles and, at times, their own children. This service is thus a way to preserve what has been gained through treatment without jumping abruptly into the often difficult task of coping again with society while taking care of themselves and dependent others.

As explained by the chief of the facility in the abovementioned documentary: "After treatment, a very challenging and difficult period begins, because the client has abstained from drugs in a protected environment up to that point, where it can be much easier to maintain abstinence than in everyday life."

People entering the aftercare centre start working about two months after entry and leave the centre after approximately six months. However, for those people who have more difficult situations, such as psychiatric disorders, SANANIM has special, sheltered, long-term accommodation for at least one year. The organisation also offers sheltered jobs, that is, opportunities in SANANIM, such as in the social enterprise Café Therapy.

In the aftercare centre, clients receive individual therapy and participate in group programmes. The centre also provides psychiatric care for those who need it. Social workers help the clients solve legal issues, such as debts, custody, or other pending issues that need addressing.

With regard to mothers, as explained by the deputy chief of the facility in the same documentary, the aftercare centre provides special accommodation and focus:

> Parents with children are a very disadvantaged group, mostly mothers taking care of one or two children. This is a specific group that we focus on a lot, and we allow them to live independently in regular apartments because their problems are more complicated and complex. We focus on them primarily from a supported employment perspective, providing them the same aftercare programme as childless clients, but working with them on a broader range of issues that they need to address. The topics are mainly related to the relationship with children, where the goal is to make the clients feel comfortable in the role of mother, to be confident in their maternal competence.

Croatia

Reto Centar

Therapeutic Community Reto Centar is the only therapeutic community in Croatia where mothers and fathers can live with their children.

As explained by Lidija Bandić, representative of the facility for this project, the Community operates an integrated model that simultaneously targets the child and the mother:

Today in Croatia most of the social programmes are targeted at saving the child. We want to transfer the focus on both mother and child, with the participation of the mother and, of course, for the benefit of the child. Our main idea is that addiction does not take away parenthood. We have seen how children are dependent on their mothers, even though they are addicts, and how mothers want to be with their children. We want the mother to participate in her motherhood until she recovers. We have been doing this since the 1990s and we have managed.

Reto Centar has different types of accommodation: in the mother-and-child area, women can live with their children after a stabilisation period. Also, children whose fathers are in treatment can live there, and spend time with their fathers after work.

If the child is a girl they spend time outside the Community in some play rooms, they go to the movies, for a walk and so on. If it's a boy, they meet in the house of men. Older boys can live in the men's section.

There is no age limit regarding children but after the child reaches the age of 14 they are accommodated in an apartment for teenagers. Most of the time these are teenagers that grew up or were born in Reto Centar or came in when they were adolescents. At the time of the interview (June 2021) there were 11 children living in the Community. Children attend the local schools and are guaranteed socialisation with other children outside the Community through social services.

In cases where both parents are in the community, after a certain time, depending on the progress of their treatment, they can live together as a family.

People who live in Reto Centar are usually long-time users. A minimum of three years of treatment is proposed, although some people never leave the community: "It becomes a lifestyle." (Lidija Bandić)

The first element of treatment is stabilisation and rehabilitation of the mother in relation to withdrawal symptoms. In this phase, the mother is placed separately from her child but close to them: she sees her child a few hours per day in supervised visits, based on an individual assessment. Meanwhile, the child lives in the house for mothers and children, which is led by social workers. When the mother is stabilised, she comes to live with her child.

The Community provides psychological support and psychiatric services for those who need it, and therapy, sociotherapy and developmental of parental skills.

> An important element of our treatment is the mothers who underwent treatment and succeeded and managed to get their children back. They are an example. One mother pushes another. (Lidija Bandić)

Cyprus

Agia Skepi

As stated on the website of Therapeutic Community Agia Skepi:[33]

> The Therapeutic Community, located near the village of Politiko, is a residential centre, where members participate in group therapy, in an ideal environment away from distractions. Daily activities include organic farming, packaging, baking bread, cooking, gardening and sports.
>
> Once the members complete the residential part of the program, they move to the reintegration hostel. While continuing group therapy, they are urged to develop the necessary autonomy to re-enter society as active members.
>
> Agia Skepi also offers counselling and support to users not enrolled in its programs and their families.
>
> In the context of work therapy, the community has developed a social entrepreneurship action in the field of organic food products.

The Community was set up in 1999 and since 2012 has operated a programme targeting women, with the support of NAAC.

> As explained by the director:
>
> We started the Therapeutic Community for both men and women but because of the very small number of women and being on a very small island at some point

33. Available at www.agiaskepi.org/about-en, accessed 22 December 2021.

at the beginning of our programme we experienced having just one woman with 15 men… and because the drug community is even smaller, we ended up having a perpetrator and the victim in the same programme. That's when we understood that we needed to have a separate programme and finally, in 2012, we launched a women's programme.

Women have a whole and autonomous area separate to the men's. Here, two rooms are exclusively for mothers who live with their children.

The preferable procedure is to have the mother enter Agia Skepi alone at first, to give her time to adjust and to start to work on herself. The child is brought in after the first weeks. If this is not possible because of a lack of safe accommodation and a safe environment for the children, or if there is a risk that they might be put into a care centre, they arrive at the Community with the mother. Usually, the children are young, the eldest ever hosted being 7 or 8 years old. Older children usually live with grandparents, other close relatives or functional fathers – not often, since they are almost never present – and come to spend their holidays with the mother. Pregnant women are admitted immediately.

The Community is located in the mountains and children attend the closest local school, which is approximately 15 minutes away. Staff drive and escort the mother and children, but it is the mother who takes her son or daughter into the school, while staff wait in the car. In this way, mothers become involved in their children's activities and are also recognised by the school community. The children return at around 4 p.m., and the mothers pause their activities with the Community to be with their children. Everybody else finishes at 9 p.m.

As noted by the director:

The programme has worked really well. We have a higher retention rate, because it's a real motivation to have their child with them. Moms also receive help from other women in the programme, that's a good help, a really good bond.

We had a woman last year or the year before, she had three children and by the time she walked through our door the children had already been put into foster care. We helped her through 12 months to get her children back. We gave her three months and then she was quite stable and then in three months' time the kids started visiting, spending the weekends here with her and at the end of the year she regained custody.

Agia Skepi operates as an organic farm – it has 2 900 chickens, which makes it the largest organic egg-producing company in the country. It also has a bakery and a dry food packaging workshop. The maximum capacity of the Community is approximately 45-50 people, with an average presence of 35-40. The highest number of women ever hosted is 8-10.

Referrals mainly come from families, social services and the courts. Also, the Community has a co-operation programme with the Attorney General, through which long-term

prisoners with a history of drug misuse are allowed to leave prison and stay in the Community as part of their sentence. People sentenced for any crime are allowed, except for homicide and sexual offences against children.

Once the clients complete the 12-month treatment, they move to a halfway house, in which they stay for about six months. In this space, men and women live together. They are helped to find a job and to progressively reintegrate until they can live on their own and be completely independent. This period is followed by another 12-month phase in which, depending on each person's profile, they will go to the halfway house for a urine test and individual counselling. The monitoring gradually spaces out until it is over. In the case of people under judicial sentence, the reviews are more frequent and last for the duration of the sentence.

The director of Agia Skepi emphasises that while this space is important, the country requires more intense outpatient services for those people who are long-term users and have parenting responsibilities, where they can be treated without separating them from their families.

Also, the lack of women-specific outpatient services is identified, particularly to provide childcare for women who need to attend treatment with their children. This need was identified by other informants as well.

Protocol to identify pregnant women who misuse drugs and refer them to trained liaison midwives

In January 2021, the Ministry of Health of Cyprus approved a protocol for the identification and referral of women who are pregnant and misuse alcohol or other drugs. While the main purpose is to act preventively in the case of unborn children who might be exposed to fetal alcohol syndrome (FAS), this tool serves as a means to detect all substance use disorders.

Midwives working in the health system are being trained to function as liaison officers for pregnant women who use alcohol or other drugs and have been identified by any services – social services, local doctors, maternity clinics, and so on.

The protocol of referral is accompanied by a quantitative and qualitative questionnaire to be completed by the practitioners in order to gather more information on the patients' profile, data that can in turn shape public policies. With these tools, midwives have more information at hand to identify the women's needs and make a proper referral. These might include dietary issues, a brief intervention, feedback on healthy lifestyles, financial support, drug treatment services, counselling and so on.

Follow-up with the women takes place during pregnancy and after birth. 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.

The protocol and the liaison officers who implement it constitute a prevention tool to enhance early detection. As reported by the informant in this case, the ideal would be for all professionals from all services to be able to make the right, timely referral. However, disconnection between services; a frequent lack of communication and

mutual knowledge, or poor efficiency in referrals; and the clients' lack of trust in the services act as barriers to effective referrals. The protocol and the liaison officers are thus a means to create trust, to make women feel safe, to reduce the fear of having their children taken away, and to make sure that they are guided and channelled to the right service in the appropriate way.

The protocol is in its initial stages and had not yet been implemented when this information was gathered (May 2021). Personnel will be trained from September 2021 to account for the delays to the process due to Covid-19. Training will be offered to five midwives who will operate in the country's five provinces, as well as to personnel from the national helpline and social workers. The aim is to train as many professionals as possible, in order to make them aware of this tool and to guarantee successful, speedy and appropriate referrals.

Greece

Sub-Unit for Addicted Mothers and their Children, Drug Dependency Unit, Attica Psychiatric Hospital

This section focuses on the Sub-Unit for Addicted Mothers and their Children attached to the Drug Dependency Unit, Attica Psychiatric Hospital, Athens. The sub-unit is a women-only space to host women who use drugs. Children aged up to 5 years can live in the sub-unit with their mother.

The sub-unit is part of, but physically separated from, the hospital. The programme described in this section has been in place since 2006, but its foundations date to 1987, which is when the Drug Dependency Unit was created. Initially, the Drug Dependency Unit functioned as a residential, drug-free treatment service that hosted both men and women. As a response to the growing evidence on the needs and specificities of women who use drugs, women were separated from men and provided with a women-only space. This decision was not intended to isolate women, but to provide them with a safe space in which the most intimate and gender-based aspects of addiction could be talked about, explored and addressed.

The sub-unit hosts women who have been dependent in the long term on any substance. It is a drug-free environment, therefore it does not implement harm reduction strategies. When it was first implemented it was targeted at women only, not their children. As explained by the informant Maria Sfikaki, a clinical psychologist with 24 years of experience working specifically with women who use drugs, the aim of a women-only treatment is to retain women and provide them with the time and the space to work on their drug use and their relationships with men and to acquire the self-esteem, the trust and the means to learn how to relate to men without an element of abuse being present.

The intervention is based on the acknowledgement of trauma in women's lives as one of the reasons for developing dependency, as well as on recognising women's

strength and capacity to deal with pain. Drug use is thus seen as a means of resisting, not succumbing.

> "For us, drug use is a survival strategy because women have to cope with all the difficulties from their previous lives." (Dr Sfikaki)

The programme evolved in 2006 when it began to admit women's children as well because, as stated by Dr Sfikaki: "We realised that women couldn't leave the children behind."

The sub-unit perceives mothers and children as a dyad. It aims at providing women with individual-centred skills related to their own paths to dependency, so they can work on trauma, build self-esteem, feel trust in others and in themselves – and it also helps them to gain the skills to build attachments to, and take care of, their children. The work is monumental and extremely hard; this is why an inpatient programme is more desirable and effective for women with 15-20 years of drug dependence. The approach to mothers and children is holistic: in addition to the psychological aspect, and always in parallel, emphasis is given to the medical condition of both mother and child, and the social and legal aspects that are the result of their drug use. The notion of care applies to both body and soul. Women follow a concrete daily routine with groups that focus on the body (gymnastics, yoga), the psyche (psychotherapy, art groups) and functional issues in their everyday life. They are helped to acquire the functional daily routine that was destroyed due to drug use.

The programme has both prevention and treatment aims: it helps women and children by avoiding separation, securing attachment, caring for both of them, and fostering mother–child bonding as well as child development.

> "It's not easy, nobody knows how to raise a child but they have to be given an opportunity to learn how to do it and then they can decide." (Dr Sfikaki)

The sub-unit has space for 15 women and five children, although usually there are about 15 people at the most. Women of all nationalities and countries are admitted, as long as they can speak Greek. The programme lasts for about three years. In the first year, women are in the residential unit, inserted into the women-only programme. This phase lasts between nine months and a year, depending on each case. Children go to the nearby kindergarten, accompanied by the sub-unit's personnel. Gradually, the mother can become involved in the child's activities, walk them to school, or accompany them to social events such as birthdays or school recitals or celebrations, always based on a case-by-case assessment and accompanied by staff. Besides school activities, the children are also supported by specialised, multidisciplinary personnel in the sub-unit, who focus on the child's development. The sub-unit is close to the children's hospital and can call on nursery support 24 hours a day.

As emphasised in the interview for this section, and also in interactions with practitioners from other countries, children are not the bearers of the pathology, but have often suffered neglect or experienced a sense of abandonment, guilt or shame; they might have witnessed drug use or remember their parents not being able to look

after their children or themselves, as well as episodes of violence. Therefore, children are also accompanied and supported through play therapy, children's stories that address the experiences the children might have lived through, and other activities that help them make sense of and understand what happened to their caregivers.

> Most of the women have a very difficult relationship with their mothers. When we become mothers, we treat children the way we have learned. In the cases of addicted mothers who had a relationship of indifference with their mothers they need treatment so they can develop a bond with their children. We help them realise how their relationship with their parents was so they won't do the same to their child as well.
>
> It has a prevention aim for the children as well. The sooner you intervene, the better. Since the beginning of this programme in 2006 it's really amazing how it has helped the children.
>
> Also it is an opportunity for children under the protection service to be given back to the mothers.

When the aims of the inpatient treatment have been fulfilled, women are introduced into the socio-rehabilitation phase in a halfway house, where men are also present. Women thus become responsible for caring for their children and maintaining their daily routine, but always in a protected environment and with their basic needs taken care of, so that the process is not abrupt and women are given the time they need to build the emotional, psychological and economic independence to live on their own with their children, while moving towards employability. While it is forbidden to engage in romantic relationships with other people living in the halfway house, women and men are given the opportunity to relate to each other in a manner that is free of abuse and gender-based violence.

After living in the halfway house, women still have a one-year follow-up with the sub-unit.

> However, as indicated by Dr Sfikaki:
>
> A therapeutic relationship is forever: these women need help all the time. Addicted women and mothers have real difficulty in trusting, the issue of trust is major. When it happens, then they respect that, they don't leave. It's difficult to make a connection. When they do, they keep it. Often it's the first time that they are given this opportunity.
>
> They need care: it's something they that lack, otherwise they wouldn't have been using drugs for 20 years.

Ireland

Coolmine

Coolmine[34] Therapeutic Community was established in 1973 and remained for over a decade the only voluntary body concerned with the treatment of people with dependent drug use in Dublin. The organisation grew further in the early 1980s in response to the heroin epidemic in Ireland. In 1989, a separate women's service was established: Coolmine Ashleigh House. While this section mainly describes the women's residential service and the Parents under Pressure (PuP) Programme (Ivers and Barry 2018), it is important to point out that Coolmine provides numerous services at different levels and settings: outpatient treatment, community and outreach programmes, prison outreach, residential services, reintegration, aftercare, lifelong support programme and so forth (these services are covered in detail on the organisation's website).

Ashleigh House

The development of a women-only facility was a direct response to the low numbers of women accessing drug treatment services in Ireland. In addition, there was a growing need to provide women with spaces that understood and responded to their stories and circumstances.

Even with the setting up of a women-only facility, women were still underrepresented in treatment services.

> As reported by Coolmine's CEO, Pauline McKeown:
>
> We were seeing a low number of women coming through for treatment and we wanted to understand better why that was, and one of the key elements and the key barriers were children and being able to access treatment with their children.

Coolmine thus developed childcare services and now has a fully regulated, Tusla-inspected Early Years and Pre-school Crèche, which is available for all the parents partaking in the programme.

Furthermore, Ashleigh House is the only mother-and-child residential treatment programme in Ireland. It consists of a 22-bed residential treatment centre for pregnant women, women with young children and women with children up to 5 years of age. One of the aims of working with mothers and children is also to pursue reunification with the other children women may have, often older and living in foster or informal care.

Overall treatment lasts 18 months, split across residential treatment (6 months); a reintegration programme, where women live outside the Community but have full support and attend outpatient treatment (6 months); and aftercare, which consists of a range of integration and aftercare programmes to support clients as they transition from high levels of support to community living, work, training

34. Available at www.coolmine.ie, accessed 23 December 2021.

and employment (6 months). It must be highlighted that all the people who have attended Coolmine's services can always go back and can rely indefinitely on the Life Long Support Programme, which is run by Coolmine's graduates and is basically a peer-to-peer intervention.

Parents under Pressure (PuP)

PuP is an Australian programme[35] that aims to improve family functioning and child outcomes by supporting parents who are, or have been, drug or alcohol dependent.

The approach was taken up by Coolmine initially in response to the challenges faced by women in treatment: even if Coolmine provided women with a space where they could stay with their children and undergo treatment, it was difficult for clients to balance the treatment and their parental role and some of them reported that they did not feel attached to their children.

PuP thus began as a pilot project in 2013 with women who were experiencing these difficulties and were in treatment at Coolmine, according to the informant.

> We did a pilot project with the women and what came out exceeded our expectations, it proved to be one of the most powerful interventions that we've had.
>
> We ran it in a group programme and one-to-one intervention within the residential centre.
>
> The fact that there were other mothers and that they could share the stigma and not be judged enabled them to believe that they could be a good enough parent for their children.

PuP is now run across all services at Coolmine, with men and women, and has been evaluated by Trinity College as one of the most successful interventions run by Coolmine (ibid.). It enables parents to acknowledge what they want for their children and identify the path to get there. It also helps find a common language and focus with social services and child protection, helping all parties to move beyond the tension that often exists between the "child-centred services" and the "mum in drug treatment" focus by providing scientific assessments of a person's parental capacities and their children's development outcomes. As reported in the evaluation (ibid.: 7):

> The men and women experienced challenges when participating in the programme.
>
> Regardless of whether or not they had access to their children, the benefits of participating in the PuP programme were apparent.
>
> External agencies such as social services and criminal justice were familiar with the PuP programme and participants received external validation and praise for their participation.
>
> All participants emphasised the importance of access during treatment. Most frequently two suggestions for change were put forth by participants; (1) including the children in the sessions and (2) adapting the content to include older adult children.

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35. Available at www.pupprogram.net.au, accessed 23 December 2021.

SAOL

Founded in 1995, SAOL[36] is a non-governmental organisation that works at the community level and provides ongoing services to women who use drugs. Its name is composed of the initials of four Irish words that, translated into English, mean "Stability, Ability, Work and Learning".

Using a case management approach, SAOL has adopted a trauma-informed practice adjusted to women's needs and unique experiences. It fosters education, training and peer work, and has a specific programme for women who face the dual issue of drug use and contact with the criminal justice system. This programme is called BRIO, which stands for "building recovery inwards and outwards".

The work in the communities and in prison is focused on women; however, SAOL also has a children's programme aimed at children from the community who live in families with drug abuse. The service currently receives 11 children who are signed up for a one or two-year programme.

SAOL aims to obtain sufficient funding to expand the number of children it receives while also offering drop-off services to women who access services provided by SAOL or other organisations, as childcare still constitutes a barrier for women who want to access services but are the primary or sole caregivers of their children.

SAOL is another example of women-only services that take into account women's pathways to drug use and, in some cases, criminalisation, in a trauma-informed, non-judgmental space. Women are not asked to be drug-free: rather, different realities of drug use, abstinence or harm reduction co-exist.

Italy

Casa Mimosa

Casa Mimosa[37] Residential Therapeutic Community is located near Modena and accredited by the Italian region Emilia-Romagna. It is part of Fondazione CEIS ONLUS and is exclusively for women who are pregnant and women who are mothers. Here, guests can live with their children aged 0 to 6 years. However, when necessary, Casa Mimosa also receives older children; for example, at the time of the interview (July 2021), there was an 11-year-old girl in the Community. Decisions are assessed case by case, depending on the children's needs and the actual situation of the family.

The facility has 12 rooms, one per family; nonetheless, Casa Mimosa usually hosts from seven to nine women with their children. At the time of the interview, there were five women and five children present.

Casa Mimosa has a multidisciplinary team of 10 that works across day and night shifts. The work has been developed along two lines. On the one hand, the mother

36. Available at www.saolproject.ie, accessed 23 December 2021.
37. Available at www.gruppoceis.it/strutture/modena/casa-mimosa, accessed 23 December 2021.

is referred from the public drug treatment services, SER.D. Meanwhile, the children are under the monitoring of child protection services, social services or the children's court. Casa Mimosa works in collaboration with both types of services. Other services that are sometimes also part of the clients' needs are mental health or neuropsychiatry services. Each case thus requires the concerted intervention of multiple actors that convene on a regular basis (every three to four months) to assess and monitor the case.

Treatment for women is divided into three phases, with an average total duration of 30 months (12+12+6): the first phase lasts about three months, but its length depends on each person. During this integration phase, women become adjusted to the Community, its rules and dynamics. Women who enter Casa Mimosa must have undergone detox and cannot access the Community if actively using drugs. A major challenge for women during the first phase, particularly the first month, is the lack of contact with the external world.

Once women have passed through the initial phase of integration, treatment begins. Women go over their relationship with substances and related experiences; they have about one month to document their story of substance abuse, to be discussed later in group sessions. This is one of the most important moments for women and coincides with the passage from treatment to the reintegration phase. Another important tool during treatment is "family constellations", a therapeutic approach aimed at revealing family dynamics and their impact and work on them.

Casa Mimosa's guests are occupied every morning in group work, except for Mondays. On Wednesdays they attend parents' groups; the women from Casa Mimosa participate together with nearby mixed Therapeutic Community La Torre, which is adjacent to Casa Mimosa and also belongs to the CEIS Foundation. The women can thus relate to bigger groups and also with members of the opposite sex. The purpose of the parents' groups is to focus on parenthood and children.

On Fridays, they are involved in the women's group and the discussion is centred on issues such as self-esteem, relationships with men and so on.

While the mornings are dedicated to work on themselves, the afternoons are focused on the children and parenthood. Women take their children to school in the morning accompanied by Casa Mimosa personnel and pick them up in the afternoon. When the children return from school, the women focus on their parental role, participating in different activities such as picnics, tours, visits to nearby attractions, and a "week at the beach".

At Casa Mimosa, mothers and children are addressed as a dyad. Casa Mimosa collaborates with Associazione Profili,[38] Bologna, an association of female psychotherapists specialised in children aged 0-6 years. The association has trained Casa Mimosa's operators on the observation of mother and child. The collaboration also involves observation of each dyad through filming in the Community (with their authorisation). The material collected over several months is edited into a segment that includes relevant moments such as the mother and the child playing. Two doctors

38. Available at www.facebook.com/associazioneprofili, accessed 23 December 2021.

from Associazione Profili then watch the film with a total of 10 Casa Mimosa personnel and review it together, opening up a plurality of perspectives. When possible, depending on each mother's situation, they also watch the video with the mothers, creating an intense but very constructive experience.

Another important component of treatment, though it is not always feasible, is the participation of family. Families are involved from the beginning: they are invited to a meeting with the operators to get to know how the Community works and the rules that everybody is expected to follow. They receive particular guidance on how to relate news from the outside world to the guests, since this can trigger difficult or challenging situations for the women in the Community.

Every Tuesday evening there is a family group session, led by the operators and a self-help group. The continuity and depth of family involvement depends on personal and family circumstances. While family support can lead to better outcomes, some families are opposed to undergoing a process that can bring to light issues that might be rooted in the family dynamics and, at times, are also related to drug dependence. It also must be pointed out that while women in the Community face the meaningful but tough work of going through their past and present history in a protected, secure and specialised environment, their families do not always have the support (outside the Community) to review and absorb the processes triggered during the family group session.

At the end of the treatment phase, the family is invited to go over its history with the client and two operators: the woman will share her story of drug dependency, narrating the facts and discussing the people and the feelings that have shaped her journey. This may include the family members present at the meeting. These are usually long and challenging sessions, but also extremely useful ones. Family members can also actively participate and comment, if they wish to do so.

With regard to the children's fathers, a relationship between them and the child is pursued only if continuity can be guaranteed and children are not exposed to renewed trauma. Usually most fathers are also drug users, scarcely attend treatment and appear only intermittently. However, there are also cases of fathers who do not use substances and have a perfectly functional relationship with their children.

Finally, the reintegration of women back into the wider world is undertaken with great care. Its timing and dynamics change according to the women's situation, both in terms of their process and practical issues such as the existence of family support, where they are originally from and whether they plan to live in the area.

As part of reintegration, women are gradually assigned structured tasks, such as going to the doctor's to pick up a prescription. From these first steps follow integration into the voluntary sector, work training and employment, as well as resettlement in a two-bedroom apartment where they can live with their children and another client, and where they only have to pay for groceries and extras such as cigarettes. Step by step, women regain their autonomy, eventually saving up money so they can rent their own apartment and purchase necessities such as a car.

San Patrignano

Founded over 40 years ago, Therapeutic Community San Patrignano[39] is a long-term, drug-free residential Community located in the Italian region of Emilia-Romagna. With room for about 1 400 people, it currently (September 2021) hosts 1 000 people (the decrease being due to the Covid-19 pandemic), including girls, boys, men, women and their children.

San Patrignano is the largest therapeutic community in the country and is known internationally. Its activities encompass its therapeutic and reintegration programmes, a prevention programme addressing teenagers (WeFree),[40] artistic activities and a plural business arm that enables the foundation to provide accommodation, food, competitive training for the labour market, schooling, sports, and a wide range of services to its residents free of charge and without a pre-defined time limit. In fact, the programmes are customised to each person's needs so there are no pre-determined, fixed therapeutic steps, although usually after their third year of stay the residents start their actual reintegration into society, completing their vocational courses or studies and evaluating their choices for the future. It might so happen that some of San Patrignano's residents apply to remain in the Community indefinitely; in this case, the person gradually becomes part of the Community as paid or volunteer personnel.

During the therapeutic process, the guests are gradually engaged in education and work activities. San Patrignano produces numerous goods for the local, national and international markets, such as dairy products, honey and related products, wine, furniture and textiles. San Patrignano also has a shop, a restaurant and a pizza restaurant. Women, like their male peers, are initially placed with the department deemed most suitable for their first period in the programme, based on availability and their personal profile, which is identified during the admission process. This provides them with a space in which they can relate to other peers and thus trigger a process of personal growth. Depending on the recovery process and the person's unique needs and inclinations, they may then choose to transfer from the initial department in which they were integrated to another of the many different activities/vocational training opportunities, attend courses or complete abandoned studies. Work and training are part of the therapeutic process, together with education, peer work and professional accompaniment, but they are also very important means to acquire experiences that will be useful once the person leaves the Community.

Women have been admitted to San Patrignano with their children since the very beginning, based on the acknowledgement that the unity of the dyad must be preserved and that separating mothers from children is not only detrimental to the mother's recovery process but also to her children.

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 San Patrignano 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

39. Available at www.sanpatrignano.org/en, accessed 23 December 2021.
40. Available at www.wefree.it/en, accessed 23 December 2021.

experiences in childhood, domestic violence and poor attachment to their children. Because of the traumas and experiences they have gone through, and 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 be given on their own. In the first 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. Women and their children are hosted in small but comfortable houses where they can establish a normalised routine. During the first year, the mother is not left alone with her child or children until it is deemed to be totally safe. Peers and educators accompany the mother and guide her through the process of both recuperating herself and learning how to take care of her child. This is to avoid ill-treatment of the child and to give space and time to the women, understanding that they are coping with many situations at the same time and that it is normal that a moment of difficulty is sometimes taken out on the children. Women are also supported by educators and other women in taking care of their children when, for instance, they attend a course or go to work. While the mother remains the centre of the child's world, this support network gives the women – and their children – the possibility of having other spaces and references as well.

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 come and visit their parents in San Patrignano, maintain constant contact with their mother, and spend summer and winter holidays in the Community.

San Patrignano co-operates with the services, particularly those related to the legal situation of the mothers and the children. It also collaborates with a network of local volunteer organisations across Italy to carry out a three-fold task: they prepare the families and the people who will enter the Community; they follow up with the residents' families; and they support the people who leave the Community during their reintegration phase.

Reintegration is carried out gradually, according to the particularities of each case. Special attention is given to women who will re-enter life outside the Community with their children. San Patrignano provides its guests with competitive training courses that guarantee rapid insertion into the labour market. It also helps them with other skills, such as driving courses to obtain a driving licence and, in the case of younger guests, high school and university education.

Finally, San Patrignano also supports women to regain full legal custody of their children and reunite with those who live outside the Community, usually older children.

Poland

Monar Zbicko

Monar[41] is a non-governmental organisation founded in 1978. It provides therapeutic and reintegration services to people who are dependent on drugs and, since 2014, has had a programme specifically for women. It is the only complex facility in Poland where women who use drugs are accepted and can live with their children.

With a population of about 44 clients at the time of the interview (September 2021), Monar Zbicko has two separate therapeutic communities – one for men and one for women and children – that are part of the same facility. It also has two hostels that serve as halfway houses: while guests go out and fulfil their daily responsibilities, such as working, studying and taking their children to school, they can live in the hostel and gradually adapt to an independent, autonomous life.

At the time of the interview, there were 13 women living in the Community, 12 of whom are mothers, including one who was pregnant. The 16 children living in the Community are mostly infants, while some go to primary school. There were also 22 children periodically visiting their mothers. Children go to school and kindergarten in the Community and there is also a kindergarten in the Zbicko Community, where children are looked after by the mothers living in the Community.

At Monar, the professional staff work both individually and in groups with the guests. Treatment lasts for about one year, followed by another year in the hostel.

Besides a psychotherapeutic process, the people in the Community are engaged in multiple activities: work, sports, theatre, kayaking, hippotherapy, competitions, concerts and so on, which are all part of the healing process. Trust in oneself, a feeling of safety and belonging, and the skills to face and overcome difficulties without drugs are part of the expected results. People are helped to be able to leave the Community and live an autonomous life, even though the support of the Community remains present.

41. Available at www.old.monar.org, accessed 23 December 2021.

Chapter V

Services for women who are victims and survivors of violence and use drugs, and their children

This chapter highlights a practice that is in urgent need of mainstreaming: the admittance of women who use drugs into shelters for women victims and survivors of violence, along with their children. This issue emerged during a Pompidou Group seminar in Rome in 2015 on women, violence and drugs and is addressed here again through very concrete examples. Focusing on Cyprus and Ireland, the chapter illustrates that drug use should not be a barrier to providing women and their children with protection. In fact, neglecting women who use drugs and their children by depriving them of protection from a shelter exposes them to new forms of symbolic violence and increases their risk of being victims of gender-based violence and violence against children.

Cyprus

SPAVO

SPAVO, 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.[42] It also provides information, support and education about matters of domestic violence through seminars and training.

A particular feature of this organisation that is relevant for this project and that can serve as an example for other shelters is that SPAVO's three shelters and nine rental apartments host women who experience domestic violence and use substances, together with their children. As outlined in the Pompidou Group publication "Improving the management of violence experienced by women who use psychoactive substances" (Pompidou Group 2016: 40-1), this is the exception rather than the norm:

42. Available at https://domviolence.org.cy/en, accessed 26 December 2021.

> The traditional facilities for women who are the victims of violence are not always adapted to the specific requirements of women users. Either they do not accept women who are active users, or it is too hard for these women to comply with the house rules.

The exclusion *de jure* or *de facto* of women who use substances from shelters increases the likelihood of their remaining with the perpetrators of domestic violence, which raises risks for both them and their children.

In SPAVO, victims of violence who use drugs and have children represent about 10-15% of the women living in the shelters.

> As reported by the organisation's director:
>
> The drugs most used are controlled medication and they are a way to handle the serious effects of trauma of violence. That's why we do not expel women, but we try to connect them with the services. The women go to treatment outside and come back to the shelter.

Children up to 14 years of age are admitted. They attend school in the villages near where the shelters are located and are involved in activities in the shelter, both as individuals and in groups. Women and children can stay for up to four months, but in some cases they can prolong their stay.

When asked if women victims of violence discriminate against those who are also in treatment for drug use, the director of SPAVO replied: "The women have a common issue that is domestic violence, and all of these women understand that the drugs are in the cycle of domestic violence and it's ok to do that."

SPAVO also provides social services to cover the needs of victims and their children, a treatment programme for perpetrators and the Woman's House (commissioned by the state under the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence), where all the voluntary organisations and government institutions involved work together, under the same roof.

Ireland

Cuan Saor

Cuan Saor is a free and confidential service for women and children experiencing domestic violence. Located in the centre of Clonmel, a large town in County Tipperary, it was established in 1994, with a helpline launched the following year. In 2000, "a large centrally located building was renovated and opened its doors to offer short-term crisis accommodation for women and children fleeing domestic violence".[43]

Cuan Saor provides the following services:

43. Available at https://cuansaor.org/about-us, accessed 26 December 2021.

- 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.

Cuan Saor provides childcare workers whose role is defined as the following:[44]

> The role of the Childcare Worker is to provide a child with a safe and caring environment where the child can explore and understand their feelings and experiences and the impact of domestic violence in their lives. The childcare worker also supports women in their parenting, helping women understand how domestic violence can affect them as a parent and also to understand the effects domestic violence can have on children.

As part of the childcare service, Cuan Saor also provides art therapy and play therapy to children who may need further therapeutic support to make sense of their experiences and undergo a healing process.

Cuan Saor is obviously an important and indispensable service, but what makes it particularly relevant and unique for the purpose of this study is that it does not shut its doors to women who use substances. On the contrary, it has a proactive and "wraparound" attitude towards women and children who face the dual issue of domestic violence and (parental) drug misuse. This could prove to be an inspiration for other refuges in Ireland and across Europe.

The consultant was able to interview Dr Sarah Morton, a leading figure on gender and drug abuse and one of the triggers for Cuan Saor's embrace of women who use drugs, as well as four members of the organisation. As explained by Project Leader Geraldine Mullane, about a decade ago Cuan Saor and other refuges in Ireland began to recognise the contradiction between being a women-centred service provider while systematically diverting women who used drugs to a treatment service as a preliminary step to being admitted by the organisation.

> We knew we were excluding a lot of women from using our services because they were using substances. We had this notion that you couldn't work with women who were actively using substances and we would encourage them to deal with their substance use via referrals to drug services and then to come back to us and we would deal with the domestic violence issue.
>
> And now looking back… it was the worst form of service and practice that you could possibly have dreamt of. We knew that, but at the time we didn't have the tools or the resources to deal with it.

44. Available at https://cuansaor.org/children-domestic-abuse, accessed 26 December 2021.

Safe Ireland[45] – the national representative body for domestic violence – began identifying the services working actively with women who experienced domestic violence and drug use. Sarah Morton was then the service manager of Safe Ireland and created the connection between Ava,[46] a UK charity working on gender-based violence and abuse, Amanda Middleton, a specialised therapist and trainer, and the 40 services (residential and outreach) in Ireland dedicated to women victims of violence. Although several services were open to addressing the issue, Cuan Saor "really took it on" according to the informants.

At first, there was concern about not being able to cope with drug misuse and its consequences, mainly stemming from a lack of knowledge about drugs, drug abuse, its relationship with gender-based violence and how to deal with it in practice.

There were many challenges, not all the staff was onboard at the outset because of lack of knowledge and fear, because we didn't have the knowledge to manage both domestic violence and drug use.

The more knowledge we got, the more training we had, the more discussions we had, the more confident we became and we realised that we could absolutely do this.

We never went back, it became part of the organisation, it's not even something we think about it anymore, it's second nature to our work nowadays. The fear factor is gone, our training taught us so much.

We see the woman, her safety, the domestic violence, the children… before we see the drug abuse and her other challenges.

We ask women to not use drugs onsite but we don't ask them to stop using drugs, because we know that that's not possible anyway; it happens, but we have the staff trained and we have a support structure.

Proactive attitudes and training opened the doors for the normalisation of a much-judged triad: womanhood-motherhood-drug dependence, a combination that still elicits much rejection and stigma, even from some drug treatment services, as reported by several informants across the 10 countries included in this study.

As reported by other members of Cuan Saor:

For me the change was when we started introducing the question "What is your drug of choice?", and then it normalised it and then it was ok … knowing that women who have specially severe domestic violence, they have used something to ease their pain.

What's lovely about it is that it's not at all judgmental, it is lovely to be part of both, of the domestic violence and the substance use as well; it is a very holistic way of looking at women and children.

45. Available at www.safeireland.ie, accessed 26 December 2021.
46. Available at https://avaproject.org.uk, accessed 26 December 2021.

Another important element in the successful work of Cuan Saor is the ongoing co-operation with the local HSE drug treatment service and other local services.

As reported by the informants: "It makes such a difference when you can work collaboratively with the appropriate service."

These testimonies and the process described by the informants point to urgent pending issues common across services and countries. In the first place, the importance of understanding drug use by women as a coping strategy, a form of resilience, an attempt to overcome a situation rather than get deeper into it, or to surrender. That strength must be acknowledged. Secondly, women who use drugs are capable, willing and fit for mothering, but they may need help, a safe place, non-judgmental attitudes, time and tools to work both on themselves and on their attachment and relationships with their children. Finally, the services can be active – though oftentimes they may be oblivious to it – sources of symbolic violence through judgmental attitudes. Their unconscious fear or the lack of appropriate resources can push women away from accessing services and thus increase vulnerability and risk for them and their children. That can be avoided through knowledge, training and proactive co-operation between the services.

At the same time, children need to be supported during their parents' dependence and recovery. Cuan Saor actively works with children as well.

Children attend a local crèche and school and they are accompanied by a child worker to other activities such as swimming classes, going to the movies, summer camps and so on, in order to give them a life as normal as possible. Children are also followed up with and supported in their own needs in relation to the experiences they have gone through: living in families where drug misuse happens; being exposed to or being direct victims of domestic violence; or having to leave their home and sometimes even their community, extended family, friends and schools. Because of the scarcity of accommodation for women and children victims of violence, mothers may uproot children not only from their home in a bid to get away from the perpetrator, but from the totality of their life. These traumatic experiences are part of the nine adverse childhood experiences (ACEs) and Cuan Saor is actively working on identifying and addressing them through a pilot project that includes a 10-question ACEs questionnaire for women accessing Cuan Saor Women's Refuge over a four-month period (Morton and Curran 2019).

According to the informants:

Sometimes we can see the ACEs as we are working with the family, and a family would come here and when they leave we know that the child that has come with mum will leave from here with four or five ACEs because of the experiences they have gone through before they even got here.

Cuan Saor also works on the mother–child relationship as a dyad and is undertaking the PuP programme (described in this study in the section on Coolmine).

While proactively working with mothers to win back custody of their children who are in foster care, Cuan Saor also offers mothers the possibility of shared custody (in collaboration with Tusla) in foster families. This can be for a few days a week, or some afternoons or even longer periods, depending on the mother and the child's needs. Sometimes mothers need a break from their parental role, and this shared custody scheme allows them to understand that it is fine to take time away.

> We see the red flag when a mother is struggling to be a parent but it is not easy for her to admit that she is struggling and it's not a fair place to be in for her, so we are able to say to her, "We have a couple of options for you and it's not because you are not being a good parent or about taking your children away, but it's so that you can have a bit of space to work through this." They are staying in the refuge, sometimes they have to go to court, meet solicitors, the perpetrator is out there…so there is a lot on them, and they are expected to look after their children all the time so this is a way to tell them, "It's ok to say that you are not in a good place." It's about normalising it for her. And the relief we see on their faces…they can't name that for themselves.
>
> And it's good for the children as well, because they also need a break from mum when mum is not in a great place.

Chapter VI

Key messages and recommendations

This report describes the experience of 28 practices from 11 countries. This has been possible thanks to the active and generous participation of 102 people in inter-country focus groups, national focus groups and semi-structured interviews. Nine of these voices belong to women in therapeutic communities who have undergone treatment or are on a path of recovery with gender-responsive, trauma-informed, wraparound services that take into account their strengths as well as their needs.

While children's voices are not included in this version of the report, Iceland's SÁÁ shared some extracts of children's voices, which are reproduced in Chapter III. Some of the messages conveyed from children to their families and to the services are:

We are not the problem, but we have to deal with it.

When an alcoholic wants to seek help, assistance needs to be available immediately.

We need help to strengthen our self-image.

Everyone has the right to receive services, regardless of where they live.

Alcoholism is a bigger problem than people think; yet, there is little discussion about it.

Do not hide the situation, talk about it.

It does not help us when someone speaks ill of our parent.

It is good when the alcoholic goes to rehab but it is difficult to deal with the long absence of a parent.

The voices of the children echo the experiences of women from San Patrignano and Casa Mimosa of growing up in families affected by alcohol and drug abuse and how this affected their own relationship with substances.

This report describes and tries to respond to the reflections, challenges, creativity, compassion and, sometimes, bias of the stakeholders and practitioners.

It focuses on the daily experiences of children and families impacted by multiple layers of vulnerabilities that intersect with the specific origins and effects of substance dependence.

There is no straight line, one-size-fits-all approach or magic solution to help children and families. However, some key messages resound clearly, and firm steps can be taken towards co-ordinated, integrated, stigma-free, gender-responsive, child and family-centred policies and interventions at the international, national and local level.

The next section develops key messages and conclusions and corresponding recommendations and proposals, directed at national governments and local stakeholders.

This project was proposed as an initiative by the Pompidou Group secretariat as a response to an invitation to contribute to the new Council of Europe Strategy for the Rights of the Child (2022-27). Following consultations with 200 children, the strategy is awaiting adoption by the Steering Committee for the Rights of the Child (CDENF) of the Council of Europe. Among the challenges it should include is the issue of children whose parents use drugs and whose cases remain undetected and unreferred, despite links with situations of child neglect.

Based on the evidence put together by this project, and the experiences shared by 102 people and 28 practices from 11 countries, the key messages are the following:

Key message 1

- Children are not the bearers of the pathology, nor are they responsible for doing something about their families' complex issues, including drug dependence.

However:

- Children may need support to deal with multiple vulnerabilities and the impacts of drug dependence on their daily lives, emotional and physical safety and well-being, self-esteem and trust, communication skills and resilience, and understanding of their parents' situation. They may also need help to identify secure contacts and channels to ask for support if required.
- Currently, services and programmes are not equally available in terms of quality and territorial distribution. So, for instance, people living in urban and rural areas will have differential access, as will people living in different regions. This depends on numerous factors, such as funding, governmental and non-governmental services available in the territory, cultural and social practices, as well as the training and commitment of operators.

Therefore:

- Countries need to develop integrated strategies to cover all children at the national and local level.

How?

I. Provide information and sensitising tools aimed at understanding the experience of parental drug dependence, and initiate discussions about it in society, schools, communities and families, with disseminating channels to ask for help and receive information.

Specific actions:

- Provide spaces for children to express their voices and experiences, and communicate with other peers and service providers.
- Develop digital and printed materials including books and other resources for children, parents and professionals, to be distributed online and through seminars and training sessions in schools, the health sector, treatment centres, social services, and so on (see Addiction Switzerland).
- Create a digital platform targeted at and adapted for children, families, parents and practitioners in which:
  - service providers from the governmental and non-governmental sectors can upload and update their information and contacts;
  - children have easy access to information and contacts;
  - parents and professionals can find information, contacts, materials and referrals for them and for their children.
- Set up a general and specific helpline (e.g. Nacoa, Addiction Switzerland) for children affected by parental drug misuse, available 24/7 through trained personnel or volunteers via phone, chat, sms and social networks, where children can talk about the problems they are facing, be listened to and, if necessary, be steered towards specific services.

It is important that the activities and materials aimed at illustrating the particular vulnerabilities of children affected by parental drug dependence do not reinforce stigmatising attitudes and beliefs around people who use drugs.

II. At the national and local level, create spaces for the integration of knowledge between the fields of social and health services, so that the topic of drug use disorders can be addressed by operators and practitioners trained in both the clinical and the psychosocial spheres. The Hidden Harm Strategic Statement and Practice Guide aim at providing such spaces, promoting integration, joint working and mutual understanding between the services and agencies.

III. Guarantee that services at the local level that address the vulnerabilities of children and families have the capacity to identify and take into account parental drug use and work co-operatively with other services, providing families and children with the support they need in relation to vulnerability and the specific intersection with drug misuse in an informed, collaborative, gender-responsive and non-judgmental way.

Specific actions:

- Make sure that children and family-oriented programmes – many described in Chapters II and III – have the capacity to quantitatively and qualitatively

identify children affected by parental drug dependence and implement actions targeting them so that while they receive the same services as other children in vulnerable situations (e.g. home education, access to sports, educational and leisure activities, involvement in children's groups, play therapy, excursions and visits), they can also have access to specific programmes of support including, when possible, tailored groups. Even if not described in this report, the experience of the Swiss expert Regula Rickenbacher is relevant to work with groups of children affected by parental drug use.

- Guarantee services for families in particularly vulnerable situations who face the risk of losing custody of their children (see Mánaberg and Keðjan, Iceland).
- Develop protocols of co-operation between social/child protection services at the local level and drug treatment services (see the experience of the municipality of Prato, Italy, in the section on P.I.P.P.I.) and, when necessary, also include services oriented towards women and children victims and survivors of violence. Such protocols should allow for the development of children and family-centred plans that make sure that all their needs are addressed. They should also help in the referral of children affected by parental drug misuse to drug treatment services that provide individual and group support (see SÁÁ, Iceland).
- Foster the work of multidisciplinary teams, which promote the operators' capacity to work collaboratively, obtain and share information, and make decisions.
- Provide training to social and child protection services on drug dependence and parenthood, in order to help reduce mentalities, practices, bias and stigma rooted in lack of knowledge, fear and "socially conveyed" messages on drugs and drug users. The experience of Cuan Saor (Ireland) is useful to understand how to do this and to see that such training does not need to be very extensive or professionalised, but enough to identify, incorporate and normalise drug misuse as part of families' realities rather than an issue that makes them incapable of parenthood.
- Reinforce parenting programmes aimed at strengthening families' skills and support (see the PuP programme, Coolmine, Ireland).
- Provide adequate and sustainable funding, to guarantee that programmes targeting a specific population or groups of families are not interrupted.

IV. Care for the caregivers. Usually, grandparents or the extended family are formally or informally declared to be responsible for the care of children. While this can provide children with a family environment and give continuity to the relationship with their parents, it can put both children and grandparents under strain. First of all, it must be remembered that drug misuse can be transgenerational and that family dynamics can be an important trigger, which means that the grandparents can share or reproduce the issues behind the problem of dependence in the first place. Secondly, unless properly supported and guided, grandparents may – consciously or not – act out mentalities around drug dependence and drug users that can be detrimental to the children's understanding of their parents' problem and their own situation. Grandparents and extended family must be accompanied, guided and

supported in the laborious task of taking care of children, both for their own sake and for the sound emotional and psychological well-being of the children under their care.

All programmes targeting children and families should be aware of the impact of gender and gender relationships and mainstream this into the conceptual and practical operation of services.

Key message 2

All countries collect data on children affected by parental drug dependence through different sources of information, in the fields of drug policy, social services and child protection.

However:

The data collected are not necessarily communicated and integrated between the services and ministries, and fail to provide a picture that allows for an estimate of the extent of the phenomenon of children affected by parental drug dependence. The Treatment Demand Indicator (TDI) currently represents the best source of information. However, it is limited to people who actually seek treatment and reports on how many of these adults have children, while not necessarily reporting on the number of children or their situation.

Therefore:

Countries could review the TDI and the current norms and practices of information gathering and sharing.

How?

I. If countries agree, they could signal to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) the need to update the TDI to include more information on children (see NDTRS,[47] Ireland).

II. If countries agree, they could suggest expanding the current TDI to include data on treatment outcomes, including information on children whose parents are in treatment.

III. If not already existing, countries could include in their current surveys on drug use among adults and underage populations questions about substance use in the family.

IV. Countries could review their current system of information sharing between ministries and agencies to make sure that data on children affected by parental substance use can be collected and used to inform national and local public policies (e.g. NAAC and the prevention programmes in Cyprus).

47. Available at www.hrb.ie/data-collections-evidence/alcohol-and-drug-treatment/how-data-is-collected, accessed 26 December 2021.

Key message 3

Substance treatment services provide individuals and their families – if they accept them – with a range of services, from low-threshold, community-level services to inpatient, therapeutic communities.

However:

Substance treatment services may resist incorporating children and parental responsibilities into the therapeutic process, and see them as a "risk" for the therapeutic alliance. Cases of treatment services not informing patients about other services available (such as communities where women can live with their children) and stigmatising attitudes have also been reported.

While social and child protection services refer adults to treatment services, these tend to under-refer cases of children affected by parental drug misuse.

Several issues may contribute to this reluctance, including: fear of criminalisation or stigma (which can also influence the service user's willingness to report their parental status to the treatment service); avoiding the risk of clients' children being identified by social services and sent into care; lack of knowledge; poor professional performance, preparation and commitment; frustration; work overload; insufficient economic resources; and gender-based stigma. Furthermore, privacy laws around substance use can undermine the connection between services and the identification of families and children affected by drug misuse.

It should be emphasised that the above statements are not meant to generalise across the performance of all treatment services, and by no means intend to diminish the important work that treatment services carry out with their clients and families.

Therefore:

Countries and substance treatment services should engage in active practices aimed at including children whose parents use drugs, encourage referral and provide information to social and child protection services:

How?

I. A wraparound, tight co-operation network with programmes and services targeting children and families.

Specific actions:

- As outlined in key message 1, develop protocols of co-operation between social/child protection services at the local level and treatment services (see the experience of the municipality of Prato, Italy, in the section on P.I.P.P.I.) and, when necessary, also include services oriented towards women and children victims and survivors of violence. Such protocols should allow for

the development of children and family-centred plans that make sure that all the family's and child's needs are addressed.

- Promote and reinforce the collaborative work of multidisciplinary teams to share knowledge and information and create co-operation schemes that allow for more holistic, family-centred interventions.
- Provide simultaneous, collaborative meetings and training to practitioners from social services, child protection and treatment services, to learn about each other, mutually understand each other's work and responsibilities, and learn about the impact of parental drug misuse on children together, sharing perspectives, knowledge and practices. This activity is meant to inform, educate, reduce stigmas and fears, and foster co-operation.
- Upload and share information on the digital platform suggested in key message 1.
- Ensure low levels of personnel turnover to guarantee continuity to the work carried out with clients and children and maintain the relationship of trust.

II. Provide services for children whose parents use substances.

Specific actions:

- Set up crèches or day centres for children to facilitate parents' attendance of treatment and provide support services (counselling, play therapy, work groups, etc.) to children. These should admit children whose parents use substances even if they are not in treatment (see SANANIM, Czech Republic; SAOL and Coolmine, Ireland; Youth Integration Centres, Mexico). In the case of small, local centres, reach out to other services for collaboration.
- Elaborate specific programmes targeting children whose parents use substances, to help them build resilience and social and communication skills; overcome shame and guilt; and provide them with a safe place and shared experiences, as well as educational and psychosocial support (see SÁÁ, Iceland and Alcohol Forum, Ireland).

III. Address parental status with parents in treatment as part of the therapeutic process and strengthen parents' skills to deal with the dual issue of parenthood and substance dependence (see Coolmine and Alcohol Forum, Ireland).

IV. Provide intensive outpatient care for clients who need it in order to guarantee the treatment's success without separating children from their parents.

Key message 4

During the fieldwork and the literature review, the need to provide services for women who use substances and are pregnant or mothers emerged strongly as an issue that should be both addressed as part of this study and as an independent topic of analysis and policy intervention.

The life stories of women who use substances are often marked by cyclical gender-based violence, low self-esteem, guilt and the auto-representation of oneself

as being of lesser or no value. Such feelings are reinforced by social norms and stereotypes of "proper feminine behaviours" that disproportionately burden women, and women who use drugs are seen as transgressors of the moral and social order. When women who use substances engage or are forced into sex work in order to sustain their dependency – and often, that of their partners – or when they become mothers, the social, family and personal judgment intensifies.

- The common view is that women who use drugs are not just incapable of being mothers, they are unwilling to be mothers, and that the best place for the child of a drug-dependent woman is in foster care or with other relatives. Such a view is often shared by the women themselves who, struggling with dependency and the difficulties that motherhood entails for all women, think of themselves as not fit for the task and doomed to fail.

- This is why interventions for and with women in women-only, gender-responsive settings are indispensable to take care of women who use drugs and their children.

However:

- Women still face barriers and stigmas when trying to access treatment. They often lack access to information and there is a scarcity of outpatient, intensive outpatient and inpatient facilities where they can take their children with them. Women who use substances and are victims or survivors of violence and their children are not always admitted to shelters. However, dependence should not be a barrier to giving women and their children protection. In fact, barring women who use substances and their children from the protection of a shelter exposes them to new forms of symbolic violence and increases their risk of being victims of gender-based violence and violence against children.

Therefore:

Countries should actively engage in analysing their current availability and quality of substance treatment services as well as services targeting women who are victims and survivors of violence and their children.

How?

I. Guarantee the presence of women-only, trauma-informed, non-stigmatising, gender-responsive inpatient and outpatient treatment where women can attend with their children (see the experiences of the Czech Republic, Croatia, Cyprus, Greece, Ireland, Italy and Poland).

II. Elaborate protocols of co-operation for the proper identification and referral of women who are pregnant and use substances (see Cyprus).

III. Make sure that treatment services provide information to women about facilities where they can live with their children.

IV. Guarantee that refuges for women victims and survivors of violence are properly trained and admit women who use substances and their children (see Cyprus and Ireland).

V. Develop paths of referral and cross-referral between services for women who are victims of violence and drug treatment services.

VI. Actively train and engage women who use or have used substances in accompanying processes for other women who use substances and need help to navigate through services.

VII. Provide women with virtual and face-to-face opportunities to speak about their experiences with the services and their relationships with substances, and develop proposals for other women and services.

VIII. Create opportunities within and between countries to further explore the aspects referred to in this report, specifically how the experiences of trauma, violence or the contexts of drug abuse during childhood can affect how mothers who use drugs see themselves and are seen by others. There is a need to speak about and look deeper into the fragility and the vulnerability associated with the dual situation of motherhood and substance dependence, in order to make it visible and legitimate, reduce stigma, improve services and empower women.

This project has endeavoured to make visible children living in families impacted by substance misuse and has identified several options to improve their lives and the fulfilment of their rights.

This is a human rights-oriented project that responds to the Pompidou Group's mission of integrating human rights in drug policy. Protecting the rights of the child is at the core of the Council of Europe's mission to safeguard human rights, uphold democracy and preserve the rule of law.

The Pompidou Group secretariat and the author of this report invite the Permanent Correspondents to review the key messages that have emerged from it.

The Pompidou Group secretariat also invites the Permanent Correspondents to entrust it with the following steps:

- produce this report as an ISBN publication in 2022;
- publish the three reports developed in 2021 and their executive summaries on a specific Pompidou Group webpage focusing on children;
- develop a written consultation (November-December) among all the Permanent Correspondents (including the 11 who participated in the current project) with information of the results of the consultation to be presented at the Bureau meeting on 8 February 2022:
  - determine who is interested in further follow-up of the project (in 2022);
  - indicate which action (among the key messages and recommendations) each country is interested to pursue;
  - develop the format of the possible actions in relation to consultation with children and consultation with women who use substances and are pregnant or mothers;

- communicate other actions or strategies that are under preparation and should be taken into account as part of this project.

- ► pursue transversal co-operation on the Council of Europe Strategy for the Rights of the Child (2022-27), which will be launched in Rome in March 2022.

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The aim of this report is to shed light on an invisible population: children and adolescents living in families where at least one parent uses drugs. This focus on children exposed to parental dependence on drugs and alcohol implies helping them and their families to overcome dependence and its consequences.

Parental drug use impacts children at every stage of their lives, from before birth and well into their adult lives. However, until now, this situation has received very little attention. This report looks at children growing up in families affected by drug and alcohol dependence, as well as the services, programmes and practices that help protect childhood and ensure children's needs are met, while at the same time addressing the needs of parents.

This project is part of the Pompidou Group's mission of integrating human rights into drug policy. It was proposed in response to the Council of Europe's invitation to the Pompidou Group Secretariat to participate in the Inter-Secretariat Task Force on Children's Rights and to contribute to the discussions on the themes which should appear in the new Council of Europe Strategy on the Rights of the Child (2022-2027).

The contents, conclusions and recommendations presented in the report contribute to the growing knowledge and interest in this topic and serve as a practical reference for the identification of promising practices and international partners. Far from being a conclusion, this report is the first step in a joint effort to give visibility to children of parents who use drugs and a tool to foster co-operation and dialogue that will continue in 2022 with Phase III of the project.

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