International Journal of Drug Policy 109 (2022) 103857

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Commentary

Child-centred harm reduction

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ARTICLE INFO

Keywords:
Child centred harm reduction
Adolescent
Drug use
Prevention
Child rights
Child protection
Pregnancy
Parental drug use

ABSTRACT

Harm reduction has become increasingly influential in drug policy and practice, but has developed primarily around adult drug use. Theoretical, practical, ethical and legal issues pertaining to children and adolescents under the age of majority – both relating to their own use and the effects of drug use among parents or within the family – are less clear. This commentary proposes a sub-field of drug policy at the intersection of harm reduction and childhood which we refer to as 'child-centred harm reduction'. We provide a definition and conceptual model, as well as illustrative questions that emerge through a child-centred harm reduction lens. Many people in different countries are already working on these kinds of issues, whose work needs greater recognition, analysis and support. In beginning to name and define this sub-field we hope to improve this situation, and inspire further international debate, collaboration, and innovation.

Introduction

Protecting children and young people from substance use is considered a global health priority (Degenhardt, Stockings, & Patton, 2016; Hall, Patton, & Stockings, 2016), reflected in the 2030 Sustainable Development Agenda, specifically Goal 3 aimed at ensuring healthy lives and promoting well-being at all ages (United Nations, 2015), and subject to a dedicated article in the UN Convention on the Rights of the Child (Article 33). Substance use disorders among parents are also a major concern for child wellbeing, from early development into adolescence (Barnard & McKeganey 2004; Giacomello, 2022). Responding to drug use and related harms among children and parents are broad, interdisciplinary challenges, across types of drugs, forms of drug use, types of harms as well as socio-economic and legal determinants.

Harm reduction is an influential approach to drug policy and practice that 'encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use' (Rhodes & Hedrich, 2010 p. 19). While a universal definition is lacking, harm reduction is distinguished by its focus on incremental positive change regarding targeted harms, which neither presupposes nor precludes abstinence as a goal. NGOs further emphasise a commitment to human rights and social justice, necessitating the separation of drug use harms from drug policy harms, and highlighting the role of policy and legal frameworks as a driver of vulnerability (e.g. HRI, n.d; HRC, n.d). Harm reduction is a cornerstone of HIV and overdose prevention, endorsed by every relevant UN agency in this regard (United Nations, 2019). It is also increasingly influential for other forms of drug use and drug related harms. However, harm reduction has primarily developed around adult drug use, obscuring theoretical, practical, ethical and legal issues pertaining to children and adolescents under the age of majority – both relating to their own use and the effects of drug use among parents or within the family.

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https://doi.org/10.1016/j.drugpo.2022.103857

Harm reduction and drug use among children

The idea of using harm reduction for adolescent substance use has long been discussed (e.g. Bok & Morales 2000; Bonomo & Bowes 2001; Burrows & Alexander 2001; Kelly, 2012; Leslie, 2008; Fletcher & Krug 2012). Harm reduction has also been suggested for, among other issues, work with sexually exploited young people (Hickle & Hallett 2016), and for non-judgmental approaches for reducing screen time among children during the Covid pandemic (Vanderloo, Carsley, & Aglipay, 2020). Fletcher et al have set out a helpful typology of harm reduction interventions that are available for adolescents who use drugs in Europe (Fletcher, Calafat, Pirona, & Olszewski, 2010). Rapid and systematic reviews of specific interventions for adolescent drug users have been conducted (Snijder, Stockinhs, & Munro, 2018; Stockings, Hall, & Lynskey, 2016; Toumbourou, Stockwell, & Neighbours, 2007). In the context of HIV and hepatitis C, a global 'snapshot of available data' on injecting drug use among under 18s was produced in 2013 by Harm Reduction International, and which collated much of the literature on that topic to that date (Barrett, Hunt, & Stoicescu, 2013). At that time a global estimate of prevalence of injecting among under 18s was not available. The literature indicated important differences between those under the age of legal majority who inject drugs and older counterparts. Guidance on interventions for young people (aged under 25) who inject drugs has since been produced (WHO, 2016) and Youth LEAD, Youth RISE and Y+ have gathered case studies from various countries on services for young injectors (Rigoni, 2021). These reports stress the need for approaches targeted to the specific needs and rights of young people. However, the evidence on harm reduction interventions for young people is weak (Stockings et al., 2016). With regard to those under the age of 18, moreover, more attention may be needed to solvents, tobacco, alcohol and cannabis than has typically been the case in harm reduction.

The literature on drug prevention interventions aimed at children and adolescents is extensive, though evaluation studies are often lacking, especially outside of the United States (Babor, Caulkins, Edwards, & Fischer, 2010). While 'indicated prevention' (EMCDDA, 2009) may intersect with harm reduction in aiming to prevent escalation of drug use, there is a long history of zero-use goals being implicitly or explicitly built into prevention theories and models (Beck, 1998). The main, current approach to understanding the aetiology of adolescent drug use, as well as designing prevention programmes, builds on the risk factors approach. According to this approach, if factors are associated with drug use, then these can be used for targeting of prevention efforts (e.g. Cambron, Catalano, & Hawkins, 2018; Jessor, 2014). Implicit zero-use goals are also present here; the science of risk factors is largely a science of use versus non-use. This hampers both the development of fundamental knowledge of the risk and protective factors for reducing harm and saving adolescent lives, but also impoverishes evaluation research in that zero-use outcomes are the sole metrics. Hence, there remains substantial debate about the effectiveness of prevention interventions based on the risk factors approach, despite over 40 years of its use (Faggiano, Minozzi, Versino, & Buscemi, 2014; Gandhi, Murphy-Graham, & Petrosino, 2007; Lemstra, Bennett, & Nannapaneni, 2010). In amongst this literature, there have both been calls for new theoretical approaches (e.g. Turner, 2022) as well as pockets of practice to drug prevention that explicitly adopt a harm reduction approach (e.g. Debenham, Champion, Birrell, & Newton, 2022; Jenkins, Slemon, & Haines-Saah, 2017).

It is difficult to extract from the literature those studies that focus specifically on harm reduction applied to children under the age of 18. Current search terms, key words and MeSH terms present a challenge. For example, in the literature we see 'youth', 'young person', 'child', 'adolescent', 'juvenile' all being used. Within these terms age disaggregation is problematic, with these various terms referring to different age groups. 'Young person' or 'youth' extends often to the mid-twenties, which crosses well into what is accepted in law and practice as adulthood. A review of the literature noted that 'more than 95% of all materials reviewed relate to "young people" "adolescents", or "young adults" aged between 15 and 24 years, and sometimes as high as 30 years of age' (International HIV/AIDS Alliance in Ukraine, 2015 p. 6). Additionally, keywords such as "drug prevention" (even combined with "adolescent" and its synonyms) would tend to result in thousands of database hits that have very little to do with harm reduction methods and goals. What is lacking in synthesis is how harm reduction approaches apply to children who use drugs, children with parents who use drugs, and the effects of drug laws and policies on harms to children. The theoretical, ethical and legal aspects are especially weak in the literature (see, however, Conner, 2015; Veit, 2000; Watson, Strike, Kolla, Penn, & Bayoumi, 2015)

Children with parents who use drugs

There is a great deal of research on the effects of parental substance use disorders on children, especially among mothers where they are the main caregivers, as well as on parent-focused interventions (Giacomello, 2022; Horgan, 2011; Niccols, Milligan, & Sword, 2012; Straussner & Fewell, 2018). The role of a harm reduction approach in improving the wellbeing of children with parents who use drugs is less clear (see however, Comiskey, Milnes, & Daly, 2017). The literature on drug use during pregnancy is similarly extensive, albeit primarily clinical, with treatment guidance available (WHO, 2014). A smaller but mounting body of research has focused on punitive or stigmatising laws and practices towards mothers and pregnant women who use drugs that frame them as unfit parents, and the detrimental effects this may have on both women and their children (e.g. Wolfson, Schmidt, Stinson, & Poole, 2021; Nichols et al 2020; Boyd, 2019). Others have drawn attention to the intersections of drug use, sexism and racism in relation to child protection (e.g. Harp & Bunting, 2020; Wakeman, Bryant, & Harrison, 2022). From a human rights perspective there have been challenges to foetal protection laws, including the criminalisation of drug use during pregnancy, with the aim of protecting the unborn child (Amnesty International, 2017). Other studies have looked into the effects of parental incarceration on children. While these do not focus specifically on drug offences, such offences are inevitably captured given the prevalence of people in prisons due to drugs (Luk, Hui, & Tsang, 2022; Murray, Farrington, & Sekol, 2012). Overall, however, evidence on the effects of drug laws and policies on children – intended and unintended - is relatively weak.

Child-centred harm reduction: a definition and conceptual framework

The above is not to say that important, innovative practice and research is entirely lacking. On the contrary, our commentary is based on the understanding that this is not the case. The challenge is how to bring existing practice and research together under an umbrella term to better facilitate learning and innovation. At present harm reduction applied to children lacks an identity as a field, with an associated weakness of information sharing and networking. The majority of the literature emanates from high income countries, and North America dominates. Those attending the International Harm Reduction Conference over the years will understand the frustration at the lack of concrete discussion of children and adolescents in 'youth' sessions, where the conversation tends to be around young adults in their 20s. Important as a focus on young people up to the age of 30 remains, there is a very big difference in terms of law, policy and practice when children cross over a legal threshold into majority, usually set at 18.

We propose a sub-field sub-field of drug policy at the intersection of harm reduction and childhood which we refer to as 'child-centred harm reduction' (or 'child-centered harm reduction'). Based on a PubMed,

Table 1
Indicative questions arising from a child-centred harm reduction framework.

Child-centred harm reduction	Theory	Law	Ethics	Practice	Monitoring and surveillance
Drug use among children <18	In what ways are child development theories and child-centred approaches utilised in creating responses to substance use among under 18s?	How does the UN Convention on the Rights of the Child apply to services for under 18s who use drugs?	What are the challenges regarding informed consent at the intersection of drug use and our understanding of 'maturity'?	How can harm reduction services be delivered on a low threshold basis in the context of child protection standards and in line with the principle of the best interests of the child?	How can data collection systems and indicators capture the prevalence of injecting or other methods of drug use among under 18s?
	Do those under 18 identify as 'drug users', and what might this mean for the accessibility of harm reduction services?	How is the 'best interests of the child' incorporated into drug laws and policies across jurisdictions?	What are the ethical challenges involved in evaluating existing harm reduction services that work with legal minors?	How can the child's right to be heard be respected in harm reduction practice, while engaging also with parents?	What are legal minors' views of existing drugs and harm reduction services?
Children with parents who use drugs	What does harm reduction theory contribute to family-centred healthcare and vice-versa?	What are the effects on dependent children of the criminalisation of drug use/possession?	Is it ethical to remove social benefits as a form of incentive to cease using drugs?	What can we learn from harm reduction services incorporating parenting support into their work?	How can we monitor and assess if/how harm reduction services for parents can improve child wellbeing?
	How can we critically interrogate prenatal drug use and foetal protectionism from an intersectional perspective?	What are the effects of laws criminalising drug use during pregnancy both for pregnant women and for foetus outcomes?	Under what circumstances is it ethical for a child to be removed from the custody of a drug using parent, and how does practice compare across countries?	What can we learn from family-based interventions addressing intergenerational drug use?	How can we develop metrics to track the realisation (or violation) of the rights of pregnant women who use drugs?

Scopus and Google search[1] this term has been used in the literature once before, referring to interactions between children who use drugs, parents and harm reduction services (Maynard, Pycroft, & Spiers, 2019). It is an example of the type of research that the concept would foreground and presents similar dilemmas to those summarised above (in relation to services for minors who use drugs), but it does not present a definition. Our proposed definition makes clear the multidisciplinary nature of the sub-field:

> *Child-centred harm reduction is the study and practice of reducing the health and social harms to those under the age of 18 due to their own drug use, parental or family drug use, or related laws and policies.*

This term, which we hope can over time be employed as a keyword in the literature, is intended to foreground children under the age of majority and for whom child rights laws apply in harm reduction theory, policy and practice. Child-centred harm reduction draws attention to the specificities of childhood in harm reduction work. Existing theories of harm reduction may need adaptation to the sociology and psychology of childhood, including the interconnected relationship between parent and child, family-centred care, and attention to children's rights (see Maynard et al., 2019). Some interventions may not be practical, effective or ethical for children (Watson et al., 2015). Research on existing harm reduction services that work with minors – including those that may not strictly be permitted to do so - may place those children or the service at risk. Issues of consent, identity, agency and maturity, as well as the child's 'best interests' may challenge the assumptions and premises upon which 'low threshold' harm reduction services are delivered (Barrett, Petersson, & Turner, 2022). Different legal and human rights standards are engaged, from drug laws to family law to child rights. Child protection laws may require duties of reporting that affect harm reduction service provision and research (ibid). In some cases both parent and child can be legal minors, leading to further challenges and complications regarding assessments of best interests. National, regional and international policy frameworks may need renewed scrutiny through a child-centred harm reduction lens (see for example Barrett, 2015).

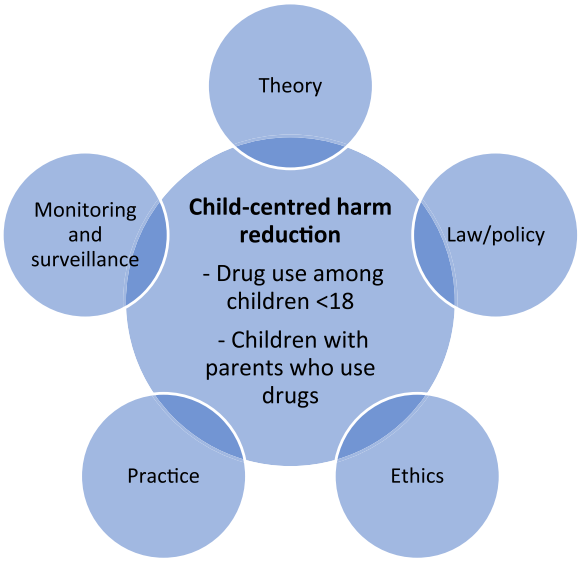

Fig. 1. conceptual framework for child-centred harm reduction.

The term is not perfect. For example, 'child' may conjure the image of only very young children, when the majority of drug use would involve older adolescents. Few seventeen year-olds would refer to themselves as children. However, those under the age of 18 are legal minors in most contexts, and are 'children' for the purposes of child rights. Other terms, such as 'youth harm reduction' reproduce the problem of age ranges noted above, while 'adolescent harm reduction' omits younger children. 'Adolescence' can also extend beyond the age of majority. 'Paediatric harm reduction' was considered, but implied an overly medical approach.

The word 'centred' is critical. Our view of child-centred harm reduction extends from neonates to adolescents, with all of the challenges and differing capacities and relationships that arise at these stages of

[1] "child centred harm reduction" OR "child-centred harm reduction" OR "child centered harm reduction" OR "child-centered harm reduction". One more example referred to faith and education in relation to LGBTI children. Wilton Park (2016) *Opportunities and challenges: the intersection of faith and human rights of LGBTI+ persons*.

development. Centring the child is key and draws our attention also, for example, to dependent children in adult harm reduction work. We believe that 'child-centred' focuses on the specificities of childhood in harm reduction and captures a holistic, rights-based, and person-centred approach.

Our conceptual framework (Fig. 1) sets out the main domains through which to consider child-centred issues. Table 1 presents some indicative questions stemming from the model, which, we emphasise, we do not claim to have posed for the first time. Rather, we aim to show how these diverse areas of inquiry can come under the banner of child-centred harm reduction.

Conclusion

Many people in different countries are already working on these and other issues that would fall under the definition of child-centred harm reduction, and whose work needs greater recognition, analysis and support. In beginning to name and define a sub-field of drug policy at the intersection of harm reduction and childhood, we hope to improve this situation, and inspire further international debate, collaboration, and innovation.

Author contributions

DB led on the drafting of the commentary. All other authors submitted substantive input and feedback. The authors wish to thank the anonymous reviewers for their thoughtful feedback.

Ethics

Ethical approval for this commentary was not required.

Declarations of Interest

The authors declare no competing interests.

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