

“Opening Doors”

Enhancing Youth-Friendly Harm Reduction a toolkit

National Drug and Alcohol Research Centre,
University of New South Wales
Access Quality International



Chiang Mai, Thailand
October 2011

“We don’t need much – we only ask that people understand us a little and give us some space to talk – that’s sufficient”

(Bangkok focus group participant)



The content of this toolkit may be freely used and/or adapted with due acknowledgement of Access Quality International (AQI).

Chiang Mai, Thailand
October 2011

Table of contents

Table of contents	3
Acknowledgements.....	4
Foreword	5
Introduction.....	6
Session 01. Youth-Friendly Services I.....	13
Session 02. Youth-Friendly Services II.....	19
Session 03. Harm Reduction For Young People Who Use Drugs.....	25
Session 04. NSP, Outreach, Drop-in-Centres, Risk and Safety.....	33
Session 05. Drugs, Withdrawal, Overdose and OST.....	48
Session 06. BBIs, HIV, HCV, HBV, TB, STIs.....	62
Session 07. Health and Nutrition	73
Session 08. Mental Health and Well-being	87
Session 09. Basic Counselling	93
Session 10. Motivational Enhancement.....	101
Session 11. Group work.....	108
Session 12. Relapse prevention	113
Session 13. Building Young Leaders – Peer Educators	129
Session 14. Activities.....	139
Session 15. Essential Networks and advocacy.....	143
Session 16. The Change Process	149
Annexes	153

Acknowledgements

We would like to thank the courageous young people who shared their stories of their lives, their struggles and their resilience in the face of so many adversities. We hope we have been faithful to them where we have included what they told their workers from the three project sites, and told us during field visits. These young people who use drugs certainly have many useful ideas as to how to increase their access to and participation in appropriate youth friendly harm reduction services and interventions.

We also thank our implementing partners – Youth Vision, Katmandu - Nepal, the Thai AIDS Treatment Action Group, Bangkok -Thailand, and the Yunnan Institute for Drug Abuse, Kunming - China. They were all receptive to new ideas and the provocation to reflect on their practices, and were challenging of what was unclear or inappropriate.

Of course the project would never have eventuated without the financial support of Aids Fonds, Netherlands.

The initial draft of the Toolkit was developed by Dr. John Howard and Simon Beck, National Drug and Alcohol Research Centre, Faculty of Medicine, University of New South Wales - Australia, and reviewed by Gerard de Kort and Ton Smits, AQI; Bijay Pandey and Sujan Joshi from Youth Vision; Karyn Kaplan, Paisan Suwannawong, Jirasak Sripramong and Amnat Chamcheun from TTAG; and Luo Jian and Drs Zhang Cumin and Yang Guogang from YIDA. Professor Gerry Stimson reviewed the Toolkit, and participants and facilitators of the Katmandu pilot training and the pilot regional held in Bangkok provided feedback.

Photos and Illustrations: Most photos were taken by the authors, some were provided by the implementing partners at the project sites. Illustrations were taken from the WHO Street Children Project with approval, and from open access resources.



Foreword

The reality of drug use among young people continues to be a sensitive issue for many public health and drugs service providers. Predominant approaches that solely focus on drug prevention and ‘just say no’ approaches has left this vulnerable population largely silenced, neglected, stigmatised, and without their needs met. Honest conversations about how to reduce harms related to drug use amongst youth are avoided, and whilst harm reduction approaches to drug use continue to be implemented and expanded in many countries, young people have not benefited from these evidence based services. A number of significant barriers have affected the ability of young people to access life saving harm reduction interventions, including the lack of targeted youth specific services.

Evidence continues to show that young people are highly vulnerable to experiencing drug related harms including HIV and hepatitis. We also now know that harm reduction approaches are among the most effective measures to protect the health and wellbeing of people who use drugs. Young people also have a right to access these services, however they also require a specific, targeted approach that is accessible, that matches their needs, and that is age appropriate.

As one of the first initiatives that addresses this urgent need for youth-friendly harm reduction, the “Opening Doors” project and the resulting toolkit are an important step towards the broader implementation of effective harm reduction approaches for young people. This toolkit contains much needed practical guidance on effective harm reduction services for young people, and addresses important and honest conversations around drug use amongst young people.

“Opening Doors” has remained committed to principles of non-judgment, respect, and human rights throughout the development of this much needed toolkit. Most importantly, they have ensured that young people most affected by drug use remain at the center of the development process, which is absolutely critical in order for interventions to be relevant, appropriate, accepted, and beneficial. The “Opening Doors” team have also illustrated how youth leadership can be fostered, and have ensured that the capacity of young people who use drugs is promoted throughout.

As the only international youth-led network that advocates for a harm reduction approach for young people, Youth RISE has been honoured to be a part of the development of this excellent toolkit. We hope this work will provide a model for the broader implementation of harm reduction approaches for young people and will help us move towards evidence based and humane societal responses for young people who use drugs that effectively reduce drug related harm.

Anita Krug | International Coordinator

Youth RISE (Resources.Information.Support.Education) for reducing drug related harm

Email: anita@youthrise.org

Introduction

This Toolkit aims to distill what was learned during the implementation of the project: “Opening Doors - Increasing access to and participation youth friendly harm reduction for young people who use drugs”, supported by AidsFonds, Netherlands. Via field visits entailing observation of programme activities at the three sites, focus groups and individual discussions conducted by staff of the three implementing partners with young people who use drugs, review of documents and literature the contents of this Toolkit were brought together.

The format came from a four-day training provided during the project on youth friendly harm reduction by Youth Vision, Nepal. It was adapted and other topics included based on suggestions from the three sites and observations and discussions during field visits.

The Toolkit is **provocative** at times – tempting services to reflect on their current practice and explore options for enhancing or developing a more youth friendly approach to harm reduction.

A secondary aim is to utilize any training provided to assist in building essential relationships and networks with key stakeholders and service providers. If a training provided includes representatives of essential key services, they should develop a better understanding of both young people who use drugs and youth friendly approaches to harm reduction.

Purpose

The purpose of the Toolkit is to provide a set of training sessions to stimulate discussion that can lead to ‘youth friendly harm reduction’ services. This may entail review of services, their renewal and, possibly, re-design.

Who is the Toolkit for?

The Toolkit can be used with a variety of audiences, and a mix and match approach can be useful. For example,

- ✓ Staff of a particular service
- ✓ Staff from other services
- ✓ Community groups
- ✓ Key stakeholders
- ✓ Young people who use drugs
- ✓ All of the above participating in the same training – an ‘ideal approach’

What the kit does NOT provide

The Toolkit does not aim at teaching or developing specific skills. The aim is to:

- ✓ Promote reflection on current practice
- ✓ The identification of specific areas that necessitate workforce capacity building
- ✓ The development of essential and supportive networks to provide what cannot currently be provided, and, possibly
- ✓ Facility re-design (for example, re-design of space allocation and use to which space is allocated) or additions (for example, in the form of equipment).

How to use the Toolkit:

The Toolkit can be used in a variety of ways:

- ✓ It can be used for staff training for a particular service. ‘Staff’ includes managers, clinicians, residential, peer and outreach workers and volunteers
- ✓ It can form the (or part of) curriculum for staff training hosted by a particular service for their own and staff of other services
- ✓ Individuals can use it in a self-directed format

A confident and experienced facilitator, who has an understanding of harm reduction, would best provide facilitation.

Not all sessions need to be provided or topics covered, nor does all content contained in the session outlines. Some services may have staff with expert knowledge in some areas, and others may decide to use some sessions as ‘refreshers’. There will certainly be topics not covered that can be added or substituted.

Some sessions contain a large amount of content – too much for a session of about 1.5 hours, which is typically the time allocated to training sessions. The information included is intended to be comprehensive, and from it a facilitator can choose what is most important for their participants. They should not attempt to include all of the content in one session. They can also decide to cover the content in two or more sessions, if there is a need for all of it to be presented.

In an attempt to include as many ideas and suggestions as possible, use has been made of bullet point lists which highlight particular ideas in a form of ‘short-hand’ [**“Did you consider?”**], and which can be followed up via the resource materials and references. In addition, there are no clear answers to some important questions, and services must make their decisions based on best evidence available, the cultural and legal environments within which they operate, the skill set of their staff, and available resources, such as financial, infrastructure and capacity to draw on the resources of other services.

Each session contains the questions to guide large and small group activity, and worksheets for participants for each session are in the Appendix. After a small group or large group activity, the materials in the session outlines can be distributed to the participants, if they have not been given out at the start of the session. The decision as to when to give the materials to the participants is up to the facilitator and their preferred style.

Sessions 1 to 4, and 13 to 16 could be regarded as the ‘core’ sessions related to the development of ‘youth friendly harm reduction’, with 5 to 12 covering more general topics such as drugs and their use, BBIs, STIs, health and lifestyle issues, individual and group counselling.

The PPT slide set may be altered to suit local needs.

If the Toolkit is to be used as the basis for a training programme, various formats are possible. For example:

- Four days of 4 sessions a day
- Two days initially, followed by two more days at a later time, selecting 8 key sessions, 4 sessions a day
- Two days selecting 8 key sessions, 4 sessions a day
- Four one-day sessions at suitable times with 4 sessions a day
- One day selecting 4 key sessions for the day
- Individual sessions each to meet individual needs of workers or agencies

There is no requirement to use sessions; they may be longer depending on need. For example, some sessions may continue for a whole day. This could occur when a service is attempting to re-design its programme/activities and use the structure and content of a session to achieve this. As mentioned above, not all sessions need to be covered – some services may have staff with expert knowledge in some areas, but others may decide to use some sessions as ‘refreshers’.



The accompanying CD/USB contains:

1. This Toolkit
2. Power-point Presentations for each session
3. A large number of resources from which much of the material in the Toolkit is drawn, and to provide more detailed information on particular topics. For example, there are documents on Counselling, Group work, Harm Reduction, MSM, Overdose, Peer Education, Adolescent, Most at Risk young people, Sexual and Reproductive Health, VCT, Youth Friendly health services

A participatory approach is essential.

The following suggestions are drawn and adapted from a Toolkit developed to address: Understanding and reducing stigma related to men who have sex with men and HIV. (UNAIDS (2010) Understanding and Reducing stigma related to men who have sex with men and HIV, Ha Noi, pp 13-18).

Mix presentation styles:

- ✓ Discussion is the core method – the activity through which participants reflect on their own experience, share with others, analyse issues, and plan for action together. All of the sessions are built around discussion.
- ✓ Presentations are kept to a minimum – use for presenting key information, guiding tasks and summarizing sessions.
- ✓ Small groups are used to maximize participation in discussions. Some trainees feel shy in a large group but in small groups may find it easier to talk. Small groups can also be used for task group work, with different groups exploring different topics.
- ✓ Buzz groups - two people sitting beside each other in pairs are a trainer’s secret weapon! They provide instant participation. It is hard to remain silent in a group of two people!
- ✓ Report backs are used to bring ideas together after small or buzz groups. Often “round robin” reporting will be used - one new point from each group going around the circle of participants. This ensures that all groups get a chance to contribute equally.
- ✓ Photos/pictures: The toolkit includes some that could be used.
- ✓ Stories/case studies can be used in a number of sessions to provide a focus for discussion.

The main presentation modes within the Toolkit tend to be:

- Information presentation 
- Provocative questions to the whole group of participants (Brainstorm) 

- Small group discussions with feedback 
- **Did you consider?** Points that might have been considered in small group activities 

Of course, a greater mix of styles will enliven any training, and the facilitator is encouraged to choose methods that best suit the participants and their own facilitation ‘style’.

While it is suggested that facilitation be provided by an experienced facilitator, the following tips may be useful:

Be well prepared

- ✓ Plan in detail each of the exercises before the training.
- ✓ Bring all materials – toolkit, reading materials, flipcharts, markers, colourful cards, etc.
- ✓ Arrive early so that you have time to be familiar with the venue and can re-arrange it if necessary and be ready to welcome participants when they arrive.

Prepare the venue

- ✓ Remove tables to make the room more spacious for group activities and making training feel more informal, if participants are comfortable without tables; remember some prefer a table so they can take notes more easily.
- ✓ Place the chairs or cushions in U-shape to ensure that everyone can see the flipcharts or screen, or whatever other format is more useful or culturally appropriate.
- ✓ Set up a separate table for markers, tape, handouts, cards, etc.
- ✓ Know where the participants are from – such as what services, what their roles are, and age, gender, cultural or religious issues that may be relevant, whether some or many are ex- or current young people who use drugs. Get as good an understanding of the ‘mix’ of participants as possible.
- ✓ Ensure enough water, tea or other means of ensuring hydration, and snacks or meals that meet any religious or other dietary requirements.

Help participants feel comfortable

- ✓ Break the ice and put participants at ease at the start of the workshop.
- ✓ Learn and memorize participants’ names, be informal, friendly, use games, songs or buzz groups.
- ✓ Acknowledge that participants already have much knowledge and skill, and you will appreciate them sharing that, and being willing to build on what they already know.

Find out what the participants really need to learn

- ✓ What knowledge or skills do the participants want to learn?
- ✓ What are the difficulties they are facing in their work?
- ✓ What new knowledge or skills would help them to improve their work?
- ✓ Acknowledge that they will have differing learning ‘styles: some learn better by listening, others by taking notes, and others by practicing.

Ask questions and lead discussion

- ✓ Ask clear and simple questions that allow participants to openly share their opinions.

- ✓ Encourage contribution – use your body language to encourage participants such as smiling, nodding, keeping eye contact.
- ✓ Wait for responses – give people time to think and come up with an answer.
- ✓ Encourage everyone to talk – buzz groups get everyone talking.
- ✓ Keep asking, ‘Who would like to add to that?’
- ✓ If there is no response, rephrase the questions.
- ✓ Show that you are listening and are interested.
- ✓ Praise responses to encourage participation.
- ✓ Rephrase responses to check that you and other participants understand.
- ✓ Redirect to involve others – “He said ... What do others think?”
- ✓ Summarise and check for agreement before moving to the next question or topic.

Use small groups to build participation

- ✓ Give clear explanations of tasks, time and reporting method.
- ✓ If the task is difficult, write instructions on a flipchart so that everyone is clear.
- ✓ Vary group sizes for different exercises – pairs, threes, fours and fives.
- ✓ Keep changing the groups so participants work with different people.
- ✓ When participants break into groups, move around checking that they understand the task.
- ✓ Use a ‘round robin’ to make report back more interesting and efficient.

Keep presentations short and simple

- ✓ Give a presentation only when you are sure people do not know the topic.
- ✓ Write main points in key words on a flipchart and then explain them.
- ✓ Speak slowly, clearly and loudly.
- ✓ Keep presentations short and simple – no more than 10 minutes. Only explain the basics.

Keep changing your methods

- ✓ Use different methods for different exercises to keep things interesting.
- ✓ Be creative – change a story or case study into a role-play or create a debate to confirm a point of view.
- ✓ Use different sizes of groups – do not buzz all the time, try threes or fours in a group.
- ✓ Change the space – go outside or re-arrange the venue.

Check the energy level

- ✓ Observe body language – do participants look bored or sleepy?
- ✓ Ask, “How are you feeling? Is it time for a break?”
- ✓ Change the topic, take a break or conduct a wake-up game.

Watch the timing and pacing

- ✓ Be time conscious – decide how much time you need for each exercise.
- ✓ Remember, small group work takes more time than you expect. Do not forget to allocate time for reporting back.
- ✓ Do not go too fast – let the group help you set an appropriate pace.
- ✓ Give groups enough time to do their work – do not rush them.
- ✓ Do small group work in the afternoon when the energy levels drop.
- ✓ Do not forget to take breaks to relax, get drinks and talk informally.
- ✓ Finish on time! Do not drag things on forever at the end of the day.

Evaluate throughout the workshop

- ✓ Evaluate as an ongoing activity, not just at the end of the workshop.
- ✓ Organise a short evaluation at the end of each day or on the following morning to encourage participants to review what was learned.
- ✓ Assess what was learned and how the learning was done.

Team facilitation

- ✓ Plan and run the workshop with another facilitator and debrief afterwards.
- ✓ Take turns in the lead facilitation role and flipchart recorder.
- ✓ Support each other – if one runs into trouble, help him or her out.

A reminder:

The maxim ‘nothing about me without me’ is central in working with young people in general, and even more so with those who are marginalized and discriminated against because of who they are and what they do. Participation in all activities is central – in identifying needs and wants, in planning and delivering interventions, and in evaluating outcomes. Listening to young people, facilitating their participation, and actively involving them leads to greater efficiency and effectiveness, and to the development of services and interventions that young people feel free to access and utilize, and in which they feel they have an investment.

It is also important to remember that when you engage with young people who use drugs, you may raise their expectations that all their problems can be fixed and that this can happen quickly. It is important to help the young person develop realistic expectations of what might be able to achieve. And, to know that you actually have something to offer, be it personal skills, access to resources and others who may be able to assist where you cannot.



Session 01. Youth-Friendly Services I

By completing this session you should have knowledge of:

- ✓ The diversity of young people – e.g. developmental stage; gender and sexual diversity; socio-economic status; and most at risk young people
- ✓ The complex pathways to risk and resilience
- ✓ Broad influences on patterns of drug use
- ✓ The functional nature of drug use
- ✓ The rationale for giving special attention to young people who use drugs

Introductory:



Why does meeting the specific needs of young people who use drugs matter?



Setting the scene: Young people are diverse. A girl of fifteen living on the streets in Bangkok is likely to have developed essential survival skills beyond those of a girl of similar age who is cared for within a financially comfortable family in Singapore. A 16-year-old heroin user in Kunming differs significantly in terms of lifestyle, risks and treatment opportunities from one in Sydney. And, a boy aged fourteen attending school in rural Katmandu will experience a vastly different array of social and structural influences on his development and exposure to risk than one in a large city such as Shanghai or as an immigrant in a suburb of Auckland.

Adolescence is a time of experimentation, exploration, curiosity and identity search, and part of such a quest involves some risk taking. Within a milieu of social and peer influence and expectations, together with easy availability of a wide variety of substances, substance use can become one aspect of the developmental process, and even a part of life. Adolescence is also the time where many patterns of behaviour become more entrenched; including personality disorders, substance use and associated problem behaviours.

Substance use is generally not mindless or pathological, but functional. When surveyed, adolescents in developed and developing countries cite boredom, curiosity and wanting to feel good (or better) as the main reasons for use. Other functions served by substance use are to relieve hunger, to adopt a rebellious stance, for peer/social acceptance, to relieve pain, keep awake or get to sleep, or to dream and for pleasure. Therefore, young people often see substance use as a solution rather than a problem.

Most young people who try drugs do not continue their use or develop significant problems. Experimentation and a variable pattern of use and cessation are common. For those who do, the consequences of use are determined in large part by the cultural, legal, social and economic context of use. Harm results directly from young people's own substance use as well as from substance use of those around them including use by other young people, family members and other adults. Harm also results from the criminalisation of users, and in particular their incarceration, which can

increase their marginalization and experience of stigma, and decrease their access to and participation in interventions to address any substance use-related harm.

As substance use is associated with many risky behaviours, broad and comprehensive rather than narrow interventions are required to deal with the range. Specific to substance use, an escalation in injecting has contributed to the rapid spread of HIV, hepatitis and other infections. Young injectors are more likely to be involved in riskier behaviours than older injectors. Risky sexual behaviour while intoxicated increases the risk of unplanned pregnancies and sexually transmissible infections (STIs). Road traffic and other accidents, often associated with alcohol use, are a major cause of mortality and injury among children and young people. To survive, many young people put themselves at risk of violence by working in the illicit drug and commercial sex industries. Finally, the troubling increase in suicide and homicide among young people, in developed countries in particular, is seen to be associated with substance use.

As substance use spreads through communities, family and social problems are more frequent. Young substance users may become alienated within their communities and experience stigma and discrimination making them more difficult to reach and more vulnerable to health and social problems. Failure at school, early 'drop out' and underachievement are further consequences. These problems translate into reduced opportunities for productive employment and independence. Alcohol and other substances are intimately inter-related with increasing problems of violence, crime and anti-social behaviour. Substance use by both parents and children often increase family tension, which may result in family breakdown and child abuse. However, the use of substances brings many rewards, such as escape and status and these perceived benefits can be associated with minimizing or ignoring risks.

The age at which initiation and in particular escalation and maintenance of use occurs is crucial. Intensive and/or prolonged use can interfere with essential maturational processes and development, producing 'developmental lags'. Initiation of substance use among very young and most at risk adolescents (MARA) and young people (MARYP) is of special concern. Recent understandings of brain and neurobiological development highlight potential risks of substance use during this developmental period, which is now understood to continue into the mid twenty years of life.

Risks can then be greater for experimenters with limited access to accurate information, equipment and supports, and for chronic dependent users. Thus, how to delay onset of use, or escalation, and route of administration are important considerations.

Those adolescents who develop patterns of regular and problematic or harmful use appear to differ from those who merely experiment, or maintain irregular use. Personality characteristics, individual differences in vulnerability, family difficulties, association with substance using peers, exposure to substances, shared and non-shared environments, and accumulations of social disadvantage, all appear to play a role in the development of substance using behaviour. The interplay of these variables in particular cultures and situations, or more broadly varying contexts, is crucial. Moreover, many of those who regularly use substances also experience other problems, such as academic failure, mental health problems and criminal behaviour, which require attention.

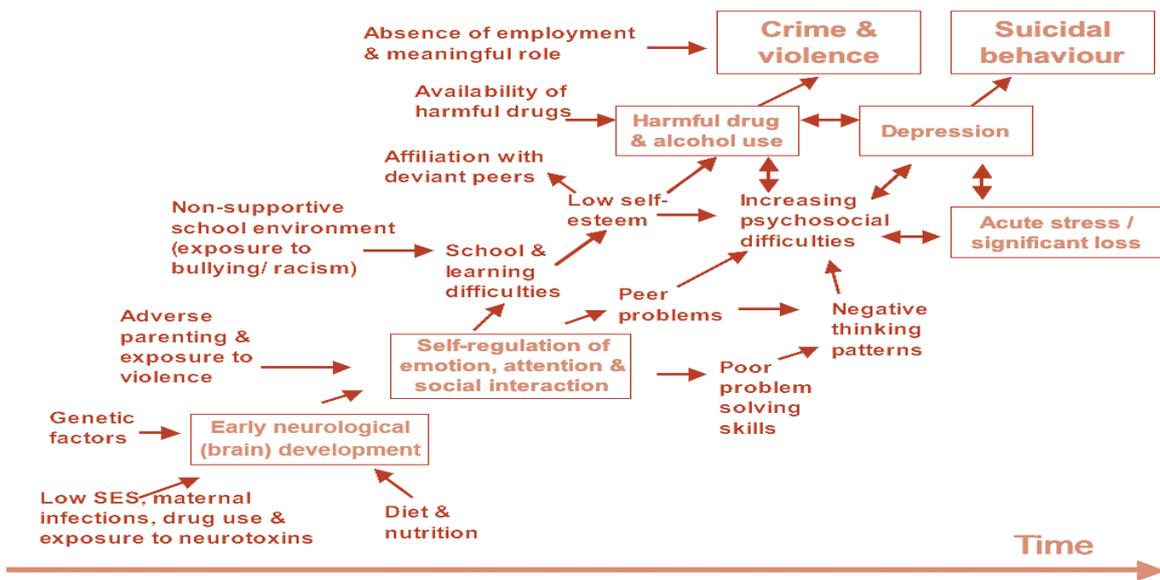
Pathways to problematic or harmful substance use are influenced by the differing contexts within which the young person lives; why, how and where substances are used, and other factors such as gender and neurobiology. A recently proposed 'causal pathway' is presented below. It draws from research that describes pathways interconnecting cascades of events from key points in life. These pathways identify conditions in the earlier years of life that can cumulatively cause social and

economic disadvantage later on in life. Such life pathways may lead either towards resilience and positive outcomes, or negatively towards a reduced capacity to respond to life events, which can lead to adverse social outcomes.

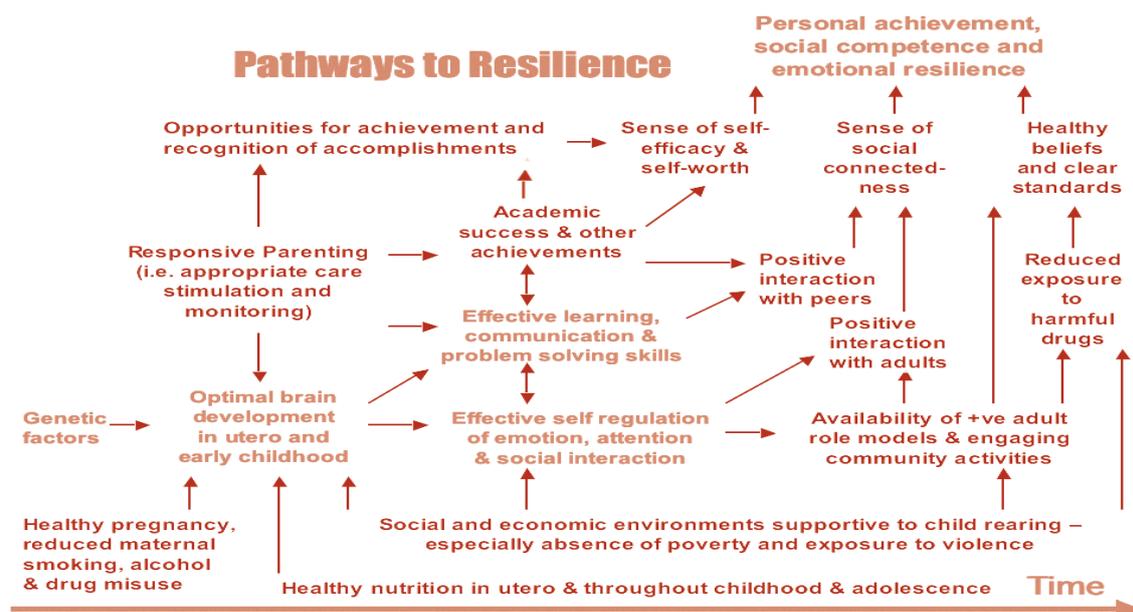
Understanding the causal pathways enables the development and implementation of effective interventions that could strategically target the critical points in the pathways. The following figure shows that interventions at critical points in the causal pathways can lead to the resilience needed to avoid adverse outcomes later on in life. It focuses on the key points in a person’s development where the greatest gains can be achieved, and, hopefully, poor health and social outcomes avoided or minimised – including substance use.

Cumulative Risk Pathways to Suicide, Violence and Crime

Understanding the causal pathways



Pathways to Resilience



Department of Indigenous Affairs (DIA), 2005, “Overcoming Indigenous Disadvantage in Western Australia Report 2005”, Department of Indigenous Affairs, Perth. Available: <http://www.dia.wa.gov.au>

Some groups of young people have been identified as being at greater risk of substance use and associated problems, usually due to a greater number of stressors in their lives, and/or weakened resilience. The burden of disease and morbidity associated with adolescent substance use tends not to be evenly distributed, but all on more vulnerable adolescents and young people now referred to as ‘most at risk adolescents’ (MARA) and ‘most at risk young people’ (MARYP). MARA and MARYP tend to be very young adolescents, same sex-attracted, minority populations/cultures, young sex workers, young workers, young parents, and those in juvenile justice/closed settings.

Of special concern are especially vulnerable adolescents from ethnic and religious minorities, children from war-torn societies, refugees, immigrants, indigenous young people, street children and other marginalised adolescents, for example same sex-attracted young people, those involved in juvenile justice systems, and adolescent parents. These adolescents may have different patterns of use and harm, and may need specific approaches targeted to their unique needs. Increased risk, of course, results from the interplay of individual, familial, community, societal and broader risk and protective factors.

Young women have particular issues in relation to substance use that require attention. There are, in addition to physiological differences, social and economic ones that impinge on their functioning and their health. Often, male partners introduce young women to substance use, and some of this use may be maintained, for some involved in sex work, by their 'pimps'. Sexual assault may be more common for young women than young men, and young women 'on the street' tend to exhibit greater levels of psychosocial distress and negative life events than do the young men. Pregnancy is also a major issue for them, and young women substance users are often viewed more negatively than young males. In addition, in many parts of the world, young females have less economic opportunities and receive less nutritious and smaller quantities of food than their brothers. All of these factors have significant health implications, especially when substance use commences.

Despite all of the above, young people who use drugs under 25 years of age are often ‘invisible’ in available data, and developmental stage-appropriate interventions are rarely available to them. Ignoring their specific needs places them at increased harm via not accessing or early disengagement from harm reduction interventions perceived as for ‘older’ opioid or alcohol users. They have health rights and are supposed to be protected. The Convention on the Rights of the Child (CRC) enshrines these rights, but breaches of this international convention appear widespread.



What is similar, what might be different between a 16 year old who injects drugs versus a 30-year-old person who injects drugs?



Did you consider?

- | | | |
|---------------------------|------------------------------|------------------------|
| • Gender | • Children/pregnancies | • Access to services |
| • Relationship experience | • Contact with family | • STIs, BBIs |
| • Sexual experience | • Brain development | • Mental health |
| • Sexuality | • Cognitive development | • Nutrition |
| • Work experience | • Drug history | • Police involvement |
| • Income | • Exposure to risks/violence | • Prison experience |
| • Living situation | • Treatment experiences | • Compulsory treatment |
| | | • Music, recreation |

Let's now consider the situation of a young person in Katmandu, Nepal; *Meet Santosh:*

- 17 year old male from Dhobighat (a slum area)
 - 2nd eldest - older brother (left home), 2 younger sisters, 1 younger brother
 - Father disabled
 - Glue use for 4 years
 - Increasing drug use recently
 - Has tried injecting x 4 - Set and Brown Sugar
 - Does not think he is HIV or HCV+
 - Worries he might have TB
 - In and out of home - with 'friends'
 - Some dealing
 - Slum ++ drug use and dealing
-
- Performed well at school, when there
 - Good at soccer
 - Rare part-time employment - food stall
 - Has leadership qualities
 - Really cares for his mother and younger sisters
 - Does not want to die



For Santosh:

- What might Santosh get from his drug use that he would see as useful or beneficial?
- What are his strengths - what we know, and what we might want to find out about?
- What are his risk factors - what we know, and what we might want to find out about?
- What does he need?
- What are his rights?



What could happen for Santosh?

- Who could assist him?
- What could assist him?
- Different if female?
- Different if aged 27?
- Different if not from Kathmandu?
- Different if from a middle class family, with father a businessman?
- Different if lived in a rural area?

What about the developmental needs of young people?



What are considered to be the developmental tasks of adolescence?

The Developmental Tasks of Adolescence – a Western view

- Develop a sense of identity
- Accept a changing body
- Accept emerging sexual needs and sexuality
- Decide on a 'lifestyle'
- Develop more mature relations with same age peers
- Gain some independence from family
- Achieve means of economic independence
- Choose a set of values, a morality to live by
- Develop a social life

 *How does this list fit for China, Nepal, Thailand, Lao PDR, Viet Nam, Pakistan, Australia...?*

 *Are the tasks different for rural and urban adolescents, males and females, those with disabilities or those not solely heterosexual?*



WHO suggests that young people need (WHO/CAH):

- ✓ Information and skills
 - They are developing
- ✓ Safe and supportive environments
 - They live in an adult world
- ✓ Services
 - They need a safety net

They also need?

- ✓ Freedom
- ✓ Structure
- ✓ Peer acceptance
- ✓ Fun
- ✓ To have their RIGHTS met

... and, **'connections'** that matter

- ✓ To family
- ✓ To a supportive adult outside the family
- ✓ To school, training, employment
- ✓ To something spiritual

(Resnick and Blum)



Session 02. Youth-Friendly Services II

By completing this session you should have knowledge of:

- ✓ What has shaped adult services
- ✓ Whether young people who use drugs need specialist services
- ✓ What does not work well for young people who use drugs
- ✓ What is more effective for young people who use drugs
- ✓ Is treatment for young people who use drugs effective
- ✓ Barriers to service access for young people who use drugs
- ✓ The characteristics of 'youth friendly services'
- ✓ The WHO keys to success for 'youth friendly services'



So many people say 'young people are the future'. If this is correct, then we must look after them. Putting them in prisons does not help. They are at a crucial developmental stage. They need specific, age-appropriate interventions. These interventions NEED to keep them connected to their families and their communities.

What has shaped adult services?

- The drugs of concern: alcohol and heroin, then ATS
- Who the services were developed for – e.g. those involved in crime, street lifestyles, periods in prison and closed settings, or middle class people
- Research – was any evidence used?
- Funding - what gets funded?
- Politicians, and
- Media?



Do youth require a different approach totally, mixed, or the same as for adults and why?



Did you consider?

Age mix:

- Very young adolescents (e.g. 12 to 15)
- Late adolescents (16-18), and
- Young people aged 19 to 25
- Adults aged 26 to 30
- Those 31 to 40, and
- Those over 40
- All of the above?



Also, mix of:

- Gender
- Users of different drugs (e.g. primary heroin users and primary ATS users)
- Young people from different classes (castes), education, cultures and religions
- Young people who have multiple and complex needs – such as, those who are injecting drugs, living with HIV, involved in sex work, have no permanent accommodation, have issues about their sexuality, and who have mental health issues which impact on their behaviour



What we know about what does NOT work well, or at all, for young people?

- Medical approaches *alone*
- Psychotherapeutic approaches *alone*
- Unreasonable and severe punishment, unreasonable consequences
- Imprisonment, Short, sharp shocks, Boot camps
- Just say 'no' *alone*
- Scare campaigns
- Many mass media approaches – 'recall' high, but behaviour change?
- NA/AA *alone*
- The 'alone' part is important



Why don't they work?

- Ignore '**why**' young people use
- Assume that reasons for use of any drug are the same
- Ignore 'loss and grief' issues in cessation of drug use
- Target too broad or too narrow
- Are delivered by inappropriate people
- Use inappropriate language/style/media
- Do not involve target young people
- Are only abstinence based
- Ignore that 'we' create the mess, and 'we' not 'they' need to be part of the solution



What seems to work better?

- Interventions based on best available evidence
- Interventions that target both risk and protective factors
- Early life-stage interventions
- Responsive approaches – balanced and with acceptable consequences for behaviour
- Multi-modal/system interventions that involve the young person, family, school, peers and community
- Cognitive behavioural approaches +

- Skills development, especially life skills
- Participatory approaches
- Attention to social determinants
- Changing ‘cultures’ – e.g. around drinking (e.g. sport)



But, does treatment work?

We know that:

- Some evidence-based treatment is usually better than none.
- No one treatment is necessarily better than another.
- Residential treatment should not be longer than about 3 months.
- Maintaining change is difficult.
- Including CBT and family involvement improves outcomes.
- Comprehensive approaches improve outcomes. Research demonstrates that effective interventions for young people can be achieved through comprehensive or linked services, which are targeted to the needs of specific groups of vulnerable young people, and which are supported by local authorities.
- Community networks form part of this and support the interventions.
- A supportive community is ESSENTIAL.

While no intervention makes a difference for all ‘at-risk’ children/young people living in risky situations, each can bring positive outcomes for many.

They reinforce:

- ✓ Relationships and opportunities

They strengthen:

- ✓ Links/connections



What are the barriers for young people in accessing services in your area?



Did you consider?

- | | |
|---|--|
| <ul style="list-style-type: none"> • There are no services • Location • Hours and waiting times • Procedures... forms ... appointments, ‘drop in’ • Attitude of staff - at all levels (security at gate/door, reception, screening, treatment/ service provision) • Staff not skilled in working with young people • Adult oriented ‘atmosphere’ | <ul style="list-style-type: none"> • Age restrictions, laws • Mix adults and young people – potential conflicts? • Gender and race issues - all welcome? • Lack of privacy/ confidentiality • Cost • Family not with them, or opposed to them seeking assistance • Lack of support • Not feeling ‘entitled’, welcome |
|---|--|

- Services needed not available, and/or [links to these not available](#)

Should young people be ***motivated*** to use and benefit from services?

Motivated clients?

- Most young people are “reluctant” clients, or are “simply looking”.
- Our role is to raise awareness and engage the young person, and to facilitate motivation - not expect or judge it.
- Motivation usually grows via this engagement process.



What are Youth-Friendly Health Services?

The term ‘adolescent friendly health service’ is widely used, but poorly understood. WHO has attempted to identify a framework for adolescent-friendly services.

A framework:

- ✓ Safe and supportive environments
- ✓ Meaningful relationships with adults, peers and partners
- ✓ Structures and boundaries for behaviour
- ✓ Encouragement of self-expression
- ✓ Educational, economic and social opportunities
- ✓ Opportunities for participation with their contributions being valued
- ✓ Minimal risk of injury, exploitation, or disease

Quality adolescent friendly services are:

- | | | |
|--------------|----------------|-----------------|
| ✓ Available | ✓ Rights based | ✓ Comprehensive |
| ✓ Accessible | ✓ Acceptable | ✓ Effective |
| ✓ Equitable | ✓ Appropriate | ✓ Efficient |

They:

- ✓ Have privacy and confidentiality ensured
- ✓ Involve of target adolescents in planning and, where appropriate, delivery of services
- ✓ Open when and where necessary
- ✓ Provide outreach and peer led interventions provided
- ✓ Have an evidence base for services provided
- ✓ Have good links for efficient referrals
- ✓ Have good monitoring and evaluation processes



What can assist in services becoming more ‘youth friendly’?



Did you consider?

- ASK young people, especially target youth!
- Consider physical aspects of facility - location, appearance, furnishing, image on walls, movement, waiting areas, staff style, music...

- Opening hours?
- Considering 'reception' and 'security'
- Observing staff interactions, mix and 'style'
- What activities comprise the 'programme'
- Ensuring capacity for participation in as many areas of service as possible - planning, service delivery, monitoring and evaluation
- Building staff capacity to become more 'youth friendly'
- Identifying what 'type' of staff (e.g. gender, mix, roles, etc.)?
- Identifying what information do staff need?
- What skills do they need?
- Employ Youth Peer Educators/Youth Outreach Workers?
- Who to employ?
- What training/ refreshing is needed?
- How to support and sustain (and protect) young staff?
- And, remember, young staff 'grow up'! What are the implications of this?



Some studies have found that, the following **attributes** for workers assist in engaging young people in helpful relationships:

- ✓ Humour
- ✓ Relating at the level of the youth
- ✓ Employing non-threatening behaviours
- ✓ Developing a trusting relationship, maintaining consistent limits, being honest
- ✓ Sharing common interests, being 'friendly', a good listener, able to 'play', actively involved,
- ✓ 'Knowing' what might be needed (being in tune)
- ✓ Having access to resources.

Also identified were some behaviours/qualities of workers for maintaining helpful relationships:

- ✓ Being reliable, demonstrating care, providing support
- ✓ Provision of a 'safe' environment, providing a 'sense of belonging'
- ✓ On-going contact
- ✓ Maintaining trust
- ✓ Being honest, allowing freedom for the youth to make choices

Young people need a safe and supportive environment within which to grow health. WHO has identified the following as crucial in developing and sustaining safe and supportive environments:

- ✓ Meaningful relationships with adults, peers and partners
- ✓ Structures and boundaries for behaviour
- ✓ Encouragement of self-expression
- ✓ Educational, economic and social opportunities
- ✓ Opportunities for participation with their contributions being valued
- ✓ Minimal risk of injury, exploitation, or disease

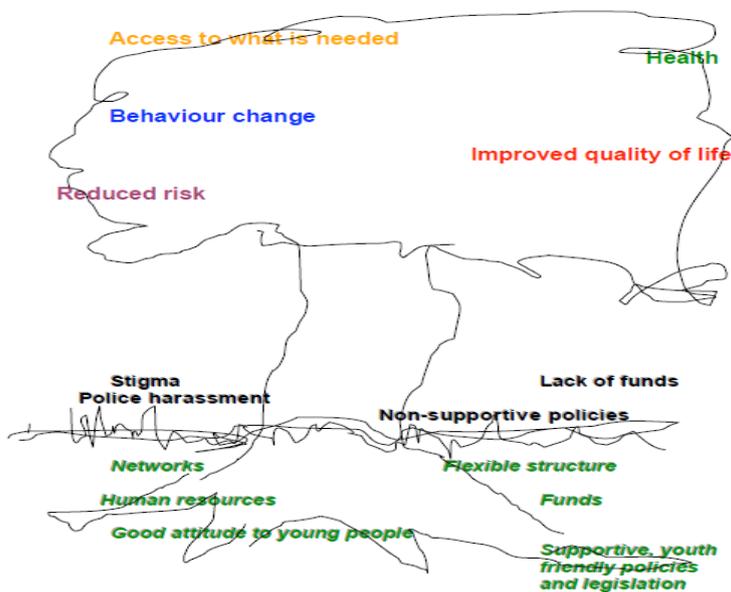
WHO/CAH

Supportive and facilitating policies and legislation make this task easier.

The Tree Exercise:

The tree drawn by a group of workshop participants represents growing youth friendly services:

- A. Roots can comprise networks, human resources, good attitude, supportive youth policies, flexible structure...
- B. Risks can include non-supportive policies, stigma, police harassment, lack of funds...
- C. Outcomes can include behaviour change, improved quality of life, health, reduced risk...



Summary: WHO suggests that Keys to Success in developing youth friendly services are to:

- ✓ Put youth at the centre
- ✓ Address multiple health problems
- ✓ Build on and link existing interventions in various settings
- ✓ Combine interventions
- ✓ Respect cultural diversity
- ✓ Create safe and supportive environments
- ✓ Encourage positive adult attitudes and behaviours

See Resource CD/USB: 5, 6, 9, 11, 20, 39, 47, 48, 54, 61, 63, and 64.

Session 03. Harm Reduction For Young People Who Use Drugs

By completing this session you should have knowledge of:

- ✓ Harm reduction
- ✓ Hierarchy of risk
- ✓ Rationale for harm reduction for young people
- ✓ Their local and national situation regarding harm reduction for young people
- ✓ Principles of harm reduction
- ✓ Human rights and harm reduction
- ✓ A package or range of harm reduction interventions for young people who use drugs
- ✓ What can be done to provide evidence informed harm reduction for young people who use drugs

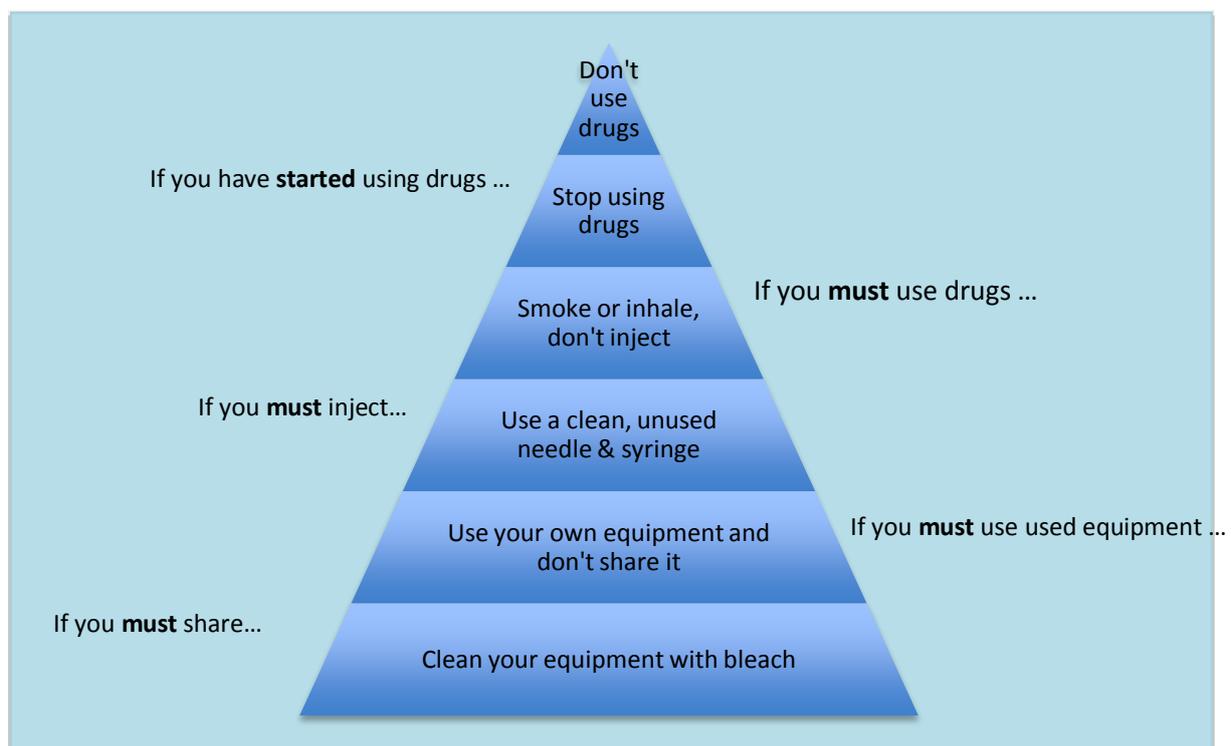


What is harm reduction?

A definition:

'Harm reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.

Hierarchy of objectives (or: "Easier said than done!")





Why should harm reduction be available for young people who use drugs?



Did you consider?

- ✓ Drug use, including IDU, initiated in adolescence/early adulthood
- ✓ Ignoring their specific and developmental needs places them at increased harm
- ✓ Earlier initiation to drug use exposes young people to more risks
- ✓ Earlier/riskier sex
- ✓ STI
- ✓ HIV, hepatitis C
- ✓ Mental health
- ✓ Social and economic exclusion
- ✓ Legislation may prohibit access to drug treatment/harm reduction – rights of young people violated, developmental needs ignored
- ✓ Coverage of voluntary treatment/harm reduction poor in most of Asia
- ✓ Few services
- ✓ Adult-focused
- ✓ Extremely limited community-based provision
- ✓ Over reliance on compulsory treatment, especially in closed settings – which is ineffective – relapse rates 80%+
- ✓ Health and Human Rights, Convention on the Rights of the Child



What evidence is there for a harm reduction approach within your service?



What evidence is there for a harm reduction approach within your country?



Are harm reduction interventions available for young people under 25 years of age? Under 18 years of age?



A position statement from the International Harm Reduction Association:

Harm reduction refers to policies, programmes and practices that aim to reduce the health, social and economic consequences of the use of legal and illegal psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself.

Harm reduction complements approaches that seek to prevent or reduce the overall level of drug consumption. It is based on the recognition that many people throughout the world continue to use psychoactive drugs despite even the strongest efforts to prevent the initiation or continued use of drugs. Harm reduction accepts that many people who use drugs are unable or unwilling to stop using drugs at any given time. Access to good treatment is important for people with drug problems, but many people with drug problems are unable or unwilling to get treatment.

Furthermore, the majority of people who use drugs do not need treatment. There is a need to provide people who use drugs with options that help to minimise risks from continuing to use drugs, and of harming themselves or others. It is therefore essential that harm

Principles

The harm reduction approach to drugs is based on a strong commitment to public health and human rights.

Evidence based and cost effective

Harm reduction approaches are practical, feasible, effective, safe and cost-effective. Harm reduction has a commitment to basing policy and practice on the strongest evidence available. Most harm reduction approaches are inexpensive, easy to implement and have a high impact on individual and community health. In a world where there will never be sufficient resources, benefit is maximised when low-cost/high-impact interventions are preferred over high-cost/low-impact interventions.

Incremental

Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative rather than coercive, and are grounded in the needs of individuals. As such, harm reduction services are designed to meet people's needs where they currently are in their lives. Small gains for many people have more benefit for a community than heroic gains achieved for a select few. People are much more likely to take multiple tiny steps rather than one or two huge steps.

Dignity and compassion

Harm reduction practitioners accept people as they are and avoid being judgmental. People who use drugs are always somebody's son or daughter, sister or brother or father or mother. This compassion extends to the families of people with drug problems and their communities. Harm reduction practitioners oppose the deliberate stigmatisation of people who use drugs. Describing people using language such as 'drug abusers', 'a scourge', 'bingers', 'junkies', 'misusers', or a 'social evil' perpetuates stereotypes, marginalises and creates barriers to helping people who use drugs. Terminology and language should always convey respect and tolerance.

Universality and interdependence of rights

Human rights apply to everyone. People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment. Harm reduction opposes the deliberate hurts and harms inflicted on people who use drugs in the name of drug control and drug prevention, and promotes responses to drug use that respect and protect fundamental human rights.

Challenging policies and practices that maximise harm

Many factors contribute to drug-related risks and harms including the behaviour and choices of individuals, the environment in which they use drugs, and the laws and policies designed to control drug use. Many policies and practices intentionally or unintentionally create and exacerbate risks and harms for young people who use drugs. These include: the criminalisation of drug use, discrimination, abusive and corrupt policing practices, restrictive and punitive laws and policies, the denial of life-saving medical care and harm reduction services, and social inequities. Harm reduction policies and practice must support individuals in changing their behaviour. But it is also essential to challenge the international and national laws and policies that create risky drug using environments and contribute to drug related harms.

IHRA

Human Rights:



Why is it crucial to use a human rights approach to harm reduction for young people who use drugs?



From an ethical perspective, no one should be denied their human rights due to drug use, drug dependence or because they have been convicted of a crime. Our work is about the reduction of drug

related harms without judgment and with respect for the inherent dignity of everyone, regardless of whether they use drugs (licit or illicit).

- *In relation to public health, the evidence is clear.*
- *International drug control policies and national policies upon which they are based have created a system within which people who use drugs are stigmatised and driven to the margins of society.*
- *A legal and policy system that stigmatises and marginalises a specific group in this way is one within which human rights abuses are more likely to be perpetrated against that group.*
- *When people who use drugs are at risk from and suffer human rights abuses, harm reduction services can never properly function, and drug related harms, including injecting-driven HIV, will be made worse.*

As such, a human rights-based approach is essential for evidence based public health interventions to be effective.

A human rights-based approach to international drug policy is one that takes human rights as a starting point, rather than an afterthought. A human rights-based approach to drug policies requires, for example:

- *Reframing the aims of drug control in line with human rights obligations.*
- *Restructuring the ‘pillars’ of drug control (supply and demand reduction).*
- *The development of a new system of indicators for drug control programmes.*
- *The interpretation of the international drug conventions in line with international human rights law.*
- *The development of international guidelines on human rights and drug policies to guide national implementation.*
- *The repeal or amendment of abusive legislation and the amendment of abusive policies or practices.*
- *The development of practical tools to assist in the development of drug policies and programmes at international and national level that are compliant with human rights.*
- *Human rights training for police, drug treatment staff, parliamentarians, civil servants and affected communities etc.*
- *A focus on vulnerability including improved data collection to uncover patterns and target responses – this includes a focus on children and young people.*
- *A holistic approach looking at the structures and policies surrounding drug use, production and trade (such as income inequality, poverty, housing, conflict and violence etc).*
- *A strong gender focus in policies and programmes.*
- *Meaningful participation of affected groups including people who use drugs.*
- *Transparency in international and national decision-making.*
- *Accountability, including the implementation of systems of redress for victims of human rights violations committed in the name of drug control.*

International Harm Reduction Association



A Comprehensive Harm Reduction package:

What is the Comprehensive Package of Interventions?

An effective and evidence-based response is required to curtail the rapid spread of HIV among drug-using populations, but also to prevent transmission to the general population. In order to achieve these goals, according to UNODC, WHO and UNAIDS, the implementation of a ‘comprehensive package’ of nine interventions for the prevention, treatment and care of HIV among people who inject drugs is essential. This package – also widely referred to as the ‘harm reduction’ approach – consists of interventions for which there is a wealth of scientific evidence supporting their efficacy in preventing the spread of HIV2:

Comprehensive Package:

1. Needle and syringe programmes (NSPs) - access to clean injecting equipment.
2. Opioid substitution therapy (OST – e.g. Methadone Maintenance, Buprenorphine, Suboxone, Naltrexone...) and other drug dependence treatment.
3. HIV testing and counseling.
4. Antiretroviral therapy (ART).
5. Prevention and treatment of sexually transmitted infections.
6. Condom distribution programmes for people who inject drugs and their sexual partners.
7. Targeted information, education and communication for people who inject drugs and their sexual partners.
8. Vaccination (as available), diagnosis and treatment of viral hepatitis (HBV, HCV).
9. Prevention, diagnosis and treatment of tuberculosis (TB).

A broader view – especially for young people?

The nine components above grew out of concern for the link between HIV and IDU. What about other aspects that can impact on risk, and/or make prevention and treatment more difficult for young people who use drugs?

For young people, and those who do not inject their drugs, it is important to add:

For example:

- Unstable or unsuitable accommodation
- Poor physical health, including nutrition
- Poor mental health
- Poor child care
- Inadequate education
- Poor access to training
- Poor access to employment
- Poor access to legal assistance
- Parenting
- Reducing transitioning to IDU
- Building community intervention capacity to enhance diversion from closed settings
- IEC - information, education and communication (IEC) programmes on HIV, drug use and other blood-borne infections for people who inject drugs
- Community mobilisation and outreach to reach people who inject drugs who do not or cannot access health services

- Advocacy for harm reduction and access to services

Application: Examples from youth focus groups in Katmandu and Bangkok, which explored how services could be more ‘youth friendly’:

Kunming focus groups with young patients in MMT, (n = 20, aged 21-24):

What services, interventions, and activities would they like:

Knowledge

- A holistic understanding to the MMT related knowledge and how long actually the treatment should be?
- Learn knowledge of how to nurture a child (new born baby and young child)
- Understand mother to child transmission of Hepatitis C
- Learn relevant knowledge of pregnancy and MMT

Activities relate to professional or vocational training

- Vocational and skills training: computer operation, driving, making cakes, tea brewing, small business
- Find a job via help
- Obtain micro-credit loan to open small shops such as food stand

Other

- Learn how to communicate and get along with other people
- Helping others, such as doing a favour for other people or something meaningful, for example, to do volunteering work for Elders Rest-house, Orphanage House, etc.
- Leisure and fun activities and could talk or chat with peers.
- ‘Collision Meeting (one of activities of Daytop, which is used to relieve the emotions of group members)
- Individual psychological counselling, if needed (such feeling sad or being hurt)
- Go to parks for group activities
- Outings
- Physical activities: such as swimming, badminton, go to gym, play cards, climb mountain, and sports competition.

Bangkok focus groups in slum community: (n = 25, aged 15-21):

What they wanted:

- Want spaces to talk, discuss, get educated, have fun
- Want job training, recreational activities (e.g. sport, music) and gym; and training in home-based crafts for sale in markets
- Want community sensitised to their needs

Kathmandu 9 focus groups with young people in slum communities (Male and female, 17- 23 average age 20-21, n= 79 (72 male, 7 female), some already parents

- Locations: 8 in slums, drop-in-centre
- Drug use: most IDUs, buprenorphine, phenergan [and antihistamine], 'set' [mix buprenorphine, antihistamines, benzodiazepines such as diazepam], 'brown sugar' x 2-3 times/day, cocaine, alcohol
- Difficulties faced by young people:
 - police, health, family problems, no work, discrimination, 'mental torture'
- Workers - what they want:
 - Some wanted peer (about same age) outreach workers, 2 working together, but more wanted older outreach workers,
 - Some wanted same gender, most did not mind M/F mix,
 - Ex-PUDs a preference for most as outreach workers

What they wanted:

- Meeting basic needs:
 - Near where they live/hang out, and at drop-in-centres
 - Safety and respect
 - Food and vitamins
 - Shelter at night
- Good opening hours
- Outreach workers:
 - Punctual, respectful, friendly, non-dominating
 - Slightly older than themselves
 - Ex-users preferred
 - Men did not mind if male or female; women preferred female workers
- Meeting health needs:
 - Information and education about drugs
 - Counselling
 - Medical checks, medicines
 - HIV voluntary counselling and testing
 - Needle syringe programme
 - Buprenorphine
 - Condoms
 - Detoxification services
- Activities to distract and to educate
 - TV, movies, computers, sports
 - Education: English classes, books, IT
 - Vocational training: motorbike repair, handicrafts
 - Interactive discussion groups
 - Training as peer outreach workers
- Family and relationships:
 - To bring their partners
 - Some wanted family meetings



How to meet these and other needs and provide enhanced ‘youth friendly harm reduction’ in your setting?



What is essential?



What is desirable?

How to:

- Put youth at the centre
- Address multiple health problems
- Build on and link existing interventions in various settings
- Combine interventions
- Respect cultural diversity
- Create safe and supportive environments
- Encourage positive adult attitudes and behaviours

What needs to be done in your service to provide a board range of youth friendly harm reduction?

For example, how to create or provide for:

- A **safe** environment – for staff and young people
- An encouraging environment
- Appropriate activities
- Identifying and managing physical health issues
- Nutrition and Wellbeing encouraged and supported
- Identifying and managing mental health issues
- Appropriate housing/accommodation
- Identifying and meeting education, training and employment needs
- Knowing if you are making a difference – data systems
- Respecting and providing for gender issues and sexuality issues
- Respecting and providing for disability issues
- IDs, Health cards,
- Family involved (as appropriate)
- Supervision, support and development of peer educators/youth leaders
- Provision, availability and use of equipment (e.g. NS, other injecting equipment condoms)
- Key networks identified and engaged
- Key stakeholders identified, linked and engaged
- Legal issues addressed
- Advocacy for young clients, service, and young people who use drugs generally
- Staffing
- Acceptable IEC (i.e. acceptable to young people, their families, the community and the authorities – e.g. schools, public security)
- Transitioning to injection drug use

See Resource CD/USB: 3, 5, 6, 10, 12, 15, 21, 30, 51, and 52.

Session 04. NSP, Outreach, Drop-in-Centres, Risk and Safety

By completing this session you should have knowledge of:

- ✓ Needle and syringe programs (NSP) – myths and evidence
- ✓ Rationale and practice of Outreach
- ✓ Necessary components of an Outreach Kit
- ✓ Rationale and practice for Drop-in-centres
- ✓ Infection risk minimisation
- ✓ Management of risk and safety concerns

Needle and syringe programmes



What is a needle and syringe programme?

A “Needle and syringe programme” (NSP) is any programme that distributes clean needles, syringes and other injecting equipment to people who inject drugs

An important aspect of NSP is that they distribute not only needles and syringes, but also other injecting equipment. For example:

- Tourniquets
- Sterilising swabs
- Sterile water
- Bleach or other disinfecting agents
- Mixing cups/spoon
- Pill filters
- Equipment for basic wound care

A second important aspect of NSP is that they collect used needles and syringes: When clients come to the NSP to collect new equipment, they may also return their used equipment for safe disposal. The NSP staff may walk around the neighbourhood in which the NSP is situated and collect injecting equipment that has been discarded on the ground.

Finally, NSP staff provide clients with information and education about:

- HIV and hepatitis C prevention
- Safer injecting techniques to prevent abscesses and vein damage
- General healthy lifestyle advice
- Where to go for other services, such as HIV counselling and testing or drug treatment
- Wound care
- And, increase the availability of clean equipment



What about young people under 25 years of age? Are there any barriers to them accessing a NSP in your service/country? What if they are under 18 years of age? [Note there may be some legal barriers to any NSP provision in your country]

Frequently asked questions about NSP



Why are people who inject drugs given needles and syringes?

HIV and other blood borne viral infections (BBVI) such as hepatitis C spread through the sharing of needles, syringes and other equipment used to inject drugs. People who inject drugs are given clean needles and syringes to help prevent the transmission of these infections. This protects the whole community against HIV and other BBVI.



Isn't it better to stop people from using drugs, rather than giving them needles?

Despite education about the harms of drug use and access to drug treatment, there will always be people who continue to inject drugs. Providing needles and syringes to people who inject drugs has two main benefits: it reduces the risk of HIV infection and it keeps them in regular contact with NSP workers who can offer advice and referrals on a range of health issues.



If clean needles and syringes are easily available, won't this encourage people to start injecting drugs or to use more drugs?

There is no evidence that providing an NSP encourages people to start injecting drugs. Among people who already inject drugs, an NSP can help to reduce drug use by referring people to treatment services. The amount of a drug that a person uses is related to factors such as price, purity and availability of drugs. There is no evidence that providing clean needles and syringes encourages people to increase their drug use.



If clean needles and syringes are easily available, will that make it less likely that a person will enter treatment for their drug use?

Entering drug treatment is related to factors such as personal motivation and treatment availability. There is no evidence that providing clean needles and syringes discourages people from entering treatment. In fact, going to an NSP may make it more likely that a person will enter drug treatment, because they are in contact with workers who can refer them to treatment services.

Issues to consider when establishing an NSP



How will you manage your relationship with the community and law enforcement?

It is crucial that the community that you are operating in understands why you are providing NSP service. Hold regular community meetings to talk about why an NSP is necessary. Meet regularly with law enforcement to discuss how the police can help with HIV prevention efforts. For example, the police should not use the NSP as a way of identifying young people who use drugs for arrest, as this will discourage NSP use.



Will the NSP be located in a building, or conducted on an outreach basis?

A fixed site NSP in a building can provide a comprehensive service. It can even be located in the same building as other services for people who use drugs, such as a health clinic offering HIV counselling and testing or methadone treatment. An outreach service is useful for making contact with ‘hidden’ drug users, such as women or young people, or any other person who is unwilling to attend a fixed site NSP. A combination of a fixed site NSP with an outreach service is an excellent service model.



What equipment will you provide?

What drugs will clients be injecting? You may need to provide different gauge (size) needles for injection of some drugs.



How many needles will you provide to each client?

As many as the client requests? As many as requested up to a certain limit (e.g. 20 needles and syringes per client per visit)? Or only on an exchange basis (one new needle for each used needle returned)?

There is evidence that the largest reductions in HIV risk behaviour occur when clients can take unlimited needles and syringes. However, this can expose clients to risk – if they are stopped by police while carrying needles and syringes, this may be used as evidence that they are a drug user.

A client taking multiple needles and syringes may engage in ‘secondary exchange’, meaning they give their extra injecting equipment to other people who inject drugs. This can be a useful way for ‘hidden’ drug users, such as women or young people, to access clean injecting equipment. However, the client can take advantage of this situation by demanding money in exchange for needles and syringes.

Requiring clients to return used needles and syringes in exchange for clean ones is a useful way of ensuring that needles and syringes are disposed of safely. However, it can expose clients to risk if police searches him or her. Also, it is unlikely that a person wanting clean injecting equipment will always have used equipment for exchange.



How will you assist clients to dispose of equipment safely?

An NSP should have appropriate containers for disposing of used needles and syringes that clients may be carrying. Provide clients with small rigid containers, if available, or encourage use of empty glass or plastic bottles that can be carried in a bag or pocket so that used needles and syringes can be disposed of straight away. Particularly useful are containers that prevent removal of a needle and syringe once it has been placed inside.

NSP staff can walk around the area surrounding the NSP to collect needles and syringes that have been discarded on the ground.



References and recommended reading

- Dolan, K., MacDonald, M., Silins, E., Topp, L. (2005). Needle and syringe programs: A review of the evidence. Canberra: Australian Government Department of Health and Ageing. Available from <http://bit.ly/63JVEZ>.
- National Centre in HIV Epidemiology and Clinical Research (2009). Return on Investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia. Sydney: National Centre in HIV Epidemiology and Clinical Research, University of New South Wales. Available from <http://bit.ly/5gBW7M>.
- World Health Organization (2004). Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Geneva: World Health Organization. Available from http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf

Outreach



What is “outreach”?

“Outreach” refers to making contact with people who use drugs in their usual surroundings in order to provide education and information about risk behaviours.

Outreach programmes first developed in the late 1970s and early 1980s. The aim was to provide hepatitis B education to risk groups such as men who have sex with men, people who inject drugs (PWID) and sex workers. In the 1980s, the focus of outreach shifted to HIV prevention.

Outreach workers visit areas where PWID gather and provide education about risk reduction and HIV prevention. Many outreach workers also distribute clean injecting equipment, bleach for cleaning injecting equipment and condoms.



Why outreach?

It is hard for traditional office-based services to make contact with people who inject drugs. Being known as someone who uses drugs stigmatises a person. People who use drugs usually try to hide their activities from their families and official agencies as they are embarrassed, ashamed or fear punishment.

Many people who use drugs may have had bad experiences with health and welfare agencies. They may have been discriminated against because they used drugs.

In some areas, presenting to health services with drug-related problems can lead to being officially registered as an illicit drug user or being prosecuted for drug crimes. People who use drugs are wary of approaching health and welfare services.



Outreach developed because many young people who use drugs in need of assistance would not approach services – the services had to go to them.



Effectiveness of outreach as an HIV prevention strategy

A review of the literature concluded that outreach programmes:

- ✓ Are effective for contacting out-of-treatment young people who inject drugs.
- ✓ Provide young people who inject drugs with information, education and equipment to change their HIV risk behaviours.
- ✓ Reinforce HIV prevention messages through education and information.

PWID who use outreach services:

- ✓ Inject less often.
- ✓ Are more likely to use condoms.
- ✓ Are more likely to enter drug treatment.
- ✓ Are more likely to stop using drugs, if that is their goal, compared to in people who inject drugs who do not use outreach services.



Services provided by outreach workers

The services provided by outreach workers target the harms caused by injecting drug use and unsafe sexual activity. Services include:

Education and information:

- ✓ Safer injecting e.g. not sharing any injecting equipment, correct injecting technique.
- ✓ HIV/AIDS and other viruses such as hepatitis B and hepatitis C.
- ✓ Vein care to help prevent abscesses.
- ✓ What to do if someone overdoses.
- ✓ Information can be passed on in conversation with PWID or in written form.

Essential equipment:

- ✓ Clean injecting equipment – including needles and syringes, sterile water for mixing drugs and alcohol swabs for wiping the injecting site.
- ✓ Bleach for cleaning used needles and syringes.
- ✓ Condoms.
- ✓ **See below for first aid essentials**

Counselling and referrals

- ✓ Drug treatment services.
- ✓ Voluntary HIV counselling and testing.
- ✓ HIV treatment.
- ✓ Other sexually transmitted infection and blood borne virus testing and treatment.
- ✓ Assistance with housing, medical needs and legal issues.

Collection and disposal of used injecting equipment

Monitoring of HIV medication adherence

Emergency medical assistance, and wound care



Who does outreach?

A broad range of skills and experience can be utilised in outreach:

- ✓ Social workers
- ✓ Counsellors
- ✓ Nurses
- ✓ Specialist drug and alcohol workers
- ✓ Current and former young people who use drugs
- ✓ Volunteers
- ✓ ***Ideally, one of outreach team should have health assistant training, and all should have up to date first aid training***



Where does outreach take place?

Outreach can take place wherever young people who inject drugs gather. Examples include:

- Public places where young people who inject drugs gather to buy or use drugs. There may be particular areas of cities that are known for their drug scenes; these are places where outreach workers would go.
- In the homes of young people who inject drugs. An outreach worker with a good rapport with a group of users might hold a group education session in the home of one user.



Subgroups of people who inject drugs to be reached

There are many subgroups of people who inject drugs to be reached:

- Users of different drugs e.g. heroin, amphetamines, cocaine
- Women
- Sex workers
- Youth
- Ethnic minorities and indigenous groups
- People living with HIV/AIDS (PLWHA)
- Prisoners and ex-prisoners
- Homeless people

Different sub-groups have different needs; for example, sex workers in particular might require sexual health services and information and education about condom use, whereas PLWHA are more in need of referrals to HIV treatment and counselling.



Are there any specific outreach issues for young people under 25 years of age?



What are equipment essentials for an outreach worker to carry in their bag?





Did you consider?

- Injection equipment
- Disposable gloves
- Some essential medicines – e.g. paracetamol, Betadine liquid, antiseptic cream, antihistamine tablets, ibuprofen, silver sulfadiazine (for burns)
- Bandages, including crepe
- Paper tape, Leucoplast
- Normal saline liquid
- Referral cards
- Condoms and lube
- Antiseptic hand wash
- Scissors
- Tweezers – dissecting and artery forceps
- Tourniquet
- Sterile water
- Dry gauze
- Dressing pads
- Tongue depressor and/or airway adjunct (e.g. oropharyngeal airway - If possible, and legal – Narcan/Naloxone)
- Sterile bowl
- Band aids
- Ambu Bag (for assist rescue breathing), bag valve mask
- OPA)
- ID cards
- Hand phone
- Notebook
- Duress alarm
- Emergency number



Drop in centres



What is a Drop-In Centre?

A drop in centre is a doorway for a young person who uses drugs to a welcoming and caring environment:

- It is a setting that communicates understanding and acceptance of the individual.
- It is a safe place free from violence, harassment and discrimination.
- It is a place to build a relationship of trust based on sincerity and respect.



Why are drop-in-centres useful for young people who use drugs?



What can a Drop-In centre provide?

- Basic health care for clients who do not have easy access to health service
- Basic nutrition
- Assistance, referral and support needed for medical treatment and specialized care
- Basic education on:
 - Drug use and its consequences
 - Rights and responsibilities
 - Health and hygiene
 - Sexual health
- Facilities for shower, laundry, rest and recreation
- Referrals for rehabilitation and where possible skill building, income generation opportunities and job-placement
- Any other support services as may be needed, dependent on resources
- Time out from a chaotic street life



Who can a Drop-In Centre be for?

- Any young person using drugs
- Relatives of people who use drugs
- People who may need information on HIV testing
- People who are HIV positive without access to care
- Marginalized individuals seeking medical and/or social assistance
- People living in the same locality/community needing information; or services and may not be using drugs
- Donors, agencies, media, researchers, other service providers and even law-enforcement people



How do we respond to people who come to the Drop-In Centre?

First of all:

- Make every effort to help the concerned person feel valued and comfortable
- Take consent for testing and medication and emphasize confidentiality
- Listen to the 'whole story'
- Observe the physical and emotional condition and jointly agree to an appropriate response
- Attend to needs identified e.g. nutrition, wound management etc.
- Identify follow-up action e.g. referral to hospitals, social support etc.

Assess health-risks of the person

- Take the medical history (by health assistant or doctor)
- Enquire about type of drug and mode and patterns of use
- Take history of exposure to contaminated blood and other risk behaviours
- Assess the level of knowledge related to disease like TB, STIs, HIV/AIDS and Hepatitis CV

Assess social wellbeing of the person

- Find out about any mental health problems
- Enquire about family history
- Note down current residence
- Find out about legal status
- Ask about sexual behaviour and practices
- Make note of education, skills, jobs, etc.



How to prevent the transmission of HIV and other blood borne diseases in drop-in-centres:

Since we do not know who is infected, we must act as if everyone is:

- Always wear protective gloves when dressing wounds or coming into contact with broken skin
- Always wash your hand with soap and water after physical examination of the client
- Always make sure to protect your feet with proper footwear
- Because of high prevalence of TB among people that seek our help the attending staff should wear a face-mask
- Blood or other discharges should be treated immediately with bleach
- The floors should be cleaned regularly during the day with disinfectants
- Medical staff should always use disposable needles and syringes and destroy them after use;
- Other reusable instruments should always be sterilized in an auto clave (10 min) or boiled for 20 minutes after use
- Used dressings should be kept in separate out-of-reach container and must be destroyed by burning after spraying with bleach and then disposed separately. (This is out of concern from the people who may get infected when they cycle or sort rubbish!)
- Always network with local hospitals and clinics to dispose contaminated materials through specialized equipment (ensure equipment is operational...)
- Condoms should be made available to all and demonstration on its proper use should be conducted with emphasis on the use of water-based lubricants only
- Whenever legally possible tourniquets should be made available to young people who inject drugs
- Sharing of all other injecting equipment like cookers and filters should be discouraged due to the easy spread of HBV and HCV
- An expectant mother who is HIV positive should be given information on all available options and support to enable her to make her choices



Useful tips for those wanting to start a Drop-In centre

- Drop in centers need to be located where young people use drugs or within easy reach of them
- Explain to the community what the drop in center is all about, why it is needed and how they will benefit
- Deal with issues of the communities fear:
 - Worries about their children being harassed by young people who use drug
 - Their watching drug use

- Their cars and homes being vandalized
- Drug use equipment such as pipes, needles, syringes found near their doorstep
- Involve the community in activities of the centre:
 - World AIDS day against illicit drugs and trafficking
 - Use community festivals to create awareness
 - Keep the community informed of what is happening



Violence

- In case of violence make sure the management is informed
- The staff who has a good relationship with the client concerned should try to intervene verbally
- Failing this the person must be told that the police will be called
- Those who are not involved must be moved out of the area
- The police may be called or the centre may be temporarily shut down in an emergency
- Make sure that clear procedures in dealing with violence exist



Drug selling and using

- Any one who is seen selling or using drugs should be made aware of the rule that prohibits such activities
- Selling drugs puts clients, staff and the centre at risk of ill repute and danger
- Any action taken must be mindful of the existing laws of the land-know the law clearly



Networking for access to additional needed resources

- Ensure a good working relationship with health care institution like public hospitals, welfare agencies, legal aid bodies and the police
- Ensure that there is a good understanding with treatment centers like detoxification and rehabilitation centers as well as other Drop-In Centers
- While using the media as a tool to generate resources, confidentiality must be maintained
- Religious institutions, hotels and public service organizations are a source of additional support (often in kind)
- Recognize that other services like detox-centres or night shelters are needed to provide optimal care – make sure that you have friends among other NGOs
- Be sure that your donors and well wishers are kept up to date with developments in your Drop-In Center



Challenges of a Drop In Centre

- There may be age or legislative or policy issues that make it difficult or illegal to provide services to young people under certain ages, or mandatory child protection reporting requirements
- To visibly change and improve the conditions of the drug using scene by decreasing violence and crime as well as improve the physical appearance of the young person who uses drugs

- To ensure that there is a beneficial relationship to the local Community that Surrounds the Drop-In Centre
- To supervise medication regimes that needs strict adherence and compliance in close co-ordination with dispensing authorities
- To be consistent in service provision
- To be able to generate sufficient resources to maintain services – staying alive
- To ensure that a system for compliance with ART is in place and that they made available to street based young people who use drugs
- Flexible working hours that suit the needs of the client
- Policies that are helpful for staff, clients and the organization



Much of what is above comes under what is known as “Low threshold services”.

Low threshold are:

- ✓ Open for longer than office hours – they are responsive to their main client “flow” hours and client consultation
- ✓ Located in or near areas where people who use drugs congregate, ideally with a discrete entrance and exit
- ✓ Run by people who use drugs, or those who can relate easily to people who use drugs – or a mix of both
- ✓ Confidential and do not require people who use drugs to provide identification or detailed personal information
- ✓ Do not impose too many rules or too much paperwork on clients
- ✓ Free
- ✓ Able to offer short waiting
- ✓ Able to offer food, a place to rest, bath or wash clothes

Later sessions also address networking, stigma, advocacy and safety issues.



Overdose or 'too high' in unsafe area.

Katmandu, 13 August 2010

Near Katmandu airport there is a nice looking golf course that caters to the rich of the capital. A shallow open gutter/creek separates the course from the main road. Some covered parts offer refuge from the sun and from the eyes of the general public and law enforcement. Young people who use drugs gather here occasionally, and at such times Youth Vision outreach workers might go there to meet their clients to offer services.

At the time the Opening Doors Project team showed up a young drug user had used too much and was maybe experiencing an overdose, and had fallen into a small creek. His peers were assisting him. He was taken to a dry spot in the shade and one of the two outreach workers checked his vital signs.



Matters seemed to be relatively OK, yet the young drug user needed constant attention, which was extended to him by (possibly) a few too many people. One peer was repeatedly beating the young man with branches he had found nearby, presumably to keep him awake... however it was also to get some 'Set' (drug vials) he had in his pocket.



It became clear that the young man had quite a lot of substances on him and that his peers were trying to make use of his current condition to get hold of some. In our presence his cigarettes were 'shared' within ten

minutes, yet no other substances appeared to have been taken. Meanwhile, the outreach workers were handing out paraphernalia, some of which were immediately put to use. One user was cleaning various parts of his body with alcohol swipes. There were numerous scars and signs of earlier injecting in the arms and the lower stomach.

After some time, when the young man began to be more alert, the project team left – the outreach workers stayed on. As soon as we reached the main road –from which one had a clear view of the proceedings below– a scuffle broke out between several of the young people. Branches and even a log were used as weapons and it might well have gotten out of hand if it wasn't for the presence of the outreach workers. Things calmed down after several minutes and the project team went on to the next site visit...



Aftermath:

At around 7 pm the same evening one of the outreach workers found a drug user from the morning scene lying under the bridge, he had overdosed was about to drown as he had fallen into the creek and had inhaled some water into his lungs. The outreach staff immediately moved the guy to a safer place and called for help. On worker informed the drop in center and the outreach van was sent to the spot. This was another case of overdose but this time it was a bit more severe. The young man was taken to the nearby hospital where the situation was underestimated by the emergency unit staff, or ignored (he was 'just a drug user'). Time and again emergency staff were informed that this was a case of heroin overdose, but nothing much was done at the hospital, in fact the emergency unit asked the outreach staff to take the young man to another hospital and have him admitted into an ICU. The doctors were saying the young man's Glasgow comma scale was too low to consider him for treatment at the emergency unit, they added he needed to be treated at an intensive care unit. Staff were requesting the medical officer there to administer a dose of Naloxone (Narcan). It seemed as if the doctors didn't have a clue what to do and only provided conservative treatment. For almost 2 hours YV staff were having dialogue with the doctor-in-charge which was worthless as they didn't appear to listen or care. YV outreach staff then tried stimulating the young man, he then started to give some response gradually and to staff astonishment, and he woke up.



What do we learn from this story?



What are some important considerations when working in injecting environments – out or indoors – where young people inject?



What are important considerations when on 'outreach'? For example when visiting 'shooting galleries', at night, near dealers, etc...?



Minimising risk:

- ✓ Work in pairs
- ✓ At all times during a field visit, staff should assess for risks to their personal safety and avoid exposing oneself to undue risk.
- ✓ Outreach workers must literally watch each other backs while on the street/communities
- ✓ Carry mobile (and possible duress alarm) and ensure fully charged!
- ✓ Ensure some good contacts with public security



Other strategies?

Needle stick injury

Wash the injury with soap and water, allow it to bleed and do not pressurize the injured area. Seek advice immediately from the local AIDS Control Programme staff for Post Exposure Prophylaxis (PEP).

General risk and safety issues:



For clients and staff how do we ensure?

- Safety
- Hopefulness/Optimism
- A sense of purpose
- A sense of movement
- Productivity
- Fun
- A sense of self
- A drug-free environment
- Order/ boundaries
- A learning environment
- A therapeutic environment
- Staff and young people's mental health and wellbeing



Risk is the unwanted subset of a set of uncertain outcomes:

- The probability that there is a threat
- The probability that there are any vulnerabilities
- The potential impact on staff, clients and the work



Reflect on your work setting – what risk and safety issues come to mind?

Did you consider:

- Injuries – in building, traveling, handling injection equipment
- Violence – verbal and physical
- Physical hazards
- Blood spills
- Air borne infections – e.g. TB, ...
- Hepatitis A, B, C
- Stress
- Staff turnover
- Burnout
- Funding concerns
- Community backlash
- Unrealistic demands – management and clients
- Clients dying, being very ill
- The complexity of some situations – leading to confusion, frustration -- stress ... depression
- Blackmail
- Problematic drug use by ex-drug user staff – Relapse
- Clients getting angry and damaging reputation and/or facilities?
- Threats – clients, public security, ...



What measures are in place to address these issues?



What measures need to be in place to address these issues?

See Resource CD/USB: 10, 12, 20, 26, 28, and 57.

Session 05. Drugs, Withdrawal, Overdose and OST

By completing this session you should have knowledge of:

- ✓ Functions of drug use by young people
- ✓ Harms that may come from drug use
- ✓ The brain and how drugs work
- ✓ The effects and side effects of:
 - Alcohol
 - Benzodiazepines
 - Amphetamine type stimulants
 - Ecstasy
 - Opioids
 - Ketamine
 - Antihistamines
- ✓ Withdrawal and its management
 - Methamphetamines
 - Opioids
 - Cannabis
 - Alcohol
- ✓ Overdose and its management
 - Opioids
 - Amphetamine type stimulants
 - Benzodiazepines
- ✓ Emergency first aid and rescue breathing
- ✓ Opioid Substitution treatment (OST)



It is important to remember at the outset that drug use by young people is not mindless, but it brings certain desired effects to the young person who uses them. For example, they may bring pleasure, relief from pain, excitement, courage, enhance sexual activity, reduce hunger, assist in forgetting problems, fitting in, and getting to sleep or keeping awake. However, like most things there can be a down side or even harms if used too much, too regularly or unsafely.

It is also important to remember that there are various patterns of drug use, such as: experimental (trying drugs),

- Recreational (using drugs to relax and have fun)
- Situational (using drugs for particular purposes, such as keeping awake)
- Harmful (when physical, emotional and or social difficulties are emerging associated with the type and level of drug use, or how they are used, for example via injection), and

- Dependent (where a strong drug habit has formed, and more drugs are needed to gain the desired effect, withdrawal symptoms begin when drug use ceases, and more intense physical, emotional and social difficulties are present)



Where do the harms from the use of drugs come from?

The DRUG

+ The **AMOUNT** used

+ The **FREQUENCY** of use

+ The **PLACE** where the drugs are used

+ The **REASON** for use

+ The **COMPANY** use with

+ The **METHOD** of use

= The Possible **HARMS**



Basics of neurotransmission and drug actions

The nervous system communicates by sending signals through networks of nerve cells. The signals are produced in response to stimulation of the nerve by another nerve, a chemical around the nerve, and in the case of nerves that carry our senses, touch or temperature. Where one nerve cell makes a 'connection' with another there is a microscopic gap between the two nerve cells called the synapse. One nerve cell releases a signaling chemical known as a neurotransmitter into the synapse where it binds to a receptor on the other nerve cell.

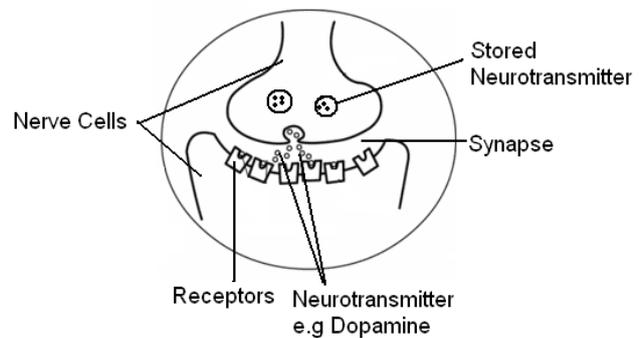


Figure adapted from: <http://en.citizendium.org/wiki/Synapse>



Drug actions

Drugs bind to receptors in the brain that are meant for normal neurotransmitters like dopamine or serotonin. This can have several effects depending on the drug:

- Can activate the nerve cell the receptor is on as if the normal neurotransmitter was binding to the receptor (e.g. heroin)
- Can activate the nerve cell the receptor is on weaker than the normal neurotransmitter and block other things binding to the receptor (e.g. buprenorphine)
- Can block the receptor so the normal neurotransmitter, and in some cases other drugs, cannot bind to it and carry out their normal function (e.g. naloxone)
- Can make it easier or harder for the nerve cell the receptor is on to become stimulated by other neurotransmitters or drugs (e.g. benzodiazepines)



The role of dopamine in drug dependence

Dopamine is an important neurotransmitter in regulating our movement, and also in our brain's pleasure and reward system. Methamphetamine is particularly associated with dopamine. When Dopamine is released we feel pleasure and reward for doing things such as sexual activity, eating foods. Most drugs of abuse also release dopamine in large quantities when a user starts out. As they use more, the amount of dopamine released decreases and the amount of receptors for dopamine also decreases. This underlies most drug dependencies (addictions). As less dopamine is released, the user must have higher doses to feel as good as they did initially.



The role of serotonin in drug dependence

Serotonin is an important neurotransmitter in regulating mood, sleep, gut function and pleasure. Ecstasy (MDMA) is particularly associated with Serotonin. Most drugs of abuse increase the levels of serotonin in the brain, which initially increases the pleasure gained from the drug and reinforces the use of that drug. When a person who uses drugs stops taking drugs their levels of serotonin drop and they have fewer serotonin receptors than normal. This can lead to feelings of sadness and depression, in addition to agitation and anxiety when a person stops taking drugs, and this can last several weeks.



What are some of the drugs commonly used by the young people you work with? What are their major effects and side effects?

Effects



Effects and side effects of the most commonly used drugs

Alcohol and Benzodiazepines

Alcohol and benzodiazepines both make it harder for nerve cells to become stimulated and transmit a signal. In this way they slow down the brains functioning. This is why they are known as depressants.

Alcohol

Alcohol is a frequently used recreational drug in many countries, and there are high rates of alcohol abuse and dependence as well. It can make the drinker feel relaxed and euphoric, lower their inhibitions, increase sexual arousal and increase their confidence, leading to its consumption in social settings. Slurred speech, impaired movement and co-ordination, mood swings, aggression and reduced intellectual ability may occur at higher doses with nausea, vomiting, loss of consciousness, reduced breathing, memory loss and potentially death occurring at still higher doses.



Long-term alcohol abuse can damage the liver, the brain, the heart, the reproductive system and the blood vessels. It can also lead to damage of the digestive system, and is associated with a higher risk of several types of cancer. Alcohol also damages fetus' and babies and so it should be avoided by pregnant or breastfeeding women.

The effects of alcohol can lead to increased risk taking behaviour such as unsafe sex, sharing needles and drink driving. Alcohol may also make criminal activity such as rape, assault or property damage more likely.

Benzodiazepines

Benzodiazepines (e.g. Diazepam, Alprazolam, Midazolam) are a commonly used medication for treating anxiety and sleep disorders, and some seizure disorders. At higher doses they produce euphoria, intense relaxation, increased confidence, reduced inhibitions, decreased co-ordination and intellectual ability, memory loss, reduced breathing, loss of consciousness and possibly death.

Injection of benzodiazepine tablets is never recommended. While you can get injectable benzodiazepine formulations, injecting pill forms of benzodiazepines puts the user at significant risk of heart, vein, brain and lung problems particularly clots, which can quite easily lead to death.

Long-term use of benzodiazepines may lead to brain damage and permanent changes in brain function, and may actually increase anxiety and aggression. Benzodiazepine use during pregnancy should be avoided as some evidence suggests that it may delay development of the baby. Benzodiazepines, like alcohol, may lead to increased risk taking behaviour particularly at the higher 'recreational' doses often taken by those not using benzodiazepines as medication.

Amphetamine Type Stimulants

*** Methamphetamine**

Methamphetamine (also known as ya ma, ya ba, crystal, shabu, point, meth, ice, speed) comes as a crystal, powder, wax (known as 'base', often discoloured yellow or red) or pill. It can be smoked, snorted, injected or swallowed.

Methamphetamine causes physical stimulation and increased energy, euphoria, a loss of appetite and increased repetitive behaviours. It can also increase sexual arousal. More negative effects include sweating, teeth grinding, hallucinations, paranoia, anxiety, uncontrollable movements, suicidal thoughts, depression, aggression and inability to sleep, with mood disturbances potentially lasting days after even a single use. It is also possible to induce a state of psychosis resembling paranoid schizophrenia after a few days of use, during which paranoia, hallucinations and aggression are common.

Long-term use is associated with malnutrition, psychosis, depression and anxiety, as well as damage to the brain. Methamphetamine may damage the unborn baby and should be avoided by pregnant women. It may also damage the heart, kidneys and liver. Poor dental health is also commonly reported in methamphetamine users.

Methamphetamine use has been associated with increased sexual risk taking behaviour such as more sexual partners and more unprotected sex, as well as injection related risk taking behaviour such as needle sharing.

*** Ecstasy (MDMA – 3,4 – methylenedioxymethamphetamine)**

Ecstasy, or MDMA, which may come as a powder or in a pill, is a common recreational drug in many countries. It causes euphoria, stimulation, empathy, reduced anxiety, increased social outgoingness, profound realizations, and strong positive emotions about others. Its undesirable effects include teeth clenching, changes in vision, reduced appetite, mood swings, upsetting emotions or thoughts, increased body temperature which may be fatal, sensation of thirst which may increase the intake of water to fatal levels, the possibility of psychosis with both single use and long term use, and the possibility of damage to the brain with longer term use.

Inhalants

Inhalants include a wide range of easily available products including:

- Aerosol sprays
- Butane gas
- Petrol
- Glue
- Paint thinners / solvents
- Amyl nitrite (poppers)



Young people often use them because they are cheap and readily available. They also often contain highly toxic and dangerous substances such as lead.

Inhalants are depressant drugs. This does not mean that they make a person depressed. It means they slow down the activity of the brain and nervous system and can cause the heart and breathing to slow down. They also affect the person's thoughts, feelings and judgment.

The effects of inhalants usually occur within 3 – 5 minutes. Inhaling will cause the person to feel light-headed and relaxed, very similar to the feeling of being drunk. The user may giggle, have slurred speech, double vision and feel drowsy. While sometimes people feel relaxed, happy or excited, others may feel agitated or uneasy.

An ongoing 'high' can be achieved through repeated sniffing but can also cause the person to black-out or hallucinate (see or hear things that are not really there).

Headaches and feeling 'hung-over' are also common and can last for several days. Long-term or regular users may also have difficulty thinking and remembering things, mood swings, paranoia (are fearful and suspicious), chronic headache and cough, weight loss, muscle weakness and feel tired a lot.

First time users may feel sick or become confused and frightened by the experience, which can put them off using again.

Immediate effects

*Happiness
Relaxation / Sleepiness
Poor coordination
Slurred speech
Irritability / Restlessness
Anxiety
Auditory and visual hallucinations
Convulsions take place (rarely)
"Sudden sniffing death" syndrome*

Longer term effects

*Nose bleeds
Skin rashes around the mouth and nose
Lack of appetite
Lack of motivation
Liver, kidney, heart and brain damage
Slowed motor actions*

"Sudden Sniffing Death" Syndrome

The most immediate danger to the user is "sudden sniffing death". When the user inhales certain solvents or aerosols, irregularities in heart rate can occur, which can lead to death. Death can also be caused by plastic bag asphyxia, aspiration of vomitus, and accidents while intoxicated.

Special considerations

- Mental health concerns - as with other substances, young people who use inhalants may like the experience and get relief from tension. This limits the development of other, more constructive coping strategies.
- Pregnancy - the effects of inhalant use on the mother and baby during pregnancy, and the effects after birth, are unknown.

Opioids

All opioids are based on the chemicals found in the opium poppy (*Papaver somniferum*). They may be extracted directly from the plant in which case they are known as opiates, for example opium itself, codeine and morphine, or they may be altered versions of drugs extracted from the plant, such as heroin which is a chemically modified form of morphine. Some opioids are also made in a laboratory (such as methadone, buprenorphine, Tramadol) but these act similarly to the natural opioids. Opioids act on the same receptors as the endorphins produced by our body. These endorphins are neurotransmitters that are involved in pleasure and reward, pain and appetite.



*** Heroin and morphine**

Heroin and morphine (M.S Contin) are very similar drugs, both of which are used to treat pain, with clinical use of heroin less common than the use of morphine, and both of which are problematic drugs of abuse. They act on opioid receptors that are normally involved in pleasure and reward, and the body's own pain management system. Their effect is to slow down the signals in the brain. The effects they produce are very similar, and include euphoria, intense relaxation, pain loss, apathy, and reduced physical and mental arousal. These effects will differ in people suffering from pain, and are rapidly reduced as tolerance develops quickly, meaning higher intake of the drug is needed. Negative effects include dry mouth, constipation, loss of consciousness (some may consider this a positive effect), nausea and vomiting which can be fatal if the vomit blocks the airway or is inhaled and introduces infection into the lung, and reduced breathing which can be fatal. Overdose is also common and even non-fatal overdoses can have lasting effects on the brain and other organs due to the lack of oxygen during the overdose.

Heroin and morphine may be dangerous to unborn babies particularly at higher doses or with long-term use. However withdrawing from these opioids during pregnancy may also place the unborn baby at risk of injury or death. In cases of pregnancy in opioid users, medical help should be sought.

*** Buprenorphine**

Buprenorphine also acts on the opioid receptors, but it only causes a mild effect, and actually blocks the effects of other opioids such as heroin. For these reasons it is sometimes used to treat recovering opioid dependence. The effects of buprenorphine include sedation and improved mood, but these are mild compared to a stronger opioid like morphine or heroin. Slower breathing is a negative effect of buprenorphine.

Buprenorphine may be dangerous to unborn babies at higher doses and should be avoided in pregnancy without medical supervision.

*** Methadone**

Methadone acts on the opioid receptors and remains active in the body for much longer than the other commonly abused opioids. For this reason it is often used as maintenance treatment for opioid dependence. The effects are similar to morphine and heroin.

Methadone is unlikely to damage unborn babies at therapeutic doses, but may potentially harm the unborn child at higher doses. Thus its use in pregnancy should only be under medical supervision.

*** Oxycodone (OxyContin, Percacet)**

Oxycodone is a strong painkiller, although not as strong as morphine or heroin. It is commonly used medically to manage severe pain, and is also commonly used for non-medical purposes. It generally comes in pill form that is often cleaned of the wax coating before being crushed for injection. The effects, side effects and overdose are similar to those of heroin or morphine. Injection of pharmaceutical pills can be dangerous due to the other filler agents in the tablets. For this reason it is essential to filter pills for injection. A syringe filter, or 'wheel filter' is desired if injecting any tablet (or powder), but a piece of cotton wool or clean cigarette filter is better than nothing.

Oxycodone may be harmful to the unborn baby at high doses and should be avoided in pregnancy without medical supervision.

Ketamine

Ketamine is an anesthetic that has psychedelic and dissociative properties. It works by blocking one of the brain chemicals that usually makes it easier for nerve cells to transmit a signal. It produces a range of dose dependent effects including euphoria and stimulation at lower doses, physical relaxation, sensory distortion, hallucinations, numbing, loss of co-ordination, out of body sensations (the separation of mind and body), confusion, paranoia, nausea, anxiety, discomfort with the intensity of the experience which may be frightening, reduced breathing and loss of consciousness.

Psychological dependence may occur and chronic use can result in problems with memory, psychological wellbeing and concentration, delusions and problems with the bladder.

The state produced by Ketamine, particularly at higher doses where dissociation and severe co-ordination impairment are experienced, may increase the risk to the user of accidents and falls.

Antihistamines (e.g. Phenergan)

Histamine is involved in regulating inflammation and immune responses among its other functions in the body. When opioids are taken, histamine is released which may cause an unpleasant sensation. This sensation is worse with some opioids than others. To avoid the unpleasant effects of histamine release by some opioids, antihistamines are often taken at the same time. Antihistamines, like

opioids, also tend to cause drowsiness and sedation and as such they may increase the opioid's effects.

Withdrawal



What are some symptoms that are experienced by most people who use drugs when they withdraw - regardless of which drug they are dependent on?



Drug use can lead to dependence that is generally characterized by the need for higher doses of the drug, a decreased concern for other aspects of life, anxiety about not being able to use the drug regularly for any reason, and a withdrawal syndrome that may consist of physical and psychological disturbances.

The withdrawal syndromes common to several different drugs of concern, along with management techniques to ease the withdrawal period are discussed below.

Methamphetamines

Withdrawal Symptoms

- Typically last between a week and a month
- Exhaustion, depression, trouble sleeping and concentrating, cravings, aches and pains, appetite changes, mood swings, anxiety and agitation, delusions and a sense of dissociation from the world are common symptoms of amphetamine withdrawal

Management

- Offer lots of social support and attempt to calm the person experiencing the withdrawals.
- Encourage relaxing activities such as light exercise, listening to music, watching TV or videos, reading or meditation
- Avoid other drug use and the use of benzodiazepines
- Ensure plentiful fluid intake and maintain nutrition
- Reduce stimulation (e.g. from noise, lots of people, etc.)
- If severe depression, anxiety, hallucinations, aggressive behaviour or psychotic thoughts are experienced, medical help should be sought for possible medical management of some symptoms and psychological observation

Inhalants

Withdrawal symptoms

Although the effects of intoxication can be severe, there are usually not any lasting physical effects for the user. The "hangover" is less severe than that which follows drinking alcohol. However, children and youth who inhale regularly may need to inhale more to experience the same effect (tolerance).

Opioids

Withdrawal Symptoms

- Last up to two weeks, with cravings lasting longer

- Sweating, chills, restlessness, agitation, aching muscles, bones or joints, runny nose or teary eyes, stomach and bowel upset including nausea, vomiting, diarrhoea and abdominal cramping, dehydration, muscle tremors, yawning, anxiety, fatigue, difficulty sleeping and goose bumps are common symptoms of opioid withdrawal

Management

- There are several medications commonly used in treating opioid withdrawals including buprenorphine, and clonidine that is a sedative with other properties that make it suitable to help with withdrawals. Management of diarrhoea and nausea is also achievable with medication, but hydration and electrolyte replacement is the most vital treatment for diarrhoea and nausea. It is preferable to consult a doctor about taking any of these medications, even the over the counter ones

Cannabis

Withdrawal Symptoms

- Last up to a week with cravings persisting
- Anxiety, irritability, mood swings, reduced appetite, difficulty sleeping, vivid dreams, depression, chills, tremor and lethargy are common symptoms of cannabis withdrawal

Management

- Ensure plenty of fluid intake and maintain good nutrition
- Avoid other drug use
- Perform regular, light exercise
- Engage in relaxing activities such as listening to music, watching TV or videos, reading or meditation

Alcohol

Withdrawal Symptoms

- Last up to a week with the more serious complications being more common in the first three days
- Sweating, raised blood pressure, tremor, fever, anxiety, co-ordination difficulties, difficulty sleeping, vivid dreams, changes in perception, nausea, vomiting, diarrhoea, reduced appetite, dehydration and poor concentration are common symptoms of alcohol withdrawal
- More serious symptoms include seizures, delirium, and severe hallucinations and delusions. Seizures and delirium are potentially fatal consequences of alcohol withdrawal, as is dehydration

Management

- Hydration and nutrition are particularly important in alcohol withdrawal, as dehydration is common and vitamin deficiencies, particularly vitamin B, are common in alcohol dependent persons
- Benzodiazepines can part of treatment for alcohol withdrawals and reduce many of the psychological symptoms as well as the occurrence of the more serious possible symptoms. They should not be used for more than a week, after which behavioural techniques such as

relaxation techniques should be used to manage the anxiety and insomnia that may last longer

- Due to the possible serious complications of withdrawal from heavy and long-term use of alcohol, for example fitting/convulsions, medical advice is definitely preferable

Managing Withdrawal Symptoms



Think of some things a young drug user experiencing withdrawals should do to try and stay healthy and more comfortable.



Did you consider?

- Try to improve diet by increasing the amount and nutritional value of the food consumed. If nausea is a problem, frequent, small meals may be better tolerated than large meals
- Fluid intake should also be increased to at least 2 litres a day, water, fruit juice or cordial are recommended. Avoid alcohol, caffeine and carbonated drinks
- Sleep will be difficult and often frustrating to normalize during withdrawals. Avoiding stimulants like coffee or cigarettes in the evening and night will help. Avoiding stimulating activities like loud TV or sports, and relaxing before bed may help
- Exercise throughout the day, such as swimming, running, walking and cycling, will help with depression and agitation, and will also help get the person tired so they can sleep easier
- Stretching may help with aches and pains; a light warm up first is a good idea even if it is just a walk. Medications like aspirin or ibuprofen may also help. Avoid opioid painkillers such as Tramadol or codeine
- If a doctor is available, they might be able to offer some medication to help with some of these symptoms, such as antidepressants or sleeping medications. Taking any such medications without a doctor's supervision may lead to another dependence and should be avoided
- Alternative medicines are also often used – (e.g. Valerian, passionflower, ginger root)

Overdose

Note: this section will not teach skills in overdose management. All staff should have up to date First Aid training.



How could you tell if a person was overdosing on opioids? How could you tell if a person was overdosing on methamphetamine? How you tell if someone was overdosing on benzodiazepines?



Make sure you consider whether you are assisting with an overdose or someone being 'too high'.

Opioids

Symptoms

- Decreased urinary output, sweating, chills, hot flushes, difficulty breathing, pale or cold skin, pale or blue lips, intense sedation and loss of consciousness
- It is generally the difficulty breathing that leads to death, and this is why other drugs which make it harder to breathe such as benzodiazepines, alcohol and Ketamine, should be avoided if opioids are going to be used. Overdose is much more common when combinations of such drugs are taken together. Another cause of death is the inhalation of vomit

Prevention and management

- Avoid using opioids alone
- Consider a non-injecting route of administration
- Start with a lower dose when using a new opioid or a new batch of heroin to work out its strength
- If an overdose is suspected, call an ambulance immediately and rest the user on their side, in the recovery position, ensuring that their airway is angled down to prevent them inhaling vomit, and clear of blockages
- If they are not breathing, or breathing very lightly, you should breathe into their mouth twice every five seconds
- If their pulse stops, CPR should be initiated immediately
- Naloxone is an effective drug in reversing opioid overdose, but the person who has experienced and overdose must be careful not to take opioids again too quickly, or they have a high risk of overdosing again when the naloxone wears off
- See the 'SCARE ME – Overdose intervention guide' for more information on managing opioid overdose



The Recovery Position (Adapted from: <http://pendekarsiber.blogspot.com/>)

Amphetamine Type Stimulants

Symptoms

- Sweating, hyperthermia, confusion, agitation, tremoring or twitching of muscles, muscle pain, seizures, chest pain, abnormal heartbeat, increased blood pressure, fainting, fast breathing, nausea and vision distortions are all common symptoms of methamphetamine overdose
- Acute psychotic episodes can be induced by methamphetamine use; this may be indicated by paranoia, delusions, fearfulness, panic, aggression and violent tendencies

Prevention and management

- Avoid using methamphetamine alone
- Consider a non-injecting route of administration
- Avoid large doses of methamphetamine particularly with injecting use

- Medical care is important if amphetamine overdose is suspected
- If the user stops breathing or the pulse ceases, CPR should be initiated
- External cooling (e.g. wet towel) and reducing stimuli by placing the user in a cool, quiet, dimly lit area until an ambulance arrives may help manage some symptoms
- Do not attempt to restrain a violent user if it is not absolutely safe to do so
- Medical management, if necessary, in the form of sedatives like benzodiazepines, antipsychotics (e.g. haloperidol), and medications to manage changes in blood pressure are available in medical settings, which is why medical intervention in suspected amphetamine overdose is important

Benzodiazepines

Symptoms

- Slurred speech, severe intoxication, severe loss of co-ordination and balance and difficulty breathing are common symptoms of benzodiazepine overdose. Other symptoms such as vomiting, aggression, coma and hallucinations are less frequently reported
- Reduced blood pressure and heart rate are also common symptoms of benzodiazepine overdose
- As benzodiazepines make it harder to breathe, combining them with other substances such as alcohol and opioids, which also make breathing harder significantly, increases the risk of overdose and death

Prevention and management

- Avoid high repeated doses of longer acting benzodiazepines such as diazepam (Valium).
- Consider a non-injecting route of administration
- Avoid combinations with other drugs that make breathing more difficult
- Fluid replacement is important to raise blood pressure back to normal, mechanical support with breathing may be required and should breathing stop CPR should be initiated
- There is a drug available that may be used to reverse the effects of benzodiazepine overdose in some cases but only in a hospital
- Due to risk of convulsions/fitting, the need to monitor vital signs and treat the symptoms of overdose, medical treatment is important in suspected benzodiazepine overdose

Fits

- Ensure the individual is in recovery position
- Make use of smelling salts, or leather or raw onion
- Use a hard object such as a spoon between the person's teeth to prevent the person from biting the tongue
- Refer to a doctor for advice



What would you do if you found a person you suspected was overdosing on a drug?



Did you consider?

- Check if they can be awakened or aroused if they are unconscious. If they are violent or aggressive as may be the case in amphetamine overdose, see if they can be calmed down but only if you feel safe doing so, and maintain distance between yourself and the drug user.
- Call for medical help if the person is unconscious, breathing does not appear to be sufficient, there seem to be seizures.
- Make sure that the person overdosing and yourself and any others helping are not in any immediate danger, if danger is present attempt to move the person overdosing to a safer location, but only if it is safe for you to do so.
- If unconscious, check that the airway and mouth are clear by looking in the mouth. Clear any obstruction from mouth if possible. Then place the person in the recovery position as described above for opioid overdose.
- Try to find out what drugs have been used by the person you are assisting.
- Check the persons breathing if they are unconscious, by watching or feeling their chest and holding a finger in front of the mouth and nose to feel for airflow. If they are not breathing, or breathing very lightly, you should breathe into their mouth twice every five seconds.
- Check their pulse at the wrist or on the neck with your index and middle finger. If their pulse has stopped you definitely need emergency medical attention, and you should initiate CPR with two breaths into their mouth, followed by 30 compressions over the middle of the chest, every 30 seconds. CPR should be continued until the pulse recovers, at which point you should go back to checking their breathing, and breathing for them if necessary, and check their pulse regularly.

The above advice can be remembered with SCARE ME:

S – Stimulation – can they be wakened?

C – Call for help

A – Airway - make sure nothing in mouth to prevent breathing

R – Rescue breathing – Hold the nose closed, tilt the head back and give two slow breaths through the mouth (each should take 1 second) until chest rises

E – Evaluate after about 12 breaths – if pulse, continue rescue breathing, if no pulse begin CPR

M – Muscular Injection – if opioid overdose – and the person is not breathing well still consider muscular injection of Naloxone (if available)

E - Evaluate

Opioid Substitution Therapy (OST)



What medications are commonly used to treat opioid addiction and what are the differences between them?



Did you consider?

- Methadone is commonly prescribed to manage opioid addiction. It has a good rate of success when accompanied by adequate psychological support. It is a long acting opioid which allows it to be taken once daily, often as a liquid but sometimes as a pill. It is weaker

than the strong opioids such as heroin and morphine, but withdrawal is also said to be easier than withdrawal from the stronger opioids.

- Buprenorphine (Subutex) is less commonly prescribed to manage opioid addiction, primarily due to its greater cost than methadone. It is a long acting opioid and is generally taken as a sublingual tablet (dissolved under the tongue) or liquid and can be taken daily or every second day. While buprenorphine has weaker effects than methadone and the strong opioids like heroin, it also has the ability to block the effects of these other opioids. This means that an opioid user on buprenorphine may not feel the effects of a dose of heroin, adding to its effectiveness in breaking addiction. As buprenorphine has no added effects above 32mg, overdose is not as likely as with methadone. Buprenorphine has a relatively mild withdrawal syndrome, and appears to cause a lower incidence of withdrawal symptoms in newborns than methadone.
- Naltrexone blocks the effect of opioids much like the Naloxone (Narcan) that is used to treat opioid overdose, however it lasts longer. It is often added to Buprenorphine tablets (e.g. Suboxone) to make them ineffective if injected. This makes it more difficult to misuse the buprenorphine tablets. It is also sometimes used for rapid detoxification in opioid addiction, but this method has not been proven to be effective.



What might be some goals and benefits of OST?



Did you consider?

- The goal may be to stop drug use altogether with gradual dose reduction and managed withdrawals, however this is not always realistic and there are many benefits of long term OST over long term illicit opioid use.
- Benefits of long term OST over illicit opioid use include reduced involvement in criminal activity, less time spent getting and using drugs, less money spent on drugs, a more organised lifestyle, reduced likelihood of injection drug use and its associated risks such as spread of BBI and a greater sense of control and social normality which may aid in improving confidence, mental health and functional ability.
- The sense of control OST gives to a drug user is often an underestimated benefit of this treatment. Take home doses for patients may further this sense of control and responsibility but may not always be available.

Some possible side effects of OST with Methadone or Buprenorphine include:

- Reduced breathing which may be fatal (more likely with methadone).
- Nausea, constipation and vomiting
- Dry mouth
- Sweating and itchiness
- Tiredness
- Low blood pressure
- Reduced libido and impotence in men should be noted that these side effects are similar to those of most of the opioids used illicitly.

See Resource CD/USB: 7, 14, 22, 25, 27, 33, 34, and 62

Session 06. BBIs, HIV, HCV, HBV, TB, STIs

By completing this session you should have knowledge of:

- ✓ Blood born infections (BBIs*)
 - HIV and AIDS
 - Hepatitis C
 - Hepatitis B
 - TB
- ✓ Assisting young people with BBIs
- ✓ Sexually transmissible infections (STIs)
 - Syphilis
 - Gonorrhoea
 - Chlamydia
 - Genital herpes
 - Genital warts
- ✓ Reducing STI risks

*BBI refers to blood born infections, including viruses.



HIV and AIDS

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV reduces the ability of the immune system to fight infection by reducing the number of a type of important regulating cell (the CD4+ T-cell) that normally control the body's response to infections, as well as infecting some other cells in the body. This can lead to:

- Increased risk of infection and increased severity of infections
- The risk of catching opportunistic infections that do not normally have the ability to infect people with a healthy immune system
- Increased risk of several types of cancer
- Problems with the nervous system such as altered feelings of touch or swelling of the brain



How is HIV transmitted?



Did you consider?

HIV is spread in body fluids containing the virus (blood, semen and vaginal fluid) and so three main methods of transmission exist:

- Sexual transmission can occur in male-to-male sexual contact or male to female sexual contact, where vaginal or anal penetration is involved, or rarely in female-to-female sexual

contact or during oral sex if the integrity of the lining of the mouth is breached. Sexual transmission is the most common mode of transfer and infection of HIV. Homosexual males and sex workers have been at particularly high risk of sexual transmission in the past, but the rate of non-sex work related heterosexual spread is increasing.

- Direct blood-to-blood transmission – the main mode for the direct transfer of blood from one infected individual to another is sharing of injection equipment or accidental contact with used injection equipment. Needles, syringes, tourniquets, swabs, cotton buds and all other injection equipment may come into contact with blood, if this equipment is then re-used by another individual, or accidentally contacted by another individual (as in needle stick injuries) the blood may enter their system, and place them at risk of infection. Blood transfusion poses some small risk of transferring HIV, but this was more of a problem before the 1990's than it is now.
- From mother to child either as the baby grows inside the mother, during birth where the baby is exposed to the mother's vaginal fluid and blood, or via breast-feeding. The period during birth and immediately after birth are the highest risk periods for mother-child spread of HIV.

Rapid HIV testing is increasingly available in some parts of the world. For example, Youth Vision, Katmandu, Nepal uses the following tests and process:

The three rapid tests used for HIV testing:

1. Determine test
 2. Unigold
 3. SD bioline
- If 1st is positive, then 2nd test is done for confirmation
 - If 1st and 2nd tests are positive, then the result is regarded as HIV-positive
 - If 1st is positive and 2nd is negative, then the third test is done. Whatever the result of the 3rd test, it is regarded as the final result



What might help a young person who is HIV positive manage their disease?



Did you consider?

- Diet changes should include an increase in the intake of fresh fruit and vegetables to increase vitamin intake and possibly the support of a multivitamin tablet daily if affordable. Overall energy intake should also be increased, and care needs to be taken to cook meat well through to reduce the risk of several animal-borne infections to which HIV positive people may be vulnerable.
- Exercises aimed at increasing your muscle mass such as weight lifting, push-ups and pull ups will help with increasing energy, sleep at night, and may improve immune function. Aerobic exercise such as walking and cycling may also help ease the symptoms of the disease.

- Maintain good mental health – HIV infection and the stigma associated with it put patients infected with this illness at increased risk of depression and some other mental health complaints. This should be managed as you would manage a normal mental health condition, but with special consideration of the serious impact this disease can have on its sufferers and the way society treats and views those people infected with HIV. HIV sufferers should be regularly asked about their happiness and mental state, as depression is associated with more serious disease.
- Educate the community where possible about HIV, to reduce the stigma surrounding the disease. This stigma is often a cause of isolation and depression among HIV positive individuals and may lead to them concealing their infection, which may increase the risk of transmission.
- While drug use has not been shown to have a direct impact on the progression of HIV, some drugs may interfere with the anti-retroviral treatment used to treat the disease, and they also often impact on the user's general health that may alter the impact of the disease on their life.
- Anti-Retroviral Therapy (ART) is generally a combination of three different drugs given at once. Treatment is usually started when the CD4 T-cell count drops < 350. These medications have a number of side effects that can be at least partly improved by lifestyle changes such as diet and exercise (See Session 7) combined with symptomatic medication given by a doctor. Continued medical care and supervision are essential in maintaining good health for HIV positive individuals.



Hepatitis C

Hepatitis C is one of the most common blood borne infections in the world. Many infected with the hepatitis C virus chronic hepatitis (swelling of the liver) will develop as the virus infects the liver cells, and the immune system battles to control its spread. This hepatitis can lead to:

- A stable disease state where the virus is not replicating. The infection can spontaneously clear, remain stable or return to an active state. It has been estimated that there is about 20-30% spontaneous clearance.
- Cirrhosis (scarring of the liver) occurs in fewer of those who develop chronic hepatitis and will lead to death in half of these individuals, especially where poor general health and poor access to adequate treatment exists. Cirrhosis is associated with reduced liver functioning which results in many other problems in the body, several of which may be fatal. These problems may include:
 - Easier bleeding or bruising.
 - Liver failure and the build-up of deadly toxins.
 - High blood pressure in the veins that drain the gastrointestinal system which can lead to fluid building up in the abdomen, or bleeding into the gastrointestinal tract which may be fatal.
 - Hepatocellular carcinoma – a type of cancer of the liver cells which is far more common in those suffering cirrhosis and Hepatitis B and C infection.

- A state of stable cirrhosis where liver function may be impaired but disease progression is halted. Again this state may alternate or progress to an active state of cirrhosis.
- Jaundice, which is noticeable by a yellowish discolouration of the whites of the eyes and the skin, dark urine and pale stools. This is the most easily noticeable sign of liver disease without medical tests but may not always be present.
- There is no vaccine available for Hepatitis C.
- Hepatitis C antibodies are found in most individuals with a past or current infection with HCV. This may not be the case in young people with a compromised immune system and it may also give a false negative if testing is done before seroconversion occurs. Various rapid anti-HCV tests exist and may take under an hour to return a result without the need for further test or laboratory equipment.
- The next level of testing confirms a current infection by testing for HCV RNA in the patient's blood. If viral RNA is found, a current infection is diagnosed with or without symptoms.



How is Hepatitis C transmitted?



Did you consider?

The major routes of transmission for Hepatitis C are:

- Blood to blood transmission is the major transmission route, with injection drug use and the sharing of injecting equipment causing the most significant number of infections. See the notes on blood-to-blood transmission of HIV above for more details.
- Mother-child transmission is relatively uncommon with Hepatitis C compared to Hepatitis B or HIV but it can still be a mode of transmission.
- Sexual transmission is possible for Hepatitis C, but it is much rarer than the sexual transmission of Hepatitis B or HIV. Nonetheless this is a transmission route of concern.
- In some countries such as Egypt, high rates of HCV are related to poor sterilization of medical equipment and blood transfusions in the past and possibly still.



What might help a young person who has Hepatitis C manage their disease?



Did you consider?

- Some sufferers of Hepatitis C do not tolerate fat well, but the level of fat in a healthy diet should not often cause a dietary problem. A generally healthy but non-specific diet is often recommended.
- Alcohol and other drugs are generally processed by the liver and in some cases, particularly alcohol, damage it as well, thus the intake of alcohol should be limited as much as possible and the use of other drugs should also be limited.
- Regular, light exercise such as walking may help with the fatigue often reported by Hepatitis C patients, as will a regular and hygienic sleeping pattern. See Session 7

- As with any chronic illness, Hepatitis C increases the risk of depression and sadness in its sufferers, so their mental state and emotions should be questioned regularly and any mental health concerns should be dealt with as normal, but with the special consideration given to the patient's state of illness and the social stigma often surrounding Hepatitis.
- There are medications available that can sometimes cure Hepatitis C, but these are currently very expensive. Medical supervision of anyone with Hepatitis C is still essential to provide symptomatic relief and advice on which medications are safe to take with reduced liver function.



Hepatitis B

- Hepatitis B is related to Hepatitis C, and while both primarily effect the liver, the progression and nature of Hepatitis B infection can be quite different to Hepatitis C:
 - The majority of Hepatitis B infections will resolve after several months and not go on to chronic infection. In fact the majority of Hepatitis B infections will not produce any noticeable symptoms, while some will experience an acute and resolving hepatitis.
 - A small proportion will experience persistent infection. The majority of these persisting cases will still resolve. A small number lead to chronic hepatitis, which can lead to cirrhosis as, described above for Hepatitis C.
- Jaundice, which is noticeable by a yellowish discolouration of the whites of the eyes and the skin, dark urine and pale stools. This is the most easily noticeable sign of liver disease without medical tests but may not always be present.
- A vaccine is available for Hepatitis B and comes in three separate injections, which may be given over different periods ranging from one month to six months depending on the selected regimen.
- There are a number of different things tested to determine the nature of a HBV infection:
 - HBsAg (Hepatitis B surface Antigen) is often seen in early infection and indicates the presence of HBV. If it is still present 6 months after initial detection then the patient is a hepatitis B carrier.
 - Anti-HBc (Hepatitis B core antibodies) are seen as Anti-HBc IgM in early infection (may be present when HBsAg is not, indicating the recent clearance of an infection).
 - Anti-HBc IgG and anti-HBs IgG (Hepatitis B surface antibodies) are seen in later infection, in the case of previous infection and in the case if vaccination.
 - HBV DNA can be measure quantitatively to determine the viral load, which is related to an individual's infectiousness and the efficacy of treatment. The presence of HBV DNA is also diagnostic of current HBV infection.



How is Hepatitis B transmitted?



Did you consider?

- Unlike Hepatitis C, Hepatitis B is easily transmissible through exchange of sexual fluids making unprotected sexual contact a primary route of transmission.
- Blood to blood transmission is another major transmission route, with injection drug use and the sharing of injecting equipment causing a significant number of infections. See the notes on blood-to-blood transmission of HIV above for more details.
- Some personal contact such as biting can transfer the disease while kissing is unlikely to.
- Sharing sanitary or personal items such as toothbrushes can also spread the disease.



What might help a young person who has Hepatitis B manage their disease?



Did you consider?

- If an acute (short-term) infection, then symptomatic management is all that is available. Testing should be performed to ensure the disease regresses and does not persist to chronic hepatitis.
- If chronic Hepatitis B infection does develop lifestyle interventions as for Hepatitis C should be followed including reduced alcohol and other drug intake, a healthy, balanced diet, getting good sleep, and getting enough exercise. Mental health concerns such as depression should also be regularly assessed and managed as is necessary with any long lasting disease. See Session 7.
- Treatment for chronic Hepatitis B should be considered if a decline in liver function is seen.



What could you do to reduce the spread of blood borne infections such as HIV and Hepatitis B and C in the young people you work with?



Did you consider?

- Encourage safe sex. Condom use during sexual penetration or oral sex, regardless whether it is heterosexual or homosexual activity, is crucial in preventing the spread of HIV and Hepatitis B.
- Encourage regular testing, if easily available. This allows the individual to know their infection status and adapt their lifestyle and seek medical care should they become infected. This also reduces the risk of transmission to others, as infected individuals are aware of the risk they pose to others.
- Encourage non-injecting routes of administration.
- Encourage experienced people who inject drugs to NOT initiate young people to injecting drug use.
- Discourage re-infection – via unsafe sex, sharing of injection equipment, blood exposure.
- Discourage the sharing of any injection equipment, and teach people who inject drugs to cap their needles after use and safely dispose of all injecting equipment preferably at a designated needle exchange or medical facility with sharps disposal facilities.

- NSPs have a significant role to play in reducing transmission of BBIs. Offer a service to dispose of used injection equipment and offer new injection equipment cheaply or freely (where legally possible) to people who use drugs in an effort to reduce injection equipment sharing.
- Educate about transmission. Explain how HIV and Hepatitis spread to encourage safe sex and injecting practices.
- Be blood aware – take care to avoid accidental needle stick injury or contact with any blood or bodily fluids.



Tuberculosis:

Tuberculosis (TB) is caused by mycobacterial infection, usually in the lungs but sometimes in other sites of the body such as the joints or nervous system. Its manifestations vary depending on the site of disease and the state of the patient's immune system. It is more common to see TB outside the lungs in patients who are immunocompromised (As in AIDS). TB may also be asymptomatic, while the infected individual may still be able to pass it on.



How is TB transmitted?



Did you consider?

The mycobacterium that causes TB is very resistant to environmental stress and so they can survive and transmit for weeks even in dry sputum (phlegm). Transmission of TB occurs mainly via exhaled water droplets when talking, spitting, coughing etc.



The most common signs and symptoms of TB are seen in the lungs:

- Coughing up sputum, often with some blood is common
- Chest pain

Systemic symptoms such as weight loss, appetite loss, fever, fatigue and sweating are also common. Its effects on other parts of the body vary significantly depending on the nature of the infection.

There is a **vaccine** for TB called the BCG vaccine, which may offer 0-80% protection against TB infection.

Testing for TB infection is also relatively easy with past exposure and immunity being tested by a Mantoux test which relies on the patient's immune response to some toxins that are similar to toxins released by the infectious agents. This test may give false positives and negatives, particularly in immunocompromised patients. It is nonetheless a good screening tool to determine who should undergo further testing.

Diagnosis in symptomatic patients may also be achieved by microscopic examination of a patient's sputum sample for the mycobacteria which are responsible for TB infection.

TB is **treated** with a long course (>6 months) of multiple antibiotic agents. The antibiotic sensitivity of the infectious organism should be tested by lab culture as soon as possible to adjust the antibiotic regimen if required (as in Multidrug Resistant TB). It is often advisable to treat and test any individuals who have had relatively close contact with an infected person. Enhanced liver care is important during treatment, as some medications may have a negative impact on the liver and its functioning.



What might help a young person who has TB manage their disease?



Did you consider?

- Regular healthy check ups
- Compliance with medication
- Reducing stress
- Encourage the cessation or significant reduction in the use of alcohol and other drugs
- Liver care – diet, nutrition, exercise



Sexually Transmissible Infections:

Syphilis

Symptoms can include:

Syphilis infection is divided into four stages: Primary, Secondary, Latent and Tertiary.

- **Primary** Syphilis presents a week to three months after infection, with a single, or less commonly multiple sores at the site of initial contact with the infection. This is often on the genitals, anus or mouth but may be elsewhere on the skin.
- **Secondary** Syphilis often presents with a reddish-brown spotty rash on the palms of the hands or soles of the feet, or sometimes elsewhere on the body. It may only be faint, or may be very noticeable and generally is not itchy. Also common are sores in the mouth or around the genitals or anus. Other symptoms of secondary stage Syphilis may include general flu-like symptoms of fever, tiredness, weight loss, sore throat and muscle aches.
- **Latent** Syphilis is a stage without symptoms that occurs after secondary symptoms. Tests can detect the disease, but no signs or symptoms are apparent in the patient. This stage can last many years or even decades, and may not progress or resolve, latent Syphilis can end in resolution of the disease or progression to tertiary Syphilis.
- **Tertiary** Syphilis is a serious and life threatening disease which may result in problems with the heart, major blood vessels, brain, nervous system, joints and bones.

The symptoms of Syphilis infection vary greatly and may not be noticed, but the risk of progressing to the life threatening or seriously debilitating tertiary stage makes testing essential if exposure or infection is suspected.

Transmission

- Skin contact with a sore caused by Syphilis.
- Sexual contact with an infected individual including oral, vaginal or anal sex.
- Transmission from an infected mother to the unborn baby.

Duration

- Varies significantly – untreated Syphilis commonly takes from one to twenty years to progress to tertiary Syphilis, and so it should be treated as early as possible.

Prevention and Treatment

- Safe sex including protected oral sex.
- Avoiding sexual activity with people who are infected or any uncovered skin contact with infected areas of skin or sores on an infected young person.
- Antibiotic treatment can generally cure the infection and should be sought as early as possible.

Gonorrhoea

Symptoms can include

- Pain or burning when urinating.
- White or off-white discharge from the penis, vagina or anus.
- Vaginal bleeding between periods or unusual pain during intercourse in women.
- Swollen testicles in the male.
- Potentially life threatening eye, joint or blood infections in newborn babies.
- Rarely, a life threatening systemic disease affecting the joints and blood.
- Progression to Pelvic Inflammatory Disease (PID) in women or epididymitis in males during which fever and abdominal pain may be experienced.
- These symptoms may impact on fertility or lead to more serious complications.
- Symptoms of Gonorrhoea are often absent in infection and may be hard to identify when they are present. This makes testing essential if Gonorrhoea infection is suspected.

Transmission

- Sexual contact with an infected individual including oral, vaginal or anal sex

Duration

- Often a long term, asymptomatic infection.
- Occasional symptomatic outbreaks are seen in some cases and are often more obvious in males.

Prevention and Treatment

- Safe sex including protected oral sex.
- Avoiding sexual activity with people who are experiencing an outbreak.
- Antibiotic treatment can generally cure the infection.

Chlamydia

Symptoms can include

- Pain or burning when urinating.
- White or off-white discharge from the penis, vagina or anus.
- Bleeding between periods in women.
- Progression to Pelvic Inflammatory Disease (PID) in women during which fever and abdominal pain may be experienced. This is common in women with untreated Chlamydia infection and often results in fertility problems

- Progression to epididymitis in males is less common than development of PID in women, but may also cause male sterility.
- Joint problems.
- Problems in newborns of infected mothers including: potentially blinding eye infection, pneumonia, and premature birth.
- Spontaneous abortion of unborn infants of infected mothers.

Symptoms of Chlamydia are often absent in infection and may be hard to identify when they are present. This makes testing essential if Chlamydia infection is suspected, particularly due to the common complication of PID.

Transmission

- Sexual contact with an infected individual including oral, vaginal or anal sex.
- Transmission from an infected mother to a newborn during vaginal birth.

Duration

- Often a long term, asymptomatic infection.
- If symptoms are experienced they tend to occur 1-3 weeks after exposure.
- The majority of people will clear the infection after several years naturally if left untreated, but this risks the more serious consequences of the disease particularly PID and pregnancy problems. Thus antibiotics are recommended.

Prevention and Treatment

- Safe sex including protected oral sex.
- Avoiding sexual activity with people who are infected.
- Antibiotic treatment can generally cure the infection.

Genital Herpes

Symptoms can include

- Itching.
- Sores (ulcers, blisters, tender and/or red areas of skin).
- Redness.
- Tingling.
- On or around the genitals and anus, or mouth and lips (cold sores), thighs, lower back, or fingers.

Transmission

- Oral, vaginal or anal sexual contact with an infected individual with the most risk of transmission being during a symptomatic outbreak.

Duration

- Life-long infection with outbreaks of symptoms lasting several days to weeks.
- The disease will often go into remission or periods of extended delay between outbreaks after several years.

Prevention and Treatment

- Safe sex including protected oral sex.

- Avoiding sexual activity with people who are experiencing an outbreak.
- Antiviral treatment is available and may be used to treat outbreaks if they are noticed early or are prolonged.

Genital Warts

Symptoms can include

- Warts – rough, firm, skin like lumps or stalks around the genitals or anus.

Transmission

- Sexual contact with an infected individual including oral, vaginal or anal sex.

Duration

- Often a long term, asymptomatic infection that may be cleared by the body later in life.
- Occasional symptomatic outbreaks are seen in some cases and are often more obvious in females.

Prevention and Treatment

- Safe sex including protected oral sex.
- Avoiding sexual activity with people who are experiencing an outbreak.
- Symptomatic treatment is available and may be used to treat outbreaks if they are prolonged or severe.
- There is a vaccine available for some of the strains of virus that can cause genital warts.



What advice could you give to a young person about reducing their risk of catching an STI?



Did you consider?

- Always practice safe sex including protected oral sex.
- Avoid sexual contact if infection of the partner is suspected.
- Avoid skin contact with any cuts, sores, rashes or lumps on other people's bodies.
- Avoid sexual activity while intoxicated as this may increase the chance of high-risk behaviour
- Get tested regularly and if you are found to be infected, contact your sexual partners and notify them to get tested and seek treatment. This may be embarrassing, but it prevents further unknown spread and harm.
- Get treated as soon as possible for those infections that are treatable. Take the whole course of medication as directed by the doctor.
- If involved in sex work, try to keep sober and learn how to negotiate safer sexual activity via verbal or non-verbal means.

STIs and HIV

It is important to note that infection with most STIs increases the risk of HIV infection and other immune system compromising infections. This is another good reason to encourage prevention strategies, regular testing for STIs and BBIs and treatment wherever possible.

See Resource CD/USB: 13, 16, 18,19, 23, 33, 35, 38, 55, 56, 57, 58, 59, and 60.

Session 07. Health and Nutrition

By completing this session you should have knowledge of:

- ✓ Barriers to maintaining health and wellbeing for young people who use drugs
- ✓ Drugs and appetite – eating well
- ✓ Improving nutrition
- ✓ Specific health issues for young women, and pregnant young women
- ✓ Importance of exercise
- ✓ Importance of sleep and ‘sleep hygiene’
- ✓ Importance of caring for skin and veins
- ✓ Importance of oral and dental care
- ✓ Sexual and reproductive health concerns
- ✓ Drugs and sex links
- ✓ Nicotine and risks



What are some of the barriers to maintaining the health and well-being of the young people who use drugs that you come in contact with?



Did you consider?

Many common problems that are related to a drug using lifestyle make it more difficult for the user to keep him/herself healthy. These problems can include:

- Not having much money
- Not having comfortable and permanent places to sleep
- Not having access to nutritious food, areas and utensils to prepare food
- Lack of access to good medical care
- Impact of injecting drugs – e.g. on veins and infections
- Chance of unsafe sex while intoxicated and/or to obtain money for drugs
- The effects of drugs on unborn and breastfeeding babies, and pregnant women
- Impact on sleep
- Reduction of healthy exercise
- Neglect of dental care
- Impact on skin
- Many drugs interfere with the normal appetite

Along with these factors, the drugs have direct effects on the health of the user, some of which were discussed in Session 5.



Drugs and appetite

Methamphetamine generally reduces the appetite of the user. This often results in weight loss and a deficiency of important nutrients. It is important to remind amphetamine users that even though they may not feel hungry while using, it is important to keep their energy and nutrition up by eating. It may be easier for them to eat more, smaller meals through the day, rather than a few large ones. Lighter foods like fruit and rice may also be easier to eat. Appetite generally starts to return two or three days after the last use.

Opioids such as heroin and morphine can cause nausea and intense relaxation, both of which may make eating more difficult. Eating before doses may be useful in maintaining a more healthy diet, but again smaller meals are better particularly if the user is sensitive to nausea when they use. Opioid withdrawals tend to suppress appetite for three to five days after the last use. During this time it is important to drink hydrating fluids (electrolytes in water) and eat small, nutritious meals if possible.

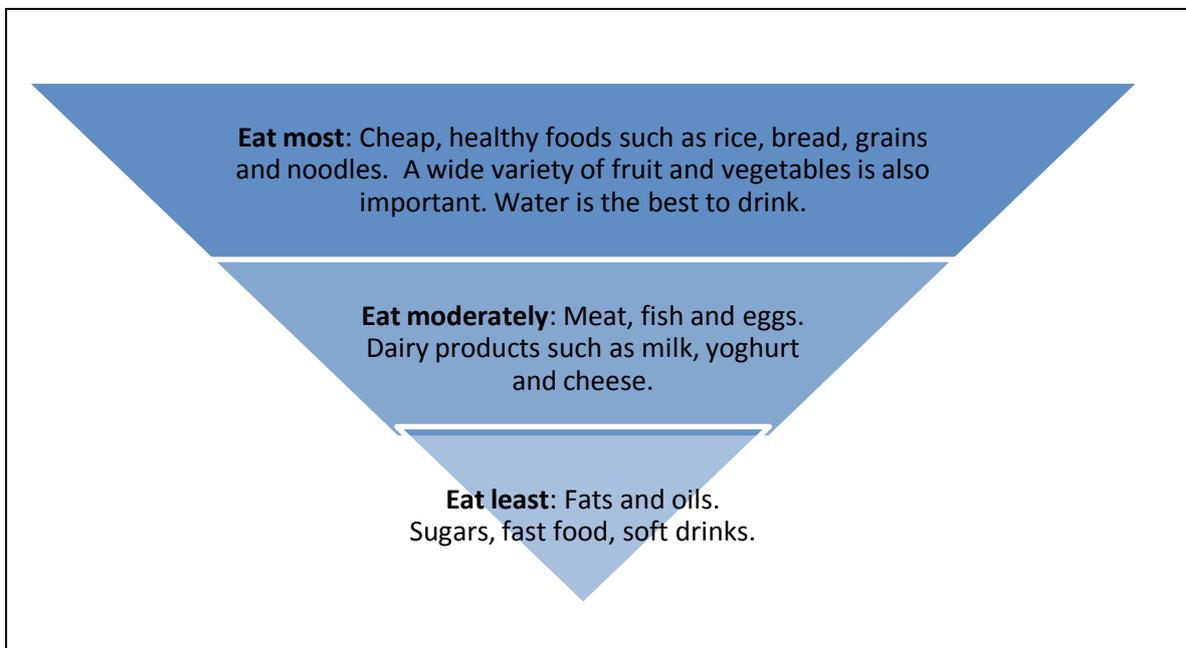
Eating well



What do you think a healthy diet would be for the young people you come into contact with who use drugs?



Below is a diagram you can use to try and guide what people should try and eat more or less of.



Try to encourage eating breakfast early in the day, if possible have it every day before the first dose of drug. Another meal or two and several healthy small meals such as fruit should be enough food throughout the day. Drinking around 8 cups of water (two litres) a day should also be encouraged.



Cheap and healthy

While cheap foods are often desirable, it is important for it to be healthy as well. Some tips for making healthier food more affordable include:

- Avoid fast food that is not freshly made.
- Form a group of people who can buy larger amounts of fresh food together to make it cheaper, especially if you have no place to store it. This avoids wasting money.
- Avoid soft drinks, cordials, coffee and alcoholic drinks. Water is healthy and cheaper.
- Packaged food is often less healthy than other alternatives for quick, small meals such as fruit.



How can you and the other outreach workers and centres help improve the diet of the young people who use drugs you come in contact with?



Did you consider?

- Staff modelling: It is important for the staff to demonstrate good eating habits in front of the young people by avoiding unhealthy foods and drinks and eating fruit and drinking water to set a good example for the young people to follow.
- Staff should also demonstrate good hygiene when preparing food or helping young people prepare food, particularly washing hands before preparing the meal, and using different utensils for meat and vegetables.
- A drop-in centre could help by offering some basic food to people, or supplying a few healthy meals a week. This food may be sourced from community donations. Providing and clean area to prepare and eat meals may also encourage healthier eating.
- Keep in mind some that some groups of young people may require particular dietary or nutritional requirements for religious or cultural reasons, or for particular health reasons such as diseases like diabetes, lactose intolerance, irritable bowel syndrome or food allergies. Pregnancy also changes the nutritional requirements.
- If a number of particularly malnourished youth are involved with your service they may require particular targeting to increase their energy and protein intake.
- Try to prepare enough so that the young people can take some food home with them.
- Involve young people in the purchasing or collecting of food and its preparation, as it can teach them food preparation skills, improve their self confidence, and provides an excellent opportunity for workers to discuss a wide range of topics with the youth in a relaxed atmosphere.
- Make sure staff and young people are both involved with cleaning up after eating - modelling responsibility and basic hygiene.



What might be some issues of concern specifically for young women who use drugs?



Did you consider?

- Pregnancy, whether expected or unexpected, dramatically changes the health needs of a young woman as well as adding additional financial stresses. Drug use also interferes with fertility and the health of the baby as described in Session 5 and later in this session. It is important also to know that the younger the girl the more risk there is of complications of pregnancy.
- Females who use drugs, particularly young ones, may trade sex for drugs or money. This practice is associated with increased risks of physical, sexual and psychological abuse, sexually transmitted infections, furtherance of drug use and the social stigma associated with sex work. Also in general, the stigma associated with drug use is greater for women who use drugs than their male counterparts.
- Females may be under increased pressure from partners to start using drugs or transition to injection drug use. Such pressure may also make it harder for the young female drug user to stop using drugs if they decide to.
- Females may also be at risk of being pressured into unsafe sex. This risk is even greater if either partner is intoxicated at the time. Such risks are significant to the sexual and general health of young women and safe sex practices as described later in this session, such as condom use should always be emphasised and followed.
- Young women may also be used as drug couriers ('drug mules').

Pregnancy (health for two or more?)



In addition to addressing concerns about drug use and related behaviours (see Session 5), how do young women who are pregnant, trying to get pregnant or breast feeding need to adapt their diet to keep themselves and baby healthier?



Did you consider?

- During pregnancy a mother needs more of certain things in her diet to help the unborn baby grow. These are a few basic diet changes to keep in mind if a woman is pregnant or trying to become pregnant:
 - Increase energy intake. An extra small meal a day, a few pieces of fruit and some milk may be enough.
 - Folate is an important nutrient for unborn babies. It can be found in lentils, beans and peas, leafy green vegetables such as lettuce, spinach, (use local examples) and citrus fruits such as oranges. One to one and a half cups of lentils a day would provide a good extra amount of folate in pregnancy.
 - Iron intake must also increase to help oxygen get to the unborn baby. Good sources of iron include food containing liver and red meat. Eating citrus fruits will also help with increasing iron levels.
 - Calcium intake should be increased. The best way to do this is to increase the intake of dairy products such as milk.

- Large fish and shellfish should be avoided as they may contain toxins that can damage the unborn baby.

Exercise



Why is exercise important for a young person who uses drugs, and what are some exercises you think they could easily do?



The health of the body is often neglected in drug use and exercise is one way to try and maintain better physical health. Encourage half an hour to an hour of light exercise a day such as aerobics, tai-chi, walking, push-ups, sit-ups and stretching. This exercise does not need to be intense, but rather light and regular. Exercise also helps to improve depression and self esteem.

Because exercise releases endorphins (the body's own pain killers) which act on the same receptors as opioid type drugs such as heroin, exercise may help particularly with making opioid withdrawals less uncomfortable or in decreasing cravings for opioids.

Sleep



What are some reasons why sleep is important in maintaining health?



Did you consider?

- Maintaining the body's natural defense against infections
- Resting the body and the brain
- Creating long term memories and forgetting irrelevant information learnt through the day
- Controlling the way we use energy and how the body controls its temperature

The effects of not getting enough good quality sleep may include:

- Tiredness, reduced concentration, forgetfulness, hallucinations
- Depression and mood swings
- Poorer immunity leading to more chance of getting sick
- Heart and artery problems
- Growth problems for children and young adults



What are some difficulties you think the young people who use drugs you come into contact with may have with getting good sleep?



Did you consider?

Using drugs can often impact on the important natural habit of sleeping, drugs can interfere with both the amount of sleep a user gets, and the quality of that sleep. Aspects of some drug user's lifestyles which might make good sleep harder to get include:

- Lack of permanent accommodation

- Poor nutrition
- Sickness
- Mental health problems such as depression
- Fears and worries
- Needing to keep alert to potential danger
- Body pain
- Overcrowding
- Poor ventilation (indoor pollution)
- Lack of access to a comfortable and safe place to sleep

Along with these lifestyle factors are the effects of the drugs themselves on sleep.

- **Cannabis** can increase the amount of sleep a user gets, but it reduces the quality of the sleep. During cannabis withdrawals, difficulty sleeping and strange dreams are commonly reported.
- **Methamphetamine** users often experience upset sleeping patterns as they are kept awake for extended periods by the drugs, often followed by periods of 'coming down' when the drug wears off, during this period the user often sleeps for a long time. This puts heavy users at potential risk of sleep deprivation, which can cause physical and mental health problems. During periods of methamphetamine withdrawal, after the comedown, sleep often becomes difficult and disturbed again for a period of time.
- **Opioids** like heroin and morphine may cause reduced or loss of consciousness, this state differs from sleep, and they may also increase tiredness during the day. Opioids reduce the quality of the sleep the user does get. During opioid withdrawal, sleep tends to be disturbed and poor quality, this difficulty sleeping may last several months.



How do you think the young people who use drugs you work with could try to improve the amount and quality of sleep they get?



Did you consider?

- Avoid alcohol and cigarettes (nicotine) for two to three hours before bedtime.
- Avoid any caffeine (for example coffee, energy drinks, cola drinks) for six hours before bedtime.
- Form a regular sleeping pattern, trying to fall asleep and wake up at similar times each day, and avoid napping during the day.
- Try to make the place you sleep as comfortable for you as possible. Some people need some light or soft noise to sleep, others need total dark or quiet, so pick a sleeping place that suits your needs. Try to find a place that keeps a comfortable temperature too.
- Avoid stimulating activity like loud music, sport, socialising or television late in the evening near bedtime. Reading a book, meditating or quiet, relaxing music before bed might help you relax for sleep.
- Try not to rely on drugs to fall asleep, and avoid using them within several hours of sleep if possible.

- Do not go to bed until sleepy, and if you haven't fallen asleep after half an hour, get up, try another relaxing activity like reading, meditating or listening to soft, relaxing music until you feel sleepy, then try to go back to bed.
- Exercise regularly during the days and especially in the early afternoon to tire yourself out for the evening. Avoid exercise at night as this might keep you awake.
- Try to make your sleeping place as safe as you can. If homeless, sleeping in a place where few people are expected to pass, and if possible with a group of trusted and known others will help minimise the chance of risks to your safety.
- Services offering a safe place for homeless people to sleep will be very helpful to homeless people who use drugs.
- Trying to keep a sleep diary may be helpful. To do this, when you wake up in the morning, write down what time you went to bed the previous night, how long you think it took to fall asleep, how difficult it was to fall asleep, anything you remember keeping you awake such as a distracting thought or noise, whether you slept through the night and if not what woke you up, how rested you feel and anything you noticed that made it easier or harder to feel tired or fall asleep. Over time this may help you realise what helps you get better sleep, and what stops you from getting good sleep.
- Bad dreams are common in drug use and withdrawal. Often once a good sleep pattern is set up the bad dreams will become less common. If bad dreams are stopping you from sleeping try getting up and performing some relaxing activity such as reading or meditation then try sleeping again.

Skin and veins



What functions do you think the skin and veins have in our body?



Did you consider?

- The skin is an important barrier that makes it harder for harmful things like bacteria to get into the body. When the skin becomes damaged it can become less useful at its job, and can often become infected itself. Skin infections may spread to inside the body if they are not properly cared for. Infections in the muscle or fat under the skin are also common in people who inject drugs.
- The veins carry our blood back to our heart and lungs and it is important that they are healthy for us to stay healthy. Injection can damage the veins, leading to them 'disappearing' and no longer being able to be used for injection. This damage can have serious complications such as heart attacks or gangrene. If infection is introduced into the vein by an injection this may spread rapidly and have serious consequences including death.



How do you think the skin and veins of a young person who uses drugs get damaged?



Did you consider?

Injection drug use can damage the skin and veins in many ways:

- Directly introduce dirt, germs and infection into the deeper layers of the skin and the muscle, veins and fat beneath it.
- Scars the inside of the vein, like skin after it is cut, making it harder for blood to flow through the vein.
- Introduces particles into the blood in the vein, which can become trapped elsewhere in the body like the heart or the lungs, where they may cause problems.
- Breaks the skin making it easier for infection to get in.

There are certain aspects of drug use and the lifestyle often associated with it that put the skin at further risk:

- Being outside a lot means exposure to more sunlight, wind and dry air. This will remove moisture from the skin allowing it to crack and making it easier for infection to start.
- Many young people who use drugs may suffer dehydration; this too removes moisture from the skin.
- Poor hygiene, which may be a result of lack of access to washing facilities, may make keeping the skin clean harder, which will also make it easier for the skin to get infected.
- Anxiety often experienced by young people who use drugs during use or withdrawals may lead to picking the skin, which breaks the skin and opens it to infection.
- Methamphetamine users frequently pick at their skin, increasing the risk of skin infection
- Young people who use drugs may miss the early signs of infection on a wound meaning the problem can become more serious before it is dealt with.



How do you think a young person who uses drugs could keep healthy skin and veins?



Did you consider?

Looking after the skin

- Use a clean alcohol swab on the area before injections.
- Use new needles.
- Try to clean the body daily, use a rag and some soapy water if a bathroom is not available.
- Avoid too much exposure to sun, wear a long sleeve shirt and pants, a hat and if possible sunscreen.
- Drink plenty of water throughout the day – around 2 litre or 8 glasses.
- Regularly check the body, particularly the feet and areas that cannot be seen like the back, for wounds and signs of infection.
- Check regularly for signs of infection at sites of injection.
- Cover all wounds in antiseptic such as iodine, bandage them with clean bandages and keep them clean until they are healed.

Looking after veins

- Use the smallest size needle possible, a higher gauge means a smaller needle. These do less damage to the veins.

- Try to rotate between several injection sites to avoid repeated damage to the same place. The veins in the arms are the safest to use, with those in the groin and neck being the least safe.
- Ensure to inject with the flow of the blood (toward the heart) and put the long ended tip of the needle into the skin first, at about a 30 degree angle.
- Avoid missing the vein, which can cause problems in the flesh around the injection site. You can tell if the needle is in the vein by lightly drawing back on it, if blood flows into the syringe, the needle is in a vein, if it is hard to pull it back, it is not in a vein.
- Never re-use your own or other people’s needles. They become much blunter after a single use and this makes them more damaging to the veins if used again. If you miss a shot and blunt the needle, it is better to put the shot into a new syringe with a new needle and try again.
- If using a tourniquet, release it as you inject your shot to avoid building up too much pressure in the vein.
- Use cotton wool or a clean cigarette filter to suck your shot into your syringe to filter out particles, which may do serious damage to the veins and lungs.

Dental care

Looking after the health of the teeth, gums and mouth is important in maintaining good health. Problems with the teeth and gums are also often very painful which is obviously a significant problem. Luckily, looking after the mouth is not difficult to do.



What are some common problems with the teeth and mouth that you see or may see in the young people who use drugs?



Did you consider?

Common dental problems and causes of pain in the mouth or toothache include:

- Cracked or chipped teeth.
- Cavities in the teeth caused by bacteria. These are holes in the hard shell of the tooth that expose the sensitive inner parts of the teeth, causing pain.
- Abscesses caused by cavities spreading deep into the base of the tooth. These may also spread infection to the jawbone causing more swelling and pain.
- Teeth pressing against a nerve in the jaw. This will often be a dull, severe and more constant pain. Wisdom teeth in youth are a common cause of this problem.
- Gum infection, often causing swollen and painful gums, and possibly causing bleeding from the gums.
- Cuts or ulcers in the mouth, which may be caused by a number of diseases
- Fungal infections such as thrush may also occur in the mouth, particularly in people living with AIDS.



What are some ways using drugs might negatively impact on the dental health of a young person?



Did you consider?

Methamphetamine and opioids:

- Cause clenching and grinding of the teeth, particularly methamphetamine, which may erode the coat of the tooth, or cause cracks and chips.
- Often causes cravings for sweet food or drink, which damage the teeth and make it easier for bacteria to grow in the mouth and cause cavities.
- Leads to periods of personal neglect during which the user is unlikely to maintain their dental hygiene.
- May cause a dry mouth ('Cottonmouth') by reducing the amount of saliva, which makes it easier for bacteria to damage the teeth and gums.
- The potentially corrosive nature of methamphetamine means smoking it may also cause damage to the teeth and gum.
- In long-term opioid use, infection in the mouth may go unnoticed, as the user may not feel the pain being caused. This may lead to infections getting far worse before being seen to



What could you recommend to a young person who uses drugs to try and improve their dental care and oral health?



Did you consider?

Tooth brushing

- Try to brush your teeth for two minutes twice a day.
- Use a medium or soft stiffness toothbrush to avoid hurting the gums, and a small amount of toothpaste. You may need to have a mouthful of water before you begin brushing to wet your mouth, alternatively wet the toothbrush.
- Brush along the front, back and top of all teeth, as well as lightly along the gum where it meets the tooth. Lightly brush the top of the tongue also. Ensure to reach the teeth at the back of the mouth. Rinse the mouth once with water after brushing.

Flossing

- Flossing your teeth helps clean where brushing cannot. Tooth floss is cheap and if you use only as much as you need each time a single packet will last a long time.
- Try to floss daily, and ensure to reach the teeth at the back of the mouth as well as those at the front. Floss between each pair of teeth, moving the floss forward and back and up and down in the gap.
- Rinse your mouth with water after flossing.

General Care

- Chewing sugar free gum, particularly gum containing Xylitol, Can help clean the teeth and helps produce saliva that protects the teeth as well.

- Drinking plenty of water and keeping a wet mouth is important in protecting yourself from dental problems. Dry gums and a dry mouth, like dry skin, are more easily infected. Also, saliva protects against the bacteria that cause cavities in your teeth.
- Try to avoid too much sugar that can feed bacteria, particularly sugary drinks like soft drink as these are also acidic which damages the teeth.



Sexual and Reproductive Health

Sexual health is an important factor in overall health. There are several simple ways to reduce your risk of catching a sexually transmittable infection, but there are other ways drug use can affect general sexual health.



What does 'safe' sex involve?



Did you consider?

- Always use a new condom or dam, and sure that it has no obvious holes or tears when putting it on. Ensure that it is the right size, if it is too small there is greater risk of it breaking, too large and it may come off. If your partner has put the condom on, ensure that it is on properly before you begin any sexual activity.
- Check the 'use by' date.
- Condoms should also be worn for oral sex; a condom can be cut and unfolded to cover the vagina during oral sex.
- Adequate lubrication of the vagina or anus is important for intercourse as it reduces the risk of bleeding, and the chance of the condom breaking. Water based lubricant should be applied as necessary before and during intercourse.
- It is common for people to try and avoid safe sex practices. It is important to be firm with your stance on safe sex regardless of any excuses your partner may use. If they continue to insist that you should have unprotected or unsafe sex, it is safer to leave than risk it. One wrong choice of partner may leave you with a terrible lifetime reminder like HIV that no one would consider worthwhile.
- Having sex while intoxicated may lead to riskier sexual practices such as not wearing a condom. Deciding to have sex while intoxicated may also lead to what would otherwise be unwanted sexual contact.



For young people who sell sex

- It is particularly important to always follow safe sex practices with the use of a condom essential with every partner. Putting the condom on a male partner yourself is also recommended to ensure it is put on properly and does not have any obvious holes or tares.
- It is common for people selling sex to be pressured into unsafe sexual activity such as sex without a condom. Young people may need assistance in developing the skills to be able to refuse unsafe sex, regardless of any offers of additional payment or other incentives.

- Getting payment before initiating any sexual activity puts more control in the hands of the sex worker, this may make the client less likely to request unsafe sex.
- Limit drug use when working to minimise intoxication and increase awareness of any risks.

Drugs and sex



What are the effects of the drugs you commonly see used by young people on sex and sexual function?



Did you consider?

Opioids (Heroin)

- Linked with infertility in males and females, making it harder to become pregnant.
- Often stops or delays a woman's menstrual cycle or causes irregularities with cycle.
- Can delay ejaculation for the male, which may be desired by a male concerned with premature ejaculation, or their partner.
- May cause reduced sex drive, as well as impotence and ongoing problems ejaculating in males (delaying ejaculation), and problems achieving orgasm in males and females.

Methamphetamine

- In the short term this increases sex drive, sensation and energy and lowers inhibitions, often making sex seem more enjoyable.
- The reduced inhibitions often lead to risky sexual practices such as unprotected sex or aggressive or violent sexual activity, which may be undesired by the partner.
- Decreases the ability to achieve orgasm for males and females and commonly makes erection difficult for the male particularly with long term use, where an eventual reduction in sex drive is also eventually seen.
- Methamphetamine may decrease fertility in the male.
- Methamphetamine may also cause changes or delays in the female's menstrual cycle.



Nicotine

Nicotine and other chemicals in cigarettes and other tobacco-based products are damaging to most of the body in one way or another. Risks of cancer, heart attack, stroke and emphysema (a lung disease) are greatly increased, along with many other problems related to smoking. The body can repair some of this damage if you stop smoking. Nicotine patches or nicotine chewing gum might help initially to stop smoking. Consideration might be given to creating 'No Smoking' areas, not smoking near children, and both worker and young people considering quitting or reducing their tobacco use.



General health

It is important to remember that while each of the individual aspects of health discussed in this session are important on their own in achieving good health, it is only when all of these aspects are

attended to together, and a personal balance of lifestyle is achieved, that physical and mental health will significantly improve. Thus educating and empowering young people who use drugs to look after their own health holds important lifetime and intergenerational implications.

See Resource CD/USB: 4, 13, 16, 17, 18, 19, 33, and 38.

Session 08. Mental Health and Well-being

By completing this session you should have knowledge of:

- ✓ The experience of mental health problems
- ✓ What would raise concerns about the mental health of a young person who uses drugs
- ✓ Symptoms of some mental health disorders:
 - Depression
 - Anxiety
 - Psychoses
- ✓ Impact of drug use on mental health
 - Amphetamine type stimulants
 - Cannabis
- ✓ Assisting young people with mental health concerns
 - Sad and depressed
 - Frightened and stressed
 - Paranoid
- ✓ General tips of managing mental health concerns



The World Health Organization defines mental health as:

“...a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.”

Thus mental health is just as important as physical health and poor mental health can be both distressing and disabling to the sufferer. Drug use and the lifestyle that can accompany it can have some negative impacts on mental health, just as they can on physical health, and vice versa.



What might it feel like to be:

- Sad – depressed and hopeless?
- Frightened – fearful?
- Anxious – stressed?
- Paranoid – feeling people after you, out to hurt you?
- Seeing things that others cannot see?
- Hearing things that others cannot hear?

Focus on mood/feelings, thoughts, behaviour from the observer and the sufferer’s perspective.



What might lead you to think that a young person who uses drugs might have the following mental health problems?

- Have depression?
- Have an anxiety disorder?
- Be psychotic



How can we tell if mental health difficulties become a mental health disorder (as defined by mental health professionals)?

The important considerations are:

- Patterns of behaviours/symptoms (not just one or two symptoms),
- Persistence of the symptoms (weeks—months)
- Decline in social or occupational functioning



Did you consider?

Depression:

Symptoms should be present for at least two weeks for a diagnosis of Depressive Episode, and for two consecutive months for a diagnosis of Major Depression include:

- Depressed mood for most of the day and nearly every day – e.g. feel sad, empty, tearful, and sometimes irritability in young people
- Loss of interest and pleasure in most activities, most of the day
- Significant weight loss or gain, appetite decreased nearly every day
- Loss of interest and pleasure in sexual activity
- Difficult in getting to and remaining asleep, or sleeping too much
- Restlessness, agitation or slowed down movement
- Loss of energy and feeling tired most of the day nearly every day
- Feelings of worthlessness, hopelessness, guilt nearly every day
- Difficulties in thinking and concentrating nearly every day
- Thinking of death, dying and or suicide most of the time

Anxiety Disorder:

Symptoms should be present for at least six months, and include:

- Excessive anxiety and worry more days than not
- Difficulty in controlling the worry
- Restlessness, on edge
- Easily tired
- Difficulty in concentration
- Irritability
- Muscle tension
- Sleep disturbance

There are various anxiety disorders, including: Generalised (anxious most of the time), Post-traumatic Stress Disorder, fear of being with people and in crowds (Social phobia), being in places or

situations where there is fear of being unable to escape- e.g. open spaces, on bridges, etc. (Agoraphobia), Panic Disorder, Obsessive-Compulsive Disorder.

Psychoses: [there are a number of psychoses, for this section the focus will be on schizophrenia – paranoid type]. Symptoms should have been present for six months [if not an acute presentation] and can include:

- Delusions (believing things that have no basis in reality)
- Hallucinations [e.g. visual (seeing), auditory (hearing), tactile (touch), olfactory (smell)]
- Disorganised speech (e.g. incoherent)
- Disorganised thinking
- Disorganised/inappropriate behaviour
- Social and occupational dysfunction

Some psychotic disorders are drug use induced, and may remit after a short period of time. Others are induced or exacerbated by drug use in people who have a vulnerability to psychoses (e.g. family history), and these usually persist, but can be managed if appropriate mental health services are available. Psychoses tend to emerge in young males in late adolescence, and for females in mid twenties.



What drugs can affect your mental health, and how?



Did you consider?

- Most drugs people take can have some negative impact on mental health in the short or the long term. The link between substance use and mental health is still somewhat unclear but young people who use drugs do complain of more mental health concerns than those who do not use drugs. Some drugs present a clearer risk to mental health than others.
- The lifestyle factors which can be associated with regular drug use such as financial problems, legal issues and involvement with the police, physical health problems, social stigma and discrimination, exposure to violence, homelessness and a lacking sense of future security may also impact on the mental health of a young drug user.
- Use of drugs may worsen existing mental health problems or make it more likely for the user to develop a mental health problem. Drug use also often makes successful treatment of mental health problems more difficult. More regular use or use of large doses generally increases the risk of negative mental health consequences of drug use.

Methamphetamines can worsen or cause several potentially distressing symptoms in the user, either while using, coming down, withdrawing or even persisting after the user stops taking it:

- Paranoia and anxiety
- Delusion and hallucination
- Depression
- Psychosis

Methamphetamine psychosis is a condition generally lasting a few hours to a day or two in a person who recently used methamphetamine. It is characterised by severe delusions and paranoia as well as hallucinations. The person may appear agitated, energetic, distressed, and may be talking to

people who are not there. Aggression is often the result of this state of mental confusion and so methamphetamine psychosis presents a risk to those around the user as well as to the user him/herself. If you suspect a methamphetamine user is experiencing a psychosis you should:

- Keep a safe distance from the person and warn others to do the same.
- Try to calm them by talking to them, avoid confronting or aggressive tones of voice and direct eye contact.
- Contact authorities if you feel the user is a serious risk to their own or others' health.
- Remember that other drugs can sometimes trigger similar episodes so trying to determine if the person has been using drugs and what they used may be useful. Also remember that several other mental health problems can resemble methamphetamine psychosis, such as paranoid schizophrenia, but these conditions generally last much longer

Cannabis can also worsen or cause several different mental health problems in some users, especially when use is begun early (i.e. early adolescence), is heavy and frequent:

- Paranoia and anxiety – these are common symptoms during intoxication, and a pre-existing anxiety disorder can be made worse by heavy and prolonged cannabis use
- Depression – cannabis may make the user feel depressed when they are intoxicated or significantly worsen existing depression. High rates of depression are found in both current users and past cannabis smokers. Age of initiating use and amount smoked are predictors of depression in cannabis users.
- Psychotic episodes when using cannabis are rarely reported but cannabis' ability to worsen existing psychotic illnesses such as schizophrenia is well documented. Cannabis use may also increase the risk of a long lasting psychotic illness developing, particularly in those with some existing vulnerability (e.g. genetic, family history).



What can you do to assist a young person who uses drugs and who also has mental health concerns?

- Make sure you considered: talking with another worker about your concerns, and getting a competent mental assessment as soon as possible.
- If the situation appears to be a mental health emergency (e.g. suicidal, acute psychosis) try to get the young person to the Emergency Room of a hospital or clinic.
- Medications may be useful, but need to be monitored by a competent medical officer, who is experienced in working with young people.
- Young people experiencing serious mental health difficulties **SHOULD NOT** self-medicate, and need to be aware that local or traditional medicines may or may not assist.



* **Sad – depressed** – support the young person, encourage them to talk about their feelings with someone you trust, cognitive behaviour therapy (CBT) is often used, and medication sometimes. Remember that most anti-depressant medications can take up to about 2 weeks to bring about significant change.

Check for suicidality!!

All thoughts of suicide must be taken seriously. A high level of intent and planning indicates a serious risk of suicide. To determine whether the person has definite intentions to take their life you need to ask them three questions:

1. Have you decided how you would kill yourself?
2. Have you decided when you would do it?
3. Have you taken any steps to secure the things you would need to carry out your plan?

You must remember that the absence of a plan is not enough to ensure the person's safety. If the person is actively suicidal, they should not be left alone. If you can't stay with them, arrange for someone else to do so. In addition, give the person a safety contact, which is available at all times (such as a telephone help line, a friend or family member who has agreed to help or a professional help giver). Do not use guilt or threats to prevent suicide (for example, do not tell the person they will go to hell or ruin other people's lives if they die by suicide). Mental health professionals advocate always asking for professional help, especially if the person is psychotic. If the suicidal person has a weapon or is behaving aggressively towards you, it may be necessary to seek assistance from the police in order to protect yourself.

*** *Frightened*** – facing fears – talking about it/them with someone they trust
Stress – stress management, meditation, breathing, etc.

If the person is anxious and panicky, take them to a quiet environment away from crowds, loud noise and bright lights and monitor them in case their psychological state deteriorates. It is important that you remain calm and you do not start to panic yourself. Speak to the person in a reassuring but firm manner and be patient. Speak clearly, slowly and use short sentences.

Rather than making assumptions about what the person needs, ask them directly what they think might help. Do not belittle the person's experience. Acknowledge that the terror they feel is very real, but reassure them that a panic attack, while very frightening, is not life threatening or dangerous. Reassure them that they are safe and that their symptoms will pass.

The symptoms of a panic attack sometimes resemble the symptoms of a heart attack or other medical problem. It is not possible to be totally sure that a person is having a panic attack. Only a medical professional can tell if it is something more serious.

*** *Paranoid***, seeing/hearing things others cannot – obtain medical assistance.

If the person appears psychotic, evaluate the situation by assessing the risks involved including whether the person is at risk of suicide. Try to find out if the person has anyone they trust (e.g. close friends, family) and try to enlist their help. Assess whether it is safe for the person to be alone, and if not, ensure that someone stays with them. It is important to communicate with the person in a clear and concise manner, using short simple sentences. Speak quietly in a non-threatening tone of voice at a moderate pace. If the person asks you questions, answer them calmly. You should comply with requests unless they are unsafe or unreasonable. This gives the person the opportunity to feel somewhat in control. You should be aware that the person might act upon a delusion (false belief) or hallucination (perception of things that are not real). In this case, it is your primary task to de-escalate the situation and therefore you should not do anything that will further agitate the person. Do not dismiss, minimise or argue with the person about their delusions or hallucinations; do not act alarmed, horrified or embarrassed by the person's delusions; do not laugh at the person's symptoms

of psychosis; if the person exhibits paranoid behaviour, do not encourage or inflame the person's paranoia.

Try to maintain safety and protect the person, yourself and others around you from harm. Be prepared to call for assistance. If the person is at risk of harming themselves or others, make sure they are evaluated by a medical or mental health professional immediately. Encourage the person to seek professional help whether you think the psychosis is drug related or not.

General tips:

Stay calm and assess the situation for potential dangers. Try to ensure that the person, yourself and others are safe.

- Talk with the person in a respectful manner using simple, clear language. Be prepared to repeat simple requests and instructions as the person may find it difficult to comprehend what has been said. Do not speak in an angry manner.
- Try to dissuade the affected person from engaging in dangerous behaviours, such as driving a vehicle or operating machinery. Tell the person that it is dangerous to drive even though they may feel alert.
- Encourage the person to tell someone if they start to feel unwell or uneasy, or to call emergency services if they have an adverse reaction. Talk in a calm, non-confrontational manner.
- Speak slowly and confidently with a gentle, caring tone of voice.
- Try not to provoke the person; refrain from speaking in a hostile or threatening manner and avoid arguing with them.
- Use positive words (such as “stay calm”) instead of negative words (such as “don't fight”), which may cause the person to overreact.
- Consider taking a break from the conversation to allow the person a chance to calm down.
- Try to provide the person with a quiet environment away from noise and other distractions.
- If inside, try to keep the exits clear so that the person does not feel penned in and you think the psychosis is drug related or not.

See Resource CD/USB: 2, 8, 24, and 38.

Session 09. Basic Counselling

By completing this session you should have knowledge of:

- ✓ What comprises 'counselling'
- ✓ Counselling 'principles'
- ✓ Helpful counsellor attitudes
- ✓ Micro-counselling skills
- ✓ Non-verbal communication
- ✓ Setting goals
- ✓ Challenges in counselling with young people
- ✓ The FRAMES approach

Note: this session will not teach counseling skills. It provides an overview of counselling, and some key concepts and ideas. For those who wish to develop counseling skills, a suitable course should be undertaken.



Counseling as a process can:

- Ensure passing on of correct information.
- Provide support at times of crisis.
- Encourage change when change is needed.
- Help clients focus and identify for themselves their immediate and long-term needs.
- Propose realistic action suitably adapted to the different clients and circumstances.
- Assist clients to accept and act on reality.



Basic Counselling:



Confidentiality – why is it a fundamental issue, especially for young people who use drugs?



It is very important that confidentiality be taken very seriously. If a young person feels strong emotions during counselling, for example becoming very sad and crying, they may be quite vulnerable when they return to their peers. It is very important to consider these issues and adjust your approach.

Likewise, it is important to provide counselling in a location where the young person feels comfortable as well as safe. While a quiet room where nobody can overhear what is being said is ideal, this may not be available.

It is possible that an outdoor setting can provide a comfortable and safe location for a young person to engage in counselling. Some snacks and drinks may also reduce tension and assist in developing the counseling relationship.



What are some of the main ‘helping processes’ in counseling?



Counselling is a helping process. Some of the elements of the process are:

- Relationship building
- Assessing the problem
- Addressing the problem

Principles of counseling:

1. **Individualization:** recognizing and understanding each client’s unique qualities. Individualization is based upon the right of human beings to be individuals.
2. **Purposeful expression of feelings:** recognition of the client’s need to express his/her feelings freely without being discouraged or condemned.
3. **Controlled emotional involvement:** sensitivity to the client’s feelings, an understanding of their meaning and a response to the client’s feelings.
4. **Acceptance:** perceiving and dealing with the client as he/she really is.
5. **Non-judgemental attitude:** excludes assigning guilt or innocence or degree of client’s responsibility for causation of the problems; includes evaluative judgements about the client’s attitudes or actions.
6. **Client self-determination:** practical recognition of the client’s right and need to freedom in making his/her own choices and decisions in the counselling process. This promotes responsibility.
7. **Confidentiality:** the preservation of private, personal information concerning the client, which is disclosed in the professional relationship. Confidentiality is a client’s basic right. However, in some countries the counsellor is legally required to report any evidence of abuse or the intention to commit suicide to the appropriate authorities.

It is important to remember that when you engage in a helpful relationship with a young drug user, you may raise their expectations that all their problems can be fixed and that this can happen quickly. It is important to help the young person develop realistic expectations of what counseling might achieve.



What are some important counsellor attitudes?



Did you consider?

- **Empathy:** Empathy is the ability of the counsellor to understand and identify with the client’s situation during their session. It is necessary for the counsellor to focus on understanding how the client sees the world, their experiences and their feelings concerning these.

- **Congruence or genuineness:** The counsellor must be sincere in the relationship with the client, not saying one thing and meaning another and not hiding their true feelings. Adolescents will easily identify inconsistencies with the counsellor's feelings and attitudes;
- **Unconditional positive regard:** This involves the counsellor being non-judgemental and accepting of the client's behaviour regardless of how offensive it may seem. It is difficult to create a trusting counselling relationship and to gain the confidence of the client without this quality.



Counselling micro-skills

These are some of the skills that the counsellor uses as he/she maneuvers through a counselling session using the questions/ pointers outlined below. The counselling micro skills below are listed as presented with explanations of their use.

- Observation:** This is the most useful skill when making an assessment of adolescents. Some areas to pay attention to when observing adolescents are: general appearance, behaviour, mood, what is said and how it is said.
- Active listening:** Active listening takes into consideration the need for the counsellor to not only listen to the client, but to also indicate to the client that he or she is listening. The following cues should be employed as appropriate during counselling sessions:
 - Non-verbal responses – Eye contact, appropriate facial expression, nodding;
 - Encouragers – “Mm-hm”, “OK”, “Really”, used in a non-judgemental manner;
 - Reflection of content and feeling – This is about rewording only the important aspects of what the client has said; for example, “you’re feeling pressured to use drugs when you are alone with him at his house”;
 - Summarizing – Briefly feeding back in your own words the salient features in the client’s story;
 - Clarifying – Restating or paraphrasing is useful when you want to be sure that you understand the client’s question or statement. It also assures the client that you are truly listening and want to understand clearly what is being said; and
 - Noticing what is missing – It is important to note what is left out of the adolescent’s story and to carefully invite the client to discuss these missing narratives as they can provide useful information about clients.
- Giving feedback:** Feedback involves providing the adolescents with information about what they have previously stated and serves several purposes. Forms of feedback include:
 - Giving compliments – Often adolescents get feedback that is related to what they have not done well. During the counselling sessions, however, the counsellor is encouraged to provide the clients with positive feedback where possible;
 - Making affirmation – This is when the counselor acknowledges and verifies a positive effort that the client has made. For example, an adolescent has indicated that he is managing to use condoms whenever he has sex. The counsellor could say, “You obviously are doing very well with your decision to use condoms consistently”;

- iii. **Normalizing** – This is a very important skill, especially when working with adolescents because it puts some perspective to their world when they feel they are going crazy. This skill allows the counsellor to tell the client that feelings associated with an extreme situation are normal, if that is the case; and
 - iv. **Reframing** – Adolescents tend to view their situations from a very shortsighted or narrow perspective. Reframing encourages them to see the larger picture and not just what they can see in the moment. Care must be exercised, however, when using this skill to ensure that the adolescent has the opportunity to discard the larger picture of their lives as detailed from the counsellor and reframe it.

- d. **Questioning:** Questioning can be used as a means of gaining information and is a necessary part of any counselling session. However, when working with adolescents, questions need to be used in moderation, so as not to get into a question and answer format during the session. Allowing the adolescent to freely express their thoughts and feelings should be a consistent focus of the counsellor. Several types of questions will be useful when using counselling a young substance user:
 - i. **Open-ended questions** – These encourage the adolescent to respond in a manner that will result in an open discussion. An example of an open-ended question is “What were the circumstances that led you to decide to use ya baa?”;
 - ii. **Closed-ended questions** – These types of questions usually require only one-word answers and limit the adolescent’s response. An example of a closed ended question is “Have you ever used cannabis?”;
 - iii. **Transitional questions** – These are very useful with adolescents as they encourage them to move from talking about one thing to another. They can be used to focus the adolescent on specific areas of the session. An illustration of this type of question is “You have told me how your mother feels about your boyfriend; now tell me how do you feel about him?”;
 - iv. **Goal-oriented questions** – These are direct questions that allow the adolescent to think about how things could be different. Such as “What might happen if you decided to stop using heroin?”; and
 - v. **Questions that exaggerate or highlight consequences** – These questions encourage the adolescent to see how well he/she is handling a situation and helps him/her discover his/her strengths. “So what prevents you from getting HIV or contracting an STI?”

- e. **Challenging:** The counsellor may use this skill when he/she feels or recognizes that the adolescent is stuck on one aspect of an issue or problem and the counsellor perceives that the adolescent needs to be encouraged to move on to other issues or see the problem via a different light.

- f. **Disclosure skills:** This involves the counsellor sharing appropriate information about himself/herself with the adolescent. This often makes the adolescent feel understood and further fosters the development of adolescent trust and confidence in the counsellor and encourages the adolescent’s disclosure on sensitive matters. Care must be taken, however, to ensure that the focus of the session returns on the clients’ needs.



Non-verbal communication – what are some important examples that could assist/decrease counsellor effectiveness?



The following list of counsellor’s non-verbal communication may be useful to you to enhance your listening skills.

	<i>Desirable</i>	<i>Undesirable</i>
Facial expression	<ul style="list-style-type: none"> • Direct eye contact (except where culturally unacceptable). • Warmth and concern reflected in your face. • Eyes at same level as client’s. • Appropriately varied and animated facial expression. • Mouth relaxed, occasional smiles. 	<ul style="list-style-type: none"> • Avoidance of eye contact (unless it is a sign of respect in your culture). • Eye level higher or lower than client’s. • Staring or fixating on person or object. • Nodding head excessively. • Frozen or rigid facial expressions. • Pursing or biting lips.
Posture	<ul style="list-style-type: none"> • Arms and hands moderately appropriate gestures. • Body leaning slightly forward, attentive but relaxed. 	<ul style="list-style-type: none"> • Rigid body positions, arms tightly, folded. • Body turned at acute angle. • Fidgeting with hands. • Clipping nails or doing other private tasks. • Rocking in chair. • Standing or placing feet on desk. • Hand or fingers over mouth. • Pointing finger for emphasis.
Physical proximity	<ul style="list-style-type: none"> • 1 – 2 metres between your chairs. 	<ul style="list-style-type: none"> • Excessive closeness or distance.
Voice	<ul style="list-style-type: none"> • Clearly audible but not loud. • Warmth in tone of voice; voice modulated to reflect feelings of concern, approval, etc. • Moderate speech tempo. 	<ul style="list-style-type: none"> • Mumbling; speaking inaudibly. • Monotone voice; frequent grammatical errors. • Prolonged silences, nervous laughter, speaking loudly.

Setting Goals



What are some important considerations in goal setting with young people who use drugs?



Did you consider?

- Goals should relate to the desired end and outcomes sought by clients;
- Goals should be defined in explicit and measurable terms;
- Goals should be feasible;
- Goals should be within the range of your knowledge and skills as a counsellor;
- Goals should be stated in positive terms that emphasize growth; and
- Goals should be consistent with the functions and mission of your group or agency.



Breaking down large goals into smaller steps:

Behaviour change is very difficult for all of us and particularly for young substance users. It is important to bear in mind that when a client agrees to carry out a task, it does not necessarily mean that the client has the knowledge, courage, interpersonal skill or emotional readiness to implement the task successfully. You need to help your client to set small, realistic goals that are achievable, so that neither of you will be disappointed by large failures at the beginning of the relationship.

Example of breaking down large goals into smaller steps:

Take the example of a severe relationship conflict. If the ultimate goal is to reduce the frequency and severity of the conflict, then the goal can be broken down into the following steps:

- To reduce criticism and put downs that provoke defensiveness and recriminations;
- To identify physical outlets or calming techniques for family members so that they can resist the impulse to use physical violence. This should be an immediate urgent priority for you as a counsellor;
- To identify sources of anger and to learn and apply effective conflict resolution skills; and
- To work together in identifying problems and employing problem solving strategies.



What are some of the possible challenges when counselling young people who use drugs, and how might you respond?



Did you consider?

1. The young person is silent – silence in a client may be as a result of several things:
→ A good place to start would be to give sufficient time for the young person to warm up to the counsellor.
2. The young person appears to have very little knowledge about substance use:
→ Your client may need educating about the issues that are being discussed.
3. The young person cries – issues involved in decision-making can be very painful for a client to discuss:

→ It is important to provide a supportive environment for your client to continue to express feelings about the issues.

→ It is OK to just let the client cry.

4. The young person wishes to talk about something else other than decision making:

→ Although it is useful to accommodate your client and their desire to talk, the proactive counsellor focuses the session on decision-making.

→ If the client is not ready to address this issue, discuss this observation with your client and further assess your client's readiness to be in counselling for the issues now.



One framework found useful in working with people who use drugs is FRAMES.

FRAMES?

Feedback

The provision of personally relevant feedback is a key component of brief intervention and generally follows a thorough assessment of drug use and related problems. Feedback can include information about the individual's drug use and problems from a screening instrument, such as the one provided in the previous chapter, information about personal risks associated with current drug use patterns, and general information about substance related risks and harms. If the client's presenting complaint could be related to substance use, it is important to inform the client about the link as part of feedback. Feedback may also include a comparison between the client's substance use patterns and problems, and the average patterns and problems experienced by other similar people in the population.

Responsibility

A key principle of intervention with substance users is to acknowledge that they are responsible for their own behaviour and that they can make choices about their substance use. The message that "What you do with your substance use is up to you" and that "nobody can make you change or decide for you" enables the client to retain personal control over their behaviour and its consequences. This sense of control has been found to be an important element in motivation for change and to decrease resistance.

Advice

The central component of effective brief interventions is the provision of clear advice regarding the harms associated with continued use. Clients are often unaware that their current pattern of substance use could lead to health or other problems or make existing problems worse. Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems will increase their awareness of their personal risk and provide reasons to consider changing their behaviour.

Menu of alternative change options

Effective brief interventions and self help resources provide the client with a range of alternative strategies to cut down or stop their substance use. This allows the client to choose the strategies, which are most suitable for their situation, and which they feel will be most helpful. Providing choices reinforces the sense of personal control and responsibility for making change and can help to strengthen the client's motivation for change. Examples of options for clients to choose could include:

- Keeping a diary of substance use (where, when, how much, who with, why);

- Helping clients to prepare substance use guidelines for themselves;
- Identifying high risk situations and strategies to avoid them;
- Identifying other activities instead of drug use – hobbies, sports clubs, gymnasium, etc.;
- Encouraging the client to identify people who could provide support and help for the changes they want to make;
- Providing information about other self help resources and written information;
- Inviting the client to return for regular sessions to review their substance use and to work through the “substance users guide to cutting down or stopping” together;
- Providing information about other groups or counsellors that specialize in drug and alcohol problems; and
- Putting aside the money they would normally spend on substances for something else.

Empathy

A consistent component of effective brief interventions is a warm, reflective, empathic and understanding approach by the person delivering the intervention. Use of a warm, empathic style is a significant factor in the client’s response to the intervention and leads to reduced substance use at follow up.

Self-efficacy (confidence)

The final component of effective brief interventions is to encourage clients’ confidence that they are able to make changes in their substance use behaviour. People who believe that they are likely to make changes are much more likely to do so than those who feel powerless or helpless to change their behaviour. It is particularly helpful to elicit self-efficacy statements from clients, as they are likely to believe what they hear themselves say.

See Resource CD/USB: 18, 19, 40, 41, 42, 43, 50, and 56.

Session 10. Motivational Enhancement

By completing this session you should have knowledge of:

- ✓ Why motivational enhancement is important
- ✓ Principles of a 'motivational interview'
- ✓ The OARS skills
- ✓ '5 key questions'

Motivation cannot be assumed, or even expected among young people who use drugs. The worker's role is more that of a coach and motivator, as most young people do not seek treatment or assistance voluntarily.



Why is enhancing motivation a most important part of working with young people who use drugs in bringing about positive change?



Motivational interviewing, a technique of a motivational enhancement approach, is a directive, client-centred style of interaction aimed at helping people to explore and resolve their ambivalence about their substance use and move through the process of change. It is especially useful when working with clients are just starting to think about change, but the principles and skills are important at all stages.

Principles of motivational interviewing:

Express empathy

In the clinical situation empathy involves an accepting, non-judgmental approach, which tries to understand the client's point of view and avoids the use of labels, such as 'alcoholic' or 'drug addict'. It is especially important to avoid confrontation and blaming or criticism of the client. The empathy of the worker is an important contributor to how well the client responds to the intervention.

Develop discrepancy

People are more likely to be motivated to change their drug use behaviour when they see a difference or discrepancy between their current drug use and related problems and the way they would like their life to be. The greater the difference between their important goals and values and their current behaviour, the more important it is likely to be to clients to change. Motivational interviewing aims to create and amplify a discrepancy between current behaviour and broader goals and values from the client's point of view. It is important for the client to identify their own goals and values and to express their own reasons for change.

Roll with resistance (avoid argument)

A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the client to consider new information and perspectives on their substance use. When the client expresses resistance, the health worker should reframe it or reflect it rather than opposing it. It is particularly important to avoid arguing in favour of change as this puts the client in the position of arguing against it.

Support self-efficacy (confidence)

Young people who use drugs need to believe that reducing or stopping their drug use is important and be confident that they are able to do so. Using negotiation and confidence building is an important part of motivational interviewing. The worker's belief in the client's ability to change their behaviour is also important and can become a self-fulfilling prophecy.

Specific skills:

Motivational interviewing makes use of five specific skills. These skills are used together to encourage young people who use drugs to talk, to explore their ambivalence about their substance use and to clarify their reasons for reducing or stopping their substance use.

The first four skills are often known by the acronym **OARS** – **O**pen ended questions, **A**ffirmation, **R**eflective listening, and **S**ummarizing. The fifth skill is 'eliciting change talk' and involves using the OARS to guide the client to present the arguments for changing their drug use behaviour.



Open-ended questions

Open-ended questions are questions that require a longer answer and open the door for the person to talk. Examples of open-ended questions include:

- "What are the good things about your drug use?"
- "Tell me about the not so good things about using...(drug)?"
- "You seem to have some concerns about your drug use; tell me more about them".
- "What concerns you about that?"
- "How do you feel about ...?"
- "What would you like to do about that?"
- "What do you know about...?"

Affirmation

Including statements of appreciation and understanding helps to create a more supportive atmosphere, and helps build rapport with the client. Affirming the client's strengths and efforts to change helps build confidence, while affirming self-motivating statements (or change talk) encourages readiness to change. Examples of affirmation include:

- "Thanks for coming today."
- "I appreciate that you are willing to talk to me about your drug use."
- "You are obviously a resourceful person to have coped with those difficulties."
- "I can see that you are a really strong person."
- "That's a good idea."
- "It's hard to talk aboutI really appreciate your keeping on with this."

Reflective listening

A reflective listening response is a statement guessing at what the client means. It is important to reflect the underlying meanings and feelings the client has expressed, as well as the words they have used. Using reflective listening is like being a mirror for the person, so that they can hear the

therapist say what they have communicated. Reflective listening shows the client that the therapist understands what is being said or can be used to clarify what the client means. Effective reflective listening encourages the client to keep talking and you should allow enough time for that to happen. In motivational interviewing reflective listening is used actively to highlight the client's ambivalence about their substance use, to steer the client towards a greater recognition of their problems and concerns, and to reinforce statements indicating that the client is thinking about change.

Examples include:

- "You are surprised that your score shows you are at risk of problems."
- "It's really important to you to keep your relationship with your boyfriend."
- "You're feeling uncomfortable talking about this."
- "You're angry because your wife keeps nagging you about your drug use."
- "You would like to cut down your substance use at parties."
- "You really enjoy your drug use and would hate to give it up, but you can also see that it is causing some financial and legal problems."

Summarize

Summarizing is an important way of gathering together what has already been said and preparing the client to move on. Summarizing adds to the power of reflective listening especially in relation to concerns and change talk. First clients hear themselves say it, then they hear the therapist reflect it, and then they hear it again in the summary. The therapist chooses what to include in the summary and can use it to change direction by emphasizing some things and not others. It is important to keep the summary succinct. An example of a summary appears below.

- "So you really enjoy using amphetamines at parties and you don't think you use any more than your friends do. On the other hand, you have spent a lot more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills. Your partner is angry and you really hate upsetting her. As well, you have noticed that you are having trouble sleeping and you're finding it difficult to remember things."

Eliciting change talk

The fifth skill, 'eliciting change talk', is a strategy for helping the client to resolve ambivalence and is aimed at enabling the client to present the arguments for change.

There are four main categories of change talk:

- Recognizing the disadvantages of staying the same
- Recognizing the advantages of change
- Expressing optimism about change
- Expressing an intention to change

There are a number of ways of drawing out change talk from the client:

- Asking direct open questions; for example:
 - "What worries you about your drug use?"
 - "What do you think will happen if you don't make any changes?"
 - "What would be the good things about cutting down your drug use?"
 - "How would you like your life to be in five years time?"
 - "What do you think would work for you if you decided to change?"

- “How confident are you that you can make this change?”
- “How important is it to you to cut down your drug use?”
- “What are you thinking about your drug use now?”
- Use the importance and confidence rulers:
 - “Why are you at ‘a’ (e.g., 3) and not at 0?” This gets the client to verbally justify, or defend, their position which can act to motivate the client to change.
 - “What would it take for you to go from ‘a’ (e.g., 3) to ‘b’ (e.g., 6) (a higher number)? This gets clients to verbalize possible strategies for change and gets them to start thinking more about change.
- Probe the decision balance by encouraging the client to talk about the benefits of change and the costs of staying the same.
- Ask the client to clarify or elaborate their statements – for example, a person who reports that one of the less good things about using cannabis is having panic attacks could be asked:
 - “Describe the last time this happened.”
 - “What else?”
 - “Give me an example of that.”
 - “Tell me more about that?”
- Ask the client to imagine the worst consequences of not changing or the best consequences of changing.
- Explore the client’s goals and values to identify discrepancies between the client’s values and their current drug use.



An example of a brief motivational enhancement approach to cannabis use: “5 Key Questions”

Rationale:

Studies indicate that many youth workers feel ill-prepared to engage in meaningful conversations with young people accessing their services with regard to reduction or cessation of cannabis use. A motivational enhancement approach can assist in opportunistic interactions with out of home/school (young people with multiple and complex needs) aged 14 to 24 to might be considering quitting or reducing their cannabis use.

The Approach:

In general conversation, cannabis use may arise and what is said indicate some possible difficulties associated with its use.

At that stage, a worker may choose to move to a more ‘motivational enhancement’ approach. This, in the main, involves consideration of five key questions within as normal a conversational flow as possible. The key questions are:

- 1) So, what do you like/enjoy about your use of cannabis? [Exhaust reasons]
- 2) Ok, and what do you like less about your use of cannabis? [Attempt to discount some, and give appropriate info as necessary]

- 3) So you say you like..., but are less happy about...have you thought about what could be good about making a change in your use of cannabis?
- 4) OK, but what might be some less good things about making a change in your use of cannabis?

i) If young person is not interested in change at this stage, 'So, you don't seem too keen on making a change in your use of cannabis at this stage. Here is some info that you might find interesting or useful. Also I am wondering what might lead you to re-think this decision at some stage?' **Add:** Before we finish, I would like to give you some info that your might find helpful and some contacts where you might get some help in if you re-consider your decision, and remember I am happy to talk with you again about this if you want.

OR

ii) If young person is interested in change 'So we talked a lot about what you like and don't like so much about your use of cannabis, and what you might gain and lose from changing your use. Before we finish, I would like to give you some info that your might find helpful and some contacts where you might get some help in making the changes you are thinking about'.

If it is part of the worker's role to provide brief interventions for young people wishing to address their cannabis use-related issues, the worker could then continue the conversation as follows:

"We did not actually talk about how much cannabis you actually use ...so, can you tell me how many days a week you use... "

Of course, the actual wording of the questions will be determined by the real world 'style' of the worker and take into account the setting and the situation of the young person. However, there should be an attempt to ensure respect and empathy and to indicate that their use of cannabis is not mindless and that they recognise the benefits and 'less good' aspects of its use. The approach also indicates that the worker understands that change is difficult, and while possibly bringing benefits (never guaranteed) there are 'costs' associated with the change process.

A useful video demonstrating the process can be found at:

<http://ncpic.org.au/workforce/alcohol-and-other-drug-workers/young-people-training-package/>

If viewing the video, it could be helpful to consider:

- Why words like 'bad' or 'negative' not used by the worker?
- What is the worker attempting to do each time he summaries the conversation so far?
- How does the worker present the predicament to the young person (i.e. how does he present the dilemma re 'good and less good' things about cannabis use, and the potentially 'good and less good' things about change?
- Why does the worker NOT really explore the many issues raised by the young person?
- How would you adapt this approach to your own 'style' of relating to young people, and your work setting and role?

Note: language in the following example is very 'Australian', and would need to be adapted to other cultures.

Dialogue
COUNSELLOR: [conversation begins as some way in to a general 'chat' Tom has been having with the youth worker] ...so, you were mentioning about using dope...
I am wondering what YOU like about it – what are some of the things you get from it
YOUNG PERSON: I really don't know what to say. I like the 'high'
What else do you like about it
Well ... it's something to do – fills the time... umm, umm ... do it with me mates .. we laugh ..
So you have some fun times with mates and it fills the time... what else
I dunno ... um ... it helps me to get to sleep.... I dunno
It's hard for you to get to sleep without it
Yep – sometimes..... like when my head is spinning and I'm think, thinking and it is giving me the shits .
Ok, so it helps you to get to sleep too ... What else does the dope do for you
I dunno ... it's fun Better than being bored and nothing to do .. and I can relax and chill...
Sounds using dope gives you something to do, some fun times and then helps you sleep..... Any more things you like about it
Hey ... what else? I dunno – I just like it (Laughs)
OK I ask a lot of questions, hey? You OK?
Yep ...
So, is there any 'down side' – things you don't like so much about dope?
Hmmm (pause) Well, umm .. costing me a lot
So, it's getting a bit expensive for you
Yep
What else?...
Ah ... sometimes I don't like what it does to my head – specially when I use by myself.... (pause)
That must be tough ... are there other things as well?
Sort of Like when I call Mum or Em (my sister) they keep saying – 'you still using dope?', 'are you stoned now?' Makes me angry and pissed off
Pissed off
Yep – at them and me!
Like?
Like they think I am some sort of loser they should talk!
OK, so there is the cost, you head spinning, being a bit worried about what is happening to your head and how your mum and sister are treating you. Other things..
Shit .. isn't that enough.... Yea .. makes me lazy too – don't get to job interviews an stuff
(smiles) Questions, questions.... But, seriously, are there other things you don't like so much about the dope?
Nah .. think they are the main ones – and I think the cops are watching me
So, have you ever tried to cut down or stop?
Yep - but it didn't work
What did you try?
Just tried to stop ...
What happened?
Didn't work .
What did you want to get from stopping or cutting down?
I dunno Head quieter, some money for stuff ... family .. I duuno
OK .. so you have some good ideas about what you wanted ... what about things that might be no

Dialogue
so good about making a change
Hmmm, ... well guess me mates .. how they will treat me...
Yes.. that is something important .. what other things
Well ... getting bored .. what will I do.... there's nothing to do.....
So, having something to do and dealing with your mates they will be hassles for you.. anything else.
Nah..... just being straight and handling things.....
Ok.... Let's see ...so you like getting stoned with mates, stops you getting bored, helps you relax and sleep, BUT on the other hand you are worried about what the dope might be doing to your head, costs you lot, makes you lazy and your mum and sister pay out on you
Yep ... guess that's it
And, you think that if you cut down you might have more money and get on better with your folks, BUT you're worried that your mates might not be so happy with you, you might then have no friends and you will be bored
Yep
So what do you think? I have some info here about how you could try to cut down or quit by yourself..... and some info on people or programmes that could maybe help you if you would prefer that .. one is even on the web
Option One: I dunno ... what if I did want to try one
Ok..... and remember we'll support you with what you choose well let's look at this stuff (brochures from NCPIC)--- fade out.
Option Two: Hmmm, not sure .. maybe too hard for me..... not sure I could do it
OK, well at least you have had a good look at your situation – what you like and like less about dope and what might be good about change, but what also might be hard what about I give you this info here and you can look at it .. OK?
Ok, yea...
Good. Oh, and, one last thing ... I just wanted to leave you with a question ...'What do you think could happen that might make you think again about making a change?'
I dunno ... maybe getting busted by the cops?.. I dunno
That could be a biggie OK – let's hope that does not happen ... if you do think again about what we have been talking about today .. you know where we are – and I'm more than happy to have another chat? OK?
Ok – thanks ---- fade out



Practice: In groups of three (3) practice the approach (1 Counsellor, 1 Young Person, 1 Observer)

See Resource CD/USB: 42.

Session 11. Group work

By completing this session you should have knowledge of:

- ✓ The uses of group work with young people
- ✓ Considerations for the use of groups
- ✓ Group counsellor/facilitator roles
- ✓ Keys to success in group work
- ✓ Group work techniques
- ✓ Some suggested topics
- ✓ Challenges in group work



The group counselling approach works as well in residential facilities as it does in the community. While the approach taken in this Toolkit can be applied in any setting, there must be modifications made to ensure the safety of young people and workers, such as peer educators and peer counsellors.

It is very important that confidentiality be taken very seriously, especially in residential settings and where young people come from the same or nearby communities. It is possible that something said in a group could be used against a young person by other residents or staff and creates serious difficulties for them. Also, if a young person feels strong emotions during counselling, for example becoming very sad and crying, they may be quite vulnerable when they return to their peers, family and community.

It is always important to consider the methods to be used when doing group work with young people. Issues to consider when deciding on the method include:

- Age range
- Literacy levels
- Gender mix (especially where culture/religion do not encourage young men and women to work together in groups)
- Experience of group members of being in groups
- Cultural background
- Any members with a mental illness
- Attention span
- Level of intoxication

Depending on the above, a decision may be made to use:

- A greater activity level
- Painting
- Drama
- Story telling
- Role playing
- Open discussion
- A mixture of these



Why use Group counseling?



Did you consider?

- To mobilize the therapeutic power of sharing thoughts and concerns with people in similar life situation (“I am not the only one!”).
- To mobilize the solution finding potential of many group members. To mobilize group members’ potential to develop and offer alternative and new opinions and meanings to problems, questions and behaviour patterns.
- To mobilize the group members’ potential to support each other for recovery and positive development.



What is the role of the group counselor/facilitator?



Did you consider?

- To establish and to maintain a safe and confidential working atmosphere for the group, including rules and timelines.
- To help the group to set goals and objectives and to work towards them.
- To help the group to keep on discussing meaningful topics and not to slide into small talk for too long.
- To encourage open discussion.
- To encourage group members to share their life stories, problems and successes and to encourage other group members to comment on each others’ contributions, especially in situations where their experiences may have been similar or different.
- To encourage group members to develop ideas and suggestions for each other, and to share these in a positive and supportive manner.
- To acknowledge progress and positive development.
- To prevent someone from dominating the discussion, to try to get the silent ones involved and to prevent anyone getting scape-goated or otherwise discriminated in the group.

- To make sure that the group session is carefully ended, and if some group members are anxious or very confused, to use time to help them to calm down.



Some **key factors** for success in group counseling:

- ✓ Stay connected whatever happens. Discussions around personal faults and shortcoming may be very tough at times.
- ✓ Remind group members that confrontations with peers can be healthy.
- ✓ Encourage group members to learn from each other's failures and successes in their common struggle to overcome their drug use.
- ✓ Each member must commit himself/herself to perform specific tasks in relation to his/her rehabilitation goals and those of the group.
- ✓ Draw the issues chosen for discussions from real-life situations that the members are likely to encounter in their everyday life, such as peer influence, coping with negative feelings, social pressure, etc.
- ✓ To fully participate, each member must be ready to provide support and encouragement to other members in difficult times.
- ✓ Participation in the group sessions is voluntary and should not be imposed on anyone.
- ✓ Be aware of young people who may be under the influence of drugs – and assess their capacity to participate.



Techniques for group counselors:

- Attending: letting others in a group know that you are paying close attention to what they say and do. Attending comes first because it is basic to all other techniques.
- Information management: asking questions and giving information in a group.
- Contract negotiation: working out an agreement on objectives for the group and for the individuals in it. Ask each member to make a pledge to respect and adhere to the group's rules and responsibilities.
- Rewarding: providing rewards, for example, praise, for effort and achievement in a group.
- Responding to feeling: letting others in a group know that you are trying to understand accurately how they feel about a situation.
- Focusing: keeping a group discussion on track.
- Summarizing: gathering together what has been said by group participants for review and consideration of next steps.
- Gate-keeping: achieving a balance of participation in a group.
- Confrontation: informing a participant, sub-group or the entire group about any contradictions between words and actions. Confrontation is placed here rather than earlier because it is more likely to be useful and creative once a group has established mutual trust.
- Modelling: teaching by demonstration and learning by imitation.
- Mediating: resolving conflicts among group participants.



What are some useful topics for groups with young people who use drugs?



Did you consider?

- Alternative recreational activities;
- Improving communication;
- Developing life skills;
- Improving problem solving;
- Resisting drug offers;
- Coping with social/family pressures;
- Coping with negative feelings;
- Identifying personal triggers;
- Understanding psychological dependence;
- Managing highly positive or happy events without using drugs;
- What is ambivalence (mixed, contradictory feelings) and how to cope with it;
- Coping with injuries and pain without using drugs;
- How to prevent a slip or lapse; The value of productive work and other activities;
- What to do immediately after a slip or lapse; and
- Other helping resources in the community.



At times a video, slide show or a brief talk by a knowledgeable person or ex-drug user who has successfully gone through all the stages of recovery can be helpful. A role-play on a particular aspect of rehabilitation is another constructive alternative. After the sharing and discussion of personal problems, and sharing of ideas and coping skills, you may assign specific tasks to individual members according to the challenges with which each is dealing. Their efforts to complete tasks or overcome challenges serve as a basis for discussion in successive meetings.



What might be some typical problems during group counselling sessions, and how might you deal with them?



Did you consider?

The group avoids talking about the topics, but jokes or changes the topic

→ The counsellor can remind the group about the objectives and goals and/or ask directly why the group seems to wish to joke and not to discuss seriously.

One group member dominates the discussion with constant talk or presenting his/her opinions as the “right” ones.

→ The counsellor can actively ask if there are alternative points of view. The counsellor can directly address questions to others. The rest of the group can form a “reflective team”, and the dominant person can be an observer.

One or more group member is silent

→ The counsellor can address questions directly to them (in a sensitive manner). The counsellor can ask other group members to guess what the silent ones are thinking or feeling.

One group member expresses strong hostility or blame towards another group member

→ To some extent open expression of emotions is a good thing. The counsellor can say, however, that usually looking for someone to blame is not beneficial for anyone, but it is better to try to focus on the topic and how to make positive steps. Also, the counsellor can say that many people will not talk openly if someone is very angry at them, or fights might happen. This does not make it safe, so how can we each take responsibility for our own behaviour and keep the group safe.

Someone gets very emotional or cries

→ Normally this is not harmful. The counsellor should rush to stop the situation, but let the group members comfort the one who is emotional. The counsellor can also encourage him/her to talk about what made him/her so emotional.

Some members are under the influence of drugs

→ Assess their capacity to participate. Possibly invite group to suggest what to do. Only ask to leave if they are disruptive?



Review the groups included in UNESCAP Tool Kit 5 – Group Counselling (See USB-stick or CD: Resource # 44). Do any of these groups seem useful in your setting?

List of groups:

- | | |
|---|---|
| 1. Getting to know you – ice breaker and trust development | 15. A very good mother – family relationships |
| 2. Something like me – ice breaker and trust development | 16. Love letter – family relationships |
| 3. Keeping the faith – trust development | 17. Sympathy for your mother – family relationships |
| 4. Blind walk – trust development | 18. My father – family relationships |
| 5. Why people do what they do – Teacher Somjai | 19. My house – family relationships |
| 6. Dice/wheel of emotions | 20. Took and Tui – Two-way communication |
| 7. Emotion card | 21. Drawing a picture following instructions: Two-way communication |
| 8. Skills in managing emotions | 22. Polite talk – respectful communication |
| 9. Self control – this bicycle provokes thinking | 23. Hunt the killer |
| 10. Being careful/aware not to make inappropriate decisions | 24. Group story telling |
| 11. Obstacles in life | 25. Roads and lanes – stress management |
| 12. How to prevent relapse | 26. Meditation to reduce stress |
| 13. Refusal skills – relapse prevention | 27. Breathing to reduce stress |
| 14. Successful refusal – relapse prevention | 28. Developing relationships in the family |
| | 29. Final activity |

Session 12. Relapse prevention

By completing this session you should have knowledge of:

- ✓ Rationale for relapse prevention
- ✓ Feelings, moods and memories as triggers
- ✓ People and relationships as triggers
- ✓ Situations and places as triggers
- ✓ Cravings as triggers
- ✓ Developing relapse prevention plans



Relapse prevention is about getting (back) a life: *A Balanced Life*

Planning for lapses and relapse is a crucial part of working with anyone who has experienced substance use-related difficulties. It is better to start to do “relapse prevention planning” from the first counselling session, in case the young person is tempted or wants to use drugs again almost immediately.

For example, it can be useful to make a **Short-term Relapse Prevention**

Plan in such cases, and for those about to leave a closed setting such as a compulsory residential drug centre.

The Longer-term Relapse Prevention Plan can be developed after the young person has settled. The plan can be reviewed and changed as necessary in future sessions when discussion takes place about what worked well, what was “OK”, and what did not work at all so that a better plan can be developed.

Relapse Prevention Plans can also be developed in groups where the groups help an individual develop a realistic Relapse Prevention Plan, or all the participants work on their own plans with guidance from the facilitator and assistance from other group members if they wish.

Relapse Prevention focuses on 3 main areas:

- Moods/ feelings – e.g. boredom, sadness, depression, frustration, anger, happiness,...
- People/ relationships – e.g. family conflict, peers, school friends or work friends,...
- Places, events and things- e.g. dealing areas, video game spots, celebrations, seeing injection equipment, bongs, smell of cannabis in house,



Thinking back on your work with young people in this area:



What do you think might be some of the feelings, moods and memories that could be related to the return to substance use by a young person?



What might be some of the relationship cues related to the return to substance use by a young person?



What might be some specific situational cues related the return to substance use by a young person; e.g., smells, places, videos, etc?



By offering these interventions in treatment we are attempting to assist young people develop and think about such statements as...

I am more likely to use X when I am

- With Y: “I am more likely to use heroin, when I feel sad, am alone and at home”
- At Z: “I am more likely to use Ice when I am bored, with my friends and at a disco”

Remember: different individuals may use different drugs for different reasons. Thus, a number of these statements may need to be generated to inform effective treatment. By recognising the triggers the young person and the treatment provider are then able to look at alternatives to drugs.



Cravings as a trigger for (re)lapse:

Managing Cravings:

- ‘Urge surfing’ – such as imaging riding waves on a surf board, or riding over small hills – to try to illustrate how craving come and go, are sometimes more intense than others
- 5 Ds:
 1. Distracting
 2. Delaying
 3. Drinking water
 4. De-catastrophising (not imagining the worst and thinking it will happen)
 5. De-stressing



Some Relapse Prevention Plans:

My reasons for changing	
(Put where you will see it often: phone, wallet, mirror, fridge, door)	
1 <i>Stay out of prison</i>	
2 <i>Get a job</i>	
3 <i>Get my mom's respect</i>	
4 <i>Get my health back</i>	

My support team	
Person	Contact details
<i>Support worker</i>	<i>9331-2266</i>
<i>Girlfriend</i>	<i>0412 564 557</i>

Non-using friend	
<i>Parent</i>	<i>9665- 3321</i>
When times get tough I will...	
<i>Call Mom</i>	
<i>Call supportive friend</i>	
<i>Call support worker</i>	
<i>Review my Relapse Prevention Plan</i>	

Relapse Prevention Plan (Put where you will see it often: wallet, mirror, fridge, door, phone)
<i>Go to Drop In Centre on Tues & Thurs & when I need extra support</i>
<i>Maybe go to NA – if suitable for me</i>
<i>See my Case worker once a week</i>
<i>Don't buy any alcohol</i>
<i>Don't go to the drug dealing areas</i>

High-risk Situations			
Places/People	Situations/Things	Thoughts/Feelings	Response
	<i>Seeing it around me & friends offering it</i>	<i>"I feel like using... What do I do?"</i>	<i>Say "I don't want it around me, so don't offer!" If they don't listen, they're not real friends.</i>
	<i>The smell of drugs</i>	<i>Wanting a smoke</i>	<i>Walk away</i>
	<i>Friends ring & tell me about a party</i>	<i>Mary will be there. We could get smashed & get on.</i>	<i>I don't need to be smashed to get on.</i>
<i>Dealing area</i>			<i>Don't go there. Everyone knows me. I just get in shit</i>
	<i>Not keeping appointments</i>		<i>Make them again & put on my calendar</i>
<i>Spending more time with Matty</i>			<i>Time to go our separate way. We just get in shit together</i>
	<i>Having an argument</i>		<i>Chill by going outside, or walking.</i>

Back-up plan If a lapse happens, I will...
<i>Think of the experience positively & remember that all isn't lost. I will avoid letting it get me down or stop me from managing my use.</i>
<i>Call support worker & together figure out how it happened & what to do next time</i>
<i>Call non-using friend</i>
<i>Not panic. A lapse is not a relapse. A lapse might just mean I have more to learn about myself. Next time I'll go longer without using</i>
<i>Review my Relapse Prevention Plan</i>
<i>Go to my support group</i>

Unhelpful thoughts	Helpful thoughts
<i>Go on, just one last smoke...</i>	<i>Now is the time to leave.</i>
<i>One won't hurt me...</i>	<i>Think about it. It all started with one cone.</i>
<i>What's the point? Who cares anyway...</i>	<i>Think about how fit & healthy I feel! People do care, & it starts with me.</i>
<i>I need it to feel right...</i>	<i>I don't "need" it. I just want it, like I want other things, like a life, job, & Mom.</i>
<i>I'll just celebrate once more...</i>	<i>How am I celebrating by messing up my life?</i>
<i>I'm missing out on a great party...</i>	<i>Think about the wasted money, the drugs making me dumb, fighting, not caring... That's what I'm missing out on.</i>

Plans need to be:

- ✓ Specific
- ✓ Do-able
- ✓ Agreed to by young person
- ✓ Agreed to by family
- ✓ Agreed to by community
- ✓ Flexible
- ✓ Reviewed... and reviewed again

Relapse Prevention not just an activity for the young person.



Who else needs to be involved?



What needs to be targeted?



Choose one or more of the case studies below of young people who use and develop a realistic Relapse Prevention Plan:

Nepal:

Ram Chandra Poudel's story:

I was born in a middle class family at Kumarigal, Boudha, Katmandu. I could not enjoy my teenage years as I was sent to India at the age of 13 where I had to work very hard as a household worker. I spent five years in India and I got back to Nepal when I was 18. I had already started smoking cigarettes when I was in India. When I reached my hometown I found that most of my childhood friends were already into drugs (brown sugar - heroin). Gradually I started using cannabis and then taking brown sugar orally with my friends. I had some money saved from India then I started using that money for drugs. Slowly I was running out of credit then I felt that my friends started avoiding me but till then I was totally addicted to drugs (brown sugar). My daily dose was also getting high then I started injecting 'set' (mix of buprenorphine, diazepam, phenergan, +). As I was from a low middle class family and could not afford using drugs then I started stealing money from my relatives.

One night I was arrested while stealing in neighborhood and was put in custody. It was becoming harder and harder for me to take drugs daily so one day I planned to rob an Indian guy and I succeeded. Then I had enough money to get drugs and I started selling it also so as to fulfill my daily dose. Then I become a renowned drug dealer in my locality, now I could also afford to bribe policemen. Likewise my daily activities continued by drug using and selling, I had almost forgot my mother. I used to spend my days and nights with my drug user friends in hotels and lodges. I was having good times with drugs but my friends betrayed me and looted all my drugs and money then I became all alone and again it was very hard for me to take my daily dose. Meanwhile I met some outreach educators from Youth Vision who gave me information about HIV, STI and other blood borne infections. I was totally disturbed being informed about HIV because I was sharing needle with my friends and was afraid that if I was infected too. Then with the help of those outreach educators I managed to get tested my HIV status at Youth Vision Integrated Health Service where I was provided pre- as well as post-test counseling.

When my report was out I was totally demoralized but I decided to take the advice and went to Y.V care and support unit where my physical assessment, CD4 count and other various tests were done. I was lost and irritated, observing my condition; the staff from care and support took me to Night Shelter for detoxification with buprenorphine. Gradually I felt better and my physical condition was also improving but one day I felt sorry for my mother as I had gave her lot of pains and I left the shelter. I went to my mother and saw that she was in a very poor condition. Despite of her poor physical condition she went to collect wood from the nearby jungle (pashupati) and sell them to maintain her livelihood. After watching her poor condition I could not stay at home; having thoughts about me diagnosed with HIV, mother's condition and no hope at all; I felt helpless and depressed. I wasn't contacting anyone but I happen to meet an old friend who has a stock of norphine- set in a large quantity and he asked for my help to sell it. Then I thought that it would be a good opportunity for me to earn money and keep my mother away from that poor condition. So I began selling his drugs and earn money but I could not stop myself from using it either.

Rohani:

The economic condition of Rohani's family was miserable with uncertain and unstable income source. She lived with her family consisting of an elder brother, father and mother. They lived in a small house build by the riverside and it had been swept away by floods for many times. This situation and circumstances lead her to drop school many times as they had to shift to other unattended places for settlement. Gradually she lost her interest on schooling and studies as it was too much for her to cope with the new environment and the worst part was where ever she went her friends laugh at her brother who was mentally retarded. She was titled as "pagal ko bahini" which means sister of mad (crazy) brother. The family condition, brothers situation and economic constrains made her decide to leave her house and she ended up at Katmandu in search of a better life.

She was just 12 at this time; she was seeking shelter as she didn't have money for food or anything else. While she was in the hunt for anything to avoid hunger and sleeping at the 'paties' (small sheds made for religious purpose), she met a person who suggested she work at a dance bar. She was unaware of the type of work that was there until when she was rape by a Japanese guy at her work place. She felt helpless as her work place owner ignored the case, and said 'what do you think you are here for'. This happened many times: sexual harassment, rape and physical assaults from the customers and the owner as well. She didn't know anything else except this dance bar. She said " my hunt for better life led to other aspects of frustration, I do live in a better place than before, I don't have to worry about flooding, or being called as ' pagal ko bahini' ..." she adds "now people call me a prostitute which hurts me ever more".

Her primary work was to please the customers at the Bar and to make them buy hard drinks. In this way she started to take alcohol herself and she said: "It did help me to cope with my life full of assaults and harassment". By now age she was engaged in prostitution and was also hooked on drugs as some of the other girls were already on drugs and they suggested trying them for relaxation and to forget the things that she considered wrong. She said: "this is the only part that I liked about the drugs". Gradually the amount of drug intake increased and she didn't enjoy drugs as she used to. However, she mentioned that the desire for these chemicals is still within her. Then she was loved by a customer who came to the dance bar, and he took her to live with him. Everything was all right till her boyfriend found out about her drug use. Conflict started then as she couldn't quit drugs and was pushed out from his house. Her condition was more destitute than ever, she was stigmatized everywhere and even her close friend didn't trust her at any matter. She was unwelcomed everywhere and had no money. At this point, while she was at her drug dealer, an outreach worker came to inform them about the treatment facilities, HIV, STI and safe injecting practices. She mentioned "I kept on thinking about the treatment and my life without drugs; a good life, living the way of life that good people live and why not I try for the treatment when it's free". After a week she again met the same outreach worker and asked her if she can take her to a treatment facility. She was willing to work at the same time because of her financial constrains. Now she is in the Detox programme at the female unit. She is also engaged in income generation activities at the female unit. But she is worried that the income from this work only will not be enough for managing her living costs.

Umesh:

Umesh was born in Rukum in 1990, a rural area located in the western part of Nepal. His family shifted to Katmandu when he was 3 yrs old. His father went to America by the time he was 6. He mentioned, that “I did feel that I missed his love and guidance which every child needs in his childhood.” I was disturbed with that and could not concentrate on my studies. When my mother realized, we shifted to another place. That really did help me by diverting my mind, sometimes I remembered my past and it just clicked like a flash back. After a while my life and my studies were going on smoothly”.

However, his mother also left him while he was in 8th grade and 12 years old. This was very frustrating for him and he said that he felt that how unlucky he was. He was then admitted to a hostel where he was influenced by his seniors who were trying different things for fun. He tried cannabis on the age of 13. After finishing schooling he felt the world outside was freer than at the hostel. By this time he was dependent to hashish and was also experimenting with some pills and pharmaceutical drugs. He says that “When I used drugs I could feel myself strong, mature and more powerful than anyone else, and experiencing sex was also a lot different.” Eventually he ended up with drug using friends having fun, street fighting and other activities than education and studies. One of his friends introduced heroin to the group, and slowly most of them became dependent on it. He mentioned that unit this point he never had financial constrains, but after he was hooked on heroin he started to feel that he didn’t have enough money to continue. About 8 months later he started to inject ‘set’ as this was cheaper and was available more easily. He realized that it was 6 years that he lived a drug dependent life he felt that he was killing himself. By this time his family also knew about his drug using behaviour and they started treating him differently from this point onwards. He was willing to quit all drugs and tried a couple of times but relapsed. He mentioned that “During my using period I got into custody many times, but luckily I never got locked up in jail for a long time. After being free from custody I started using again every time, I couldn’t control it.”

He got caught once again but this time there was no one to free him. He says “Luckily a friend with me in custody was from Youth Vision and he called for help there and I was freed.” This turned his thoughts the other way and he decided to try his best to get rid of using drugs. He thought that a rehabilitation centre gives you a hard time; they never treat you well and give punishment over punishment. He said: “I was very scared but had no options, but once I came here, I found it a totally different environment than what I thought.” Now he thinks that his fragmented life can be regrouped and make his life once again meaningful and purposeful. He adds “Today I’ve my freedom with me.”

Umesh completed the residential programme. His parents remain overseas, and he is living with his grandparents. The relationship with girlfriend is not so good, but he is coping with that. He is very scared of relapsing – especially as he is having recurring dreams of using heroin and cannabis – then he wakes, and thinks ‘good I am safe’ – but it is wearing him down. He feels very lonely – coming to day programme is vital for him. He is wanting to study computing and animation – and he is good at it.

Thailand:

Sak's Story

Sak is 17 years old. At this time he lives in a juvenile detention centre because he stole motorcycles. He has been at the centre for 3 months and is due to be released next week. This is his second time in custody. Last time he was in the detention centre for punching another young man many times. He tells everyone that "he just felt like it". The real reason was because the other man wanted to have sex with Sak. But, Sak does not want anyone to know about it. He wants people to think he likes girls and is "tough".

Sak likes being in the detention centre as he can easily get what he wants. He has been able to manipulate people with his words. His mother always said that he had the gift of talking and that he was always able to make people laugh. But she does not talk to him much anymore because she is angry with him for being arrested again.

Sak is nervous about being out of the detention centre as he has not used heroin in custody and does not want to go back to using it when he is free. Being out of custody feels strange to Sak because he has become used to the routine and way of life in the detention centre. When he is not in the detention centre, Sak is often alone as his peers are scared of him.

He lives on and off with his mother and father in a slum area. Sak's parents argue constantly and when they get intoxicated, the fighting escalates. When Sak's father comes home from the beer hall on Saturday nights, his parents get into violent arguments and his father often assaults his mother. One night, his father assaulted Sak when he defended his mother. Sak has a younger brother aged 13 years and a sister aged 8 years and he is protective of them. When he is at home and his parents start fighting, Sak takes his siblings into his bed and they sleep with him.

Sak's father works with a number of local construction firms. His mother looks after his brother and sister at home. His family has not visited him in the juvenile detention centre this time. His father told him at the police station that he has had too many chances and that he was tired of putting up with Sak's bad behaviour. Sak called his mother but she told him she does not have any money to come and visit him. She also cannot get anyone to care for the other 2 children if she visited.

Sak's grandmother and grandfather do come to visit him every 2 weeks and they bring his brother and sister to see him. Last week his grandmother sent him some sweets that she had made.

Sak remembers a holiday he had with his family when he was 11 years old. They went to the beach and stayed there for a week. He went fishing with his father and they caught some big fish. He wishes things were more like those times.

Before being placed in custody Sak was suspended 3 times from his school, twice for fighting with other students and once for throwing a desk at a teacher. Sak thought school was a waste of time. He never saw the relevance of maths and history to his life and so would often not go to those classes. He never got good marks for any of his classes except woodwork, metalwork and art.

However, he has been attending school in the detention centre and enjoys it. He has the choice of signing up for courses that he likes. He discovered that he is able to follow the lessons if he only does 1 or 2 subjects. In his old school, he did 6 or 7 subjects. The principal of the school in the detention centre is helping him to gain entry into a similar school in the community. Sak will be

enrolling for woodwork and carpentry. He was awarded a merit certificate for “excellence in woodwork” for a table that he made this semester.

Most of Sak’s friends use many different kinds of drugs. There is not much else to do. Many of them prefer heroin. A few of his friends were in custody with him. Like Sak, two of them are trying to never use heroin again. Other friends there said that they would continue using drug after they are released from the detention centre. The workers in the centre have made it clear to Sak that he will not be able to stay off the drugs if he spends a lot of time with friends who are still using drugs. Sak is worried as one of his friends has promised to set him up with a dealer who can offer lower prices. There is also the possibility that this man can employ Sak as a dealer. Although he is uncomfortable with these suggestions, he sees them as an easy way of making money.

Ms. Bell, Age 22, “Ice” smoker

Bell started using drugs 10 March 2004. At that time, her boyfriend was a drug user (methamphetamine, or “ya ba”). She never forgot that day. Her boyfriend invited her to use with him. She realized she wanted to try it, and also she wanted to spite her boyfriend too. After she tried it that day, she never stopped. First she smoked from foil, using a straw. She smoked like this for 3 years. She stopped for 3 years and returned to using again last year, using “ice” this time. Today, she continues to use “ice.”

Bell once stayed in the hospital for 3 days due to a miscarriage resulting from methamphetamine overuse, according to her doctor. Bell reported no problems with the treatment or services.

Between 2007-09 she was arrested 3 times because of urine testing positive for drugs. She was arrested “prong nai” because each time she had no drugs in her possession. She was intimidated into going to the police station each time, and the following would happen to Bell down at the station: The police would see Bell riding her bicycle in the soi (lane), and would call her to stop her bike. They would search and intimidate her, and demand she identify dealers and users in the vicinity: where they lived, who they were. The police told Bell that if she told them they would let her free but if not they would arrest her. They said that even if she didn’t have any drugs on her they could make sure they would find them on her anyway. Bell didn’t tell them where users or dealers were, so they brought her down to the station and she entered a detention area where they forced a confession and planted a methamphetamine pill on her. They forced her to accept the possession charge. She went to court and was sent to compulsory treatment center “Klong 5” in Pathum Thani province (next to Bangkok) for 45 days. This happened to Bell 3 times.

After Bell went into Klong 5, she felt oppressed. The treatment of youth and other detainees were treated in an unfriendly manner; they were spoken to harshly (verbal abuse) by guards and for those who didn’t follow orders or who were unable to handle the workload were beaten. There were many kinds of forced work and for those who failed to meet the quota, they were punished. It was a very tough experience for Bell, especially fear of the guards’ treatment.

Regarding Bell’s ideal expectation of Mitsampan, as a participant and leader in the youth project, she’d like MSHRC to support the following, as much as possible: job training, computer instruction, continuing to provide a relaxing space, supporting youth-specific activities, and giving youth-specific information and education that will help her take better care of herself and her peers.

Mr. Mat, 25 years, user of glue, methamphetamines/ice, cannabis

Mat, a young Muslim boy from Bang Kaw Laem, Bangkok, started using at 17 years. The reason he attributes is that during that period, he had saved up 20,000 THB to buy a motorbike; however, someone in his family took the money from him. He was filled with anger but couldn't do anything. He was stressed out, and at one point soon after, he was with friends who were smoking methamphetamine. He began to smoke, and has done so for the past 8 years. When he doesn't have "ya ba" or money he chooses cheaper choices like glue. Mat began using ice 3-5 months ago because, as he says, it's "better" and he's "high longer," and ice doesn't make him "confused, as out-of-it or paranoid" He does not inject. He lives with his parents, and his girlfriend.

Mat once went into the hospital, for a motorcycle crash. His main complaint about that government hospital was the long wait and number of patients.

Mat's biggest problem concerns the justice system. He complains that the very people responsible for upholding the law are the very people who commit rights violations. He said he's been arrested and sent to compulsory drug treatment. This happened because the police sent his friends to follow him to his friend's room. The police arrived and forced him to do a urine test. He was brought to the police station and forced to sign in acceptance of the charge of possessing one methamphetamine pill, which the police planted on him at the station. He went to court and was then sent to "Klong 5" rehab in Pathum Thani province. This was because he couldn't pay the 5,000 THB fine required by the court, so he had to go in for 45 days (at 200/THB per day paid back to the State). It was very difficult. He described the conditions there, which were very and crowded, dirty, and with backed-up, broken toilets. Sleeping rooms were small and dirty. The eating area was next to the bathrooms. Mat had to work making satay/luuk chin skewers from bamboo. There was no time allotted for rest or breaks. If production quotas weren't met he was punished by beating. There was no vocational or job training of any kind.

The second time Mat was arrested through similar means, he called Mitsampan Harm Reduction Center and was released due to the intervention of MSHRC staff, who challenged the arbitrary arrest. He was not forced to undergo compulsory drug detention and is now a peer leader at MSHRC drop-in center, where he engages in training and education so he can share his rights and health knowledge with young people in his community.

Mat's expectations of MSHRC, other than gaining leadership skills, human rights education for advocacy, and harm reduction and drug information for balanced and informed decision-making, include supporting activities that increase knowledge, support job training, sports activities, youth computer area, and an instructor who can teach various vocational trainings, including motorcycle repair, hair-cutting, or anything.

Ms. Bee:

Ms Bee is 25 years of age and comes from the south of Thailand. She identifies as Transgender, and has lived as a woman for some time, Her parents are aware of this. After she came to Bangkok she worked as a 'show girl' and in sex work. She is living with HIV, has tested positive for TB, and has been on ART for five months. She has refused to adhere to TB medication, as she does not like having to travel to the clinic to obtain her medication as her treating doctor believes she is

‘irresponsible’ and will not agree to her getting her medication closer to where she lives.

Ms Bee uses ATS via smoking and some via injecting, and also uses inhalants and cannabis. She has been arrested for using/possessing cannabis and fined 10,000 Baht and placed on 6 months probation. She has not been complying with the conditions of her court order.

She lives with her boyfriend, aged 28, who is also living with HIV, and comes to the MSP drop-in-centre.

Ms Bee has indicated that she would like to be a youth worker, but, at times, recognizes how chaotic her life is at present. She is very ‘moody’, high maintenance, and at times states that she is very depressed. She appears to actively seek help every so often, but then frequently sabotages the help offered and storms off to find another ‘helping service’ where she repeats the same cycle of behaviours.

China:

Zhou Jin

Zhou Jin, is a 24 year old female, born in Chuxiong. When Zhou Jin was very young, she came to live in Kunming with her mother. As her father was a heavy drinker and the relationship between her parents was not so desirable, Zhou Jin had been looked after by her mother. When she was 8 years old, her parents got divorced and the court ruled that Zhou Jin live with her father. But one year later, Zhou Jin returned to her mother and lived with her again. When Zhou Jin was 11 years old, her father died. Later, her mother remarried and her stepfather treated her ok. Anyway, it was her mother who controlled and educated her. When she was in Grade Two at junior high school, under the influences of her playmates, Zhou made some fair-weather friends, began to cut classes and made a boyfriend. As Zhou Jin did not live with her family, her mother did not know how Zhou Jin got along and had difficulties in taking care of the daughter. After having controlled and educated her in vain, her mother had to help her go through formalities of leaving school. Zhou Jin dropped out then.

When she was very young, Zhou Jin saw the younger sister and classmates of her mother using heroin at home. The schoolteachers and her mother also taught her about illicit drugs. When she was in Grade Two of junior high school, Zhou Jin used triazolam and felt drowsy but did not become dependent on it. After having dropped out of school, she had neither job nor income, and was under pressure. Her boyfriend often quarreled with her. All this made her very upset. Then she began to use heroin because of the lures of her friends.

We can see that, in the early years of Zhou Jin’s life, her parents not getting well along with each other, lack of family education, divorce of her parents, death of her father and second marriage of her mother made Zhou Jin lacked due caring and mental supports. Zhou Jin felt unsafe, ignored and lacked love and care. When entering puberty, rebellious thoughts and loneliness after she dropped out became the risk factors for her use of drugs. In the key period of puberty, Zhou Jin’s family did not notice in time the changes in her mind and behaviours. Her school only provided her with knowledge of drugs, but ignored the changes that the teenagers in puberty would experience physically and psychologically. Under such circumstances, Zhou Jin, who lacked the emotional support, was lured to use drugs.

Zhou Jin just felt drowsy, with no other discomfort when she first used triazolam. She did not feel dependent on the drug. The first time when Zhou Jin used heroin, the symptoms included serious vomiting and drowsiness, and her mind went blank. Two months later, as she made friends with more and more young people who used drugs, Zhou Jin once again used heroin regularly. As she always threw up when using heroin, her friends told her that she would not vomit if she injected heroin. In less than one month after she had re-used heroin, Zhou Jin began to inject heroin. Some of her friends persuaded her that it was ok to use heroin for fun, but not get addicted to it. But then, what Zhou Jin wanted was to grasp the feelings of “drowsiness” brought by heroin, the persuasions of the others were blank and void. During this period, although her mother had never abandoned her, ultimately Zhou Jin still fell into the vicious circle of using drugs, sent for education through labor, detoxification and relapse.

From 2007, Zhou Jin was been treated at Fuchun MMT Clinic of Kunming. She complied well with the treatment and her life has gradually returned to normal. As Zhou Jin was good at communication, she was employed as an outreach worker of HAARP and responsible for exchange of clean needles and syringes. Zhou Jin had been a key member of Xuezhongtan (literally “to help a lame dog over a stile”) Group (an IDU group) and in charge of publicizing MMT. During this time, she knew another patient who was also on MMT and got married to him. In 2009, Zhou Jin got pregnant. Based on her actual situations, in addition to regularly participating in group activities, she also obtained individual counseling on “the relevant knowledge of pregnancy when on MMT”, “nutrition in the time of pregnancy”, “prevention and treatment of Hepatitis C”, “how to raise a baby”, etc. Zhou Jin was good at communicating with others. If she felt unhappy or puzzled with her life, she was willing to talk with the doctors and staff at the methadone clinic and got the help from them.

Bao Qiyuna

Bao Qiyuna, is a 23 year old Han female, born in Kunming, with an educational level of Junior High School. When she was three months old, her parents got divorced and Bao Qiyuna was taken care of by her father. Her mother came to see her occasionally, but did not care or look after her much. When Bao Qiyuna was young, her father sometimes pampered her and sometimes beat her, but did not communicate with her much and was unwilling to tell her the reason why it was so. When Bao Qiyuna was in Grade 3 of junior high school, she was fed up with her school life. She often cut class to play around with her friends. Occasionally, she slept over. Then she learned to smoke. When she was 15, she dropped out of school.

When at school, Bao Qiyuna had never learned anything about illicit drugs from her teachers. It was her friends who told her that one could not try drugs; otherwise he/she would become dependent on them.

After dropping out, without the control of her family or tied up by school, Bao Qiyuna was very happy. On Children’s Day in 2001, in order to “celebrate our own festival”, Bao Qiyuna and one of her girl friends (whose boyfriend was a drug dealer) inhaled heroin for the first time.

Though Bao Qiyuna threw up when she inhaled heroin for the first time, for three consecutive days, she did not crave heroin or have any discomfort as her friends had told her she might. She thought that heroin was not as terrible as that was said. Later she tried heroin again. Still, she did not have any discomfort. The third time, she used heroin for a week and began craving for heroin. After that, Bao Qiyuna had been using heroin regularly.

In 2002, Bao Qiyuna and her friends were caught by the police when using heroin. The police let Bao Qiyuna go because she was too young. The experience made Bao Qiyuna have the idea of leaving things to chance. She believed that she was so young that she would not be sent for detoxification. During this period, Bao Qiyuna's father did not realize that his daughter was using heroin. Instead, he blamed her for being a heavy smoker, "how can you stay at your room and smoke night after night?"

In 2004, Bao Qiyuna was sent to Chang Po Compulsory Drug Detox Center. It was at that time that her father knew she was heroin dependent. Although her father did not say much, Bao Qiyuna knew that he must be very disappointed at her. Her father persuaded her not to use heroin any more, and, if she was released from the Center, she should find a job and not keep in touch with other young people who use drugs any more. As his wage was not high, he did not give her much help financially.

Half a year later, Bao Qiyuna left Chang Po Compulsory Drug Detox Center. The first thing she did was to use heroin. After that, due to her continuous use of heroin, half year after she left Chang Po Compulsory Drug Detox Center, she was sent for education through labor. The two years spent in the re-education camp did no good for her. When she was released, she still used heroin. One year later, she was sent to Chang Po Compulsory Drug Detox Center again. This time she stayed there for one year and three months.

Bao Qiyuna had given up heroin at home several times, but relapsed when she felt unhappy or upset. To her, breaking up with her boyfriend was something more horrible than doomsday. She was afraid that she might be abandoned. Quarrelling with her father also disappointed her, because "the only family does not care for me much."

In 2007, when playing cards with her friends, because of the persuasion of her friends and curiosity, she used ephedrine from bong. Later, she used ephedrine 7-8 times on and off.

Bao Qiyuna had used heroin by way of smoking, because she was afraid to get vasculitis, which might affect her work in the future. But several years later, she found that the teeth of many heroin addicts who smoked heroin dropped and that her own teeth also loosened. She tried and asked her drug dealer friends to inject heroin for her several times. Since she has been on methadone from 2008, Bao Qiyuna felt that she had recovered much better physically, "at least I do not use heroin as I did before."

However, at a routine checkup, Bao Qiyuna was informed that she was infected with HIV. She was very frightened. She did not dare to tell her father but wanted to find someone to pour out her troubles. During this period, she made an older boyfriend who was also a patient at MMT clinic. The reason for them to be together was just because "he does not care whether I am HIV positive", but she complained that her boyfriend "is not satisfactory, so old, so ugly and incapable. And I have to make money to pay for his drugs."

Bao Qiyuna liked children very much. When she visited orphanages, she shed tears and asked for many times "if I can adopt a kid." In her opinion, she was HIV positive and could not have her own kid, for "even if the risk is one millionth, I can not transmit the disease to my kid."

Because of her contradictory thoughts, sometimes Bao Qiyuna used heroin in order to forget the bitter reality for the time being.

Therefore, in addition to the routine group activities, staff and the doctors at the clinic gave Bao Qiyuna individual counseling many times, for example, “be responsible for your own feelings”, “how to adjust your mood”, “how to communicate with your family”. They did their best to correct her misunderstandings when she found herself infected with HIV and teach her such life skills as how to better adjust her moods.

Zhong’s Story

Zhong is 18 years and an only child. Zhong lived in a village, which was demolished to become a suburb of a rapidly growing city. All the villagers were displaced and offered state built housing near where their village once stood. This housing is not of the same high standard of the new, expensive private housing being built. Zhong’s family has to contribute some of their income to pay for their new home. This has taken nearly all their savings. Zhong is angry but has been trying to fit in to his new environment – a city and not a village.

Zhong finished school at the same time his village was demolished. His mother works hard and his father has been working building the new private housing. His father comes home tired from work, drinks too much beer and frequently gets into arguments with his wife and Zhong.

His new home is near the major bus station. The main train station is also nearby. These areas have attracted criminals, drugs users and sex workers who rent rooms in cheap hotels with their customers. The taxi drivers know many of those involved in illegal activities and some of the friendlier drivers have offered Zhong part-time work. But Zhong is not sure he wants to be a taxi driver.

Zhong is now 18 years old and is not sure where to head in his life. He is able to communicate well with people. He also likes to do carpentry work and is good with his hands. He has been hanging around with some of the young people who use drugs and dealers and those involved in crime for the past year. He has helped them sell stolen goods and they have offered him heroin in payment. So far he has resisted injecting heroin, but did use it via inhaling off foil once. He vomited and has not used since. However, he has begun drinking alcohol with them and sometimes he has sex with sex workers who hang around the area.

He feels comfortable with the drug dealers and taxi drivers, and the sex workers are friendly. Friends and some outreach workers have given him information on substance use, safe sex, HIV and hepatitis from an NGO. Choi, also 18, is a friend and he is worried that he might end up like him. But, he thinks, are there any better alternatives?

Choi’s Story – a friend of Zhong

Choi is 18 years old now. His is very similar to many other young people in his hometown who have come to the city to find work and make money. He used drugs (cannabis) for the first time when he was 15 years old. Soon after he began to smoke opium and sometimes to inhale it (‘Chasing the Dragon’). Then he was introduced to heroin and started to inject it. He became dependent on heroin when he was 16 years old. He has been hanging around with some of the young people who use drugs and dealers and those involved in crime for the past year. He helped them sell stolen goods and they have given him heroin in payment and some small amounts of money. He likes the

feeling of heroin as it helps him forget his troubles. He has dropped out of school and has no job. He has managed to give up heroin several times but was unable to maintain a heroin-free lifestyle.

While he did not return to daily heroin use for a short time while he had some work helping in the kitchen of a restaurant owned by friends of his family who did not know about his drug use, he has become dependent on heroin twice this year and was using it every day for some weeks. First he detoxified with his friends who were looking after him – ‘cold turkey’ but drinking a lot of alcohol and taking some ‘pills’ (probably an anti-anxiety tranquilliser or sleeping pill). The second time he went to a community health centre and they assisted him by referring him to a clinic where he was given methadone daily for some weeks to detoxify him from heroin.

Choi is struggling. Sometimes he cries to himself and wants his life to be happy and ‘normal’. But, at other times, he craves the feeling of heroin in his body – it makes him so relaxed and he forgets all his worries. He is not sure that he can fit in with non-drug using young people and make friends. He feels he has done so much more than them and their lives sometimes look so boring. He has a girlfriend, but he is not sure of her. She is also a heroin user, but uses less regularly than he does.

Recently he has come in contact with some outreach workers from a drop-in-centre where he goes to relax, get clean syringes and equipment and condoms. He has shared injection equipment a number of times with other people who injection drugs, and been now given information on safe sex, HIV and hepatitis. He has become very concerned when one of the workers at the drop-in-centre who is used to use drugs and who underwent treatment at the therapeutic community in the city told him that 70% of those in the treatment centre are HIV-positive and 40% have hepatitis C. Choi has shared injection equipment and knows he has not always practised safe sex. He does not know what to do. He does not want to be sent to the compulsory detoxification programme run by the police and security forces but is not sure he can give up heroin.

See Resource CD/USB: 46 and 50.

Session 13. Building Young Leaders – Peer Educators

By completing this session you should have knowledge of:

- ✓ Qualities and skills of effective youth leaders
- ✓ Developing the skills of young leaders
- ✓ Keeping young leaders safe
- ✓ Group Level Intervention For Methamphetamine Users (GLIMU) approach
- ✓ Break the Cycle approach



What do young people who use drugs think leaders should be like?

Here is what some beginning young peer leaders said in Bangkok:

What do young people who use drugs think leaders should be like?

- ✓ Listen before talking
- ✓ Good communicator
- ✓ Approachable
- ✓ Can resolve conflict, negotiate
- ✓ Brave
- ✓ Compassionate
- ✓ Accepting and non-judgemental
- ✓ Can assess and read people and what they need
- ✓ Problem solver
- ✓ Loyal
- ✓ Willing to help
- ✓ Love family and friends



How to identify potential leaders?



What skills do they need?

What some young youth leaders in Bangkok said:

- ✓ Depth communication – able to talk about deep problems
- ✓ Basic counselling
- ✓ Confidence
- ✓ Be able to remember what has been taught (how to memorise) – various ‘learning styles’ in the group
- ✓ How to speak clearly and communicate information
- ✓ Other possible issues to consider:
- ✓ Good knowledge about drugs, BBIs, STIs, harm reduction...
- ✓ Respect for diversity among young people who use drugs
- ✓ Knowing when something or someone is not going well and where difficulties are emerging – ‘early warning signs’
- ✓ Knowing when to ask for assistance – when ‘getting out of your depth’, feeling ‘overwhelmed’ – and having a good idea of sources of help

- ✓ Knowing when you are not going well, and need support
- ✓ How to manage confidentiality, when you live in the community
- ✓ How to be 'professional' in your work – knowing your 'boundaries'
- ✓ How to easily document your work
- ✓ Knowing when you are at risk of relapse
- ✓ Knowing rights, and responsibilities
- ✓ Understanding the importance of documenting work, and having IT skills to assist in this and other work
- ✓ Have group skills
- ✓ **Knowing how to help reduce harms that you see and are aware of**



How to develop these skills in the identified leaders/peer educator?



Did you consider?

How to develop young leaders/peer educators?

- Slowly build
- Identify essential skills required by youth leaders, for example:
 - How to develop trust
 - How to provide accurate information to peers
 - Basic counseling skills
 - How to know limits
 - Recognizing their 'difference' from their peers when they become a youth leader/peer educator – and how to manage this, when to refer
 - ...
- Provide mentors, buddies
- Provide strong support - continually
- Have routine and regular 'Checking in'
- Developing trusting groups where they can disclose concerns, share, and gain support
- Have supervision mechanisms in place and used
- Recognise the strong possibility of risk of (re)lapse - identifying potential triggers among youth leaders and peer educators, and having in place mechanisms for how to manage and respond to potential and actual (re)lapses
- Remember that of those who start development as youth leaders, many will drop out, and interest and motivation will fluctuate

Young people who use drugs in Katmandu identified the following triggers:

- No work
- Family hassles (especially about drug use)
- Drug use of friends
- Impulsivity
- Lack of family support
- Feeling watched and that people would not believe they had changed, the probable negative reactions of and difficulty getting back with positive friends and the community

- Not keeping busy
- Sexual activity and memories of how they lasted longer and felt the sex was better when using opioids+ other drugs – they worried that their girlfriends might not like them any more – especially if girlfriends did not use drugs.



How to help keep youth leaders and peer educators safe and continuing to grow and develop?



When to ‘let go’ (knowing when a peer/youth leader is ready to move on from this role as peer educator/leader)?



Two approaches in using peers and current young people who use drugs to reduce harm.

- I. **GLIMU**
- II. **Break the Cycle**

GLIMU uses a diffusion of information model, whereby ‘educated and trained’ peers disseminate information and harm reduction strategies to their peers.

Break the Cycle aims at engaging with current injectors and encouraging them not to initiate young people who use drugs or have the potential to use drugs to transition to or begin injecting.



Consider each approach that builds youth leaders and peer educators. Select one that is more suitable your setting, and consider how it could be implemented and any risks in doing so.



I. GLIMU, The Group Level Intervention For Methamphetamine Users

The Group Level Intervention for Methamphetamine Users (GLIMU) is a cognitive behavioural, peer education intervention designed to reduce drug and sexual risk behaviours among young people who use drugs who use methamphetamines. Using structured groups, this intervention provides a comprehensive risk reduction educational format that supports changing social norms within targeted methamphetamine using community to reduce risks and improve health.

A GLIMU is cycle of 10 weekly group sessions. Each group session is 90 minutes in length. Participation is limited to 8-10 methamphetamine users.

GLIMU is not a support group for people trying to overcome drug addiction (e.g. not a 12-step group such as Narcotics Anonymous or Alcoholics Anonymous).

While participants may choose cessation of drug use as a personal goal, the purpose of GLIMU is to build harm reduction collaboration with those in our community who currently use methamphetamines, as well as to foment the establishment of health-positive messages within their community.

The **primary** goal of GLIMU is to reduce risk behaviours among methamphetamine users. It also strives to increase understanding of drug-use patterns in relation to HIV infection risk and other harms.

GLIMU Targets Young People Who Use Methamphetamine

- Participants are treated with respect as partners working together with staff to improve the health of the methamphetamine using community
- They are not infantilized, demonized, or ostracized
- They exert significant control over the direction and strategies of the intervention
- GLIMU builds a harm reduction collaboration with methamphetamine users in our communities
- GLIMU seeks to change individual behaviour within context of a group setting
- GLIMU uses a client-centered approach, which helps create a partnership based on trust and understanding between staff and clients
- Through training and support, participants become active players in the educational process rather than passive recipients or messengers

GLIMU Has 7 Core Elements

1. Recruit and maintain a core group of 8 to 10 methamphetamine users as participants
2. Staff and participants interact and collaborate to identify and intervene on problems related to illicit methamphetamine use
3. Teach skills to reduce harms of drug use and unprotected sexual activities
4. Train participants to be peer educators
5. Train participants to endorse the benefits of harm reduction in their conversations and to offer practical steps to achieve change
6. Conduct 10 group sessions
7. Conduct enrollment and exit sessions

GLIMU Cycle

- One cycle contains 10 weekly group sessions
- Each group session is 90 mins in length
- Session 1 is used to introduce GLIMU to participants
- Sessions 2-9 run as designed with a different focused activity each week
- Session 10 is reserved for exit interviews, wrap up, and graduation

Staff lead participants in the following activity sessions:

- Session 1 Introduction to GLIMU
- Session 2 About methamphetamines
- Session 3 Peer outreach
- Session 4 HIV prevention for methamphetamine users
- Session 5 Overdose
- Session 6 Sexual behaviour & methamphetamine Use
- Session 7 About women who also use methamphetamines
- Session 8 Other health issues
- Session 9 Agency choice
- Session 10 Exit interviews, graduation and wrap-up

Clients can also **design and produce** written harm reduction and other informational materials during this component. For example:

- Flyers
- Zines (self published magazine)
- Brochures
- Referral documents

Participants:

- Receive support, training and supervision for their work as peer educators
- Submit peer outreach data collection forms
- Receive incentives
- Restock their peer outreach supplies

Staff must determine a candidate's eligibility before enrollment. The following criteria must be met:

- Did not participate in GLIMU during the previous 12 months
- Is a current, regular user of methamphetamines
- Agrees to participate in all 10 consecutive sessions
- Agrees to participate in the intake and exit interview



II. Break the Cycle

Injection drug use initiation

The first injection is described as an initiation into a ritual of injecting drug use. Most people who inject drugs report that their first injection is unplanned in some social situation. However, in some cases, users may actively seek out established injectors and ask to be included in their drug-injecting activities. Most injectors report being injected by somebody else the first time, usually a more experienced injector. Female heroin users are more likely to have been given their first injection by a sexual partner than were males. Men and women are equally likely to get injected by a friend as their first injection.

The location of the first injection may also vary. In an Australian study of adolescent correctional facility inmates, 26 percent reported first injection on the street, 31 percent at a friend's house, and 15 percent at home. A significant minority of participants in a second Australian study had first injected in prison. The time between initiation of injecting and the next injection, like other aspects of initiation, may also vary. One study reported that 15 percent of their sample injected again the same day, with another 14 percent within two days.

Factors predisposing young people who use drugs towards injecting

Drug transitions are complex. Young people move between different drugs and levels of intensity of use, with an overall tendency to move toward more intense use of drugs between the early to late teenage years. Initiation to injecting drug use is typically preceded by use of alcohol, cannabis and solvents by several years. Injection without very substantial exposure to illicit drugs is rare, though much more common in Eastern Europe and Central Asia than in Western Europe and North America.

The choice of drug for first injection varies by social network and availability of particular drugs. Young people acquire their drugs knowledge and make drug use decisions based on the views of friends and personal experiences. A 2005 study in three regions of the Russian Federation found

much higher rates of heroin availability and use compared with Western Europe. Heroin use was found to be common among young women and normalized as part of youthful recreational drug use, rather than a sub-cultural activity. Heroin use was thus found to be associated with intimate domestic routines such as watching TV with friends. Heroin use does not exclude people from local communities – heroin users retain mainstream norms and contacts with mainstream society.

The social network establishes group norms and influences the transition to injection drug use. Influences on transition include drug use by family, friends and sexual partners, greater effect at lower cost of injection, and the extent of injection in their local neighbourhoods. According to some studies, most heroin injectors start at approximately 18-20 years of age, are 3-4 times more likely to be male, poor and live in an urban environment, though this will vary according to region.

Route transitions

Transitions in the major route of drug administration are defined as “Changes in the exclusive or predominant route of administration lasting one month or more”. Studies show that a single transition from non-injecting to injecting is most common. The longer heroin is used the more likely the user is to make a transition to injecting.

A study of amphetamine users found that the first use of amphetamines was by injecting for 23 percent of the users, snorting (57 percent), swallowing (19 percent) and smoking (1 percent). Of all respondents, 40 percent made a transition towards injecting from another method of use because of a better “rush” and lower cost. Approximately 9 percent moved away from injecting drug use mainly because of concern about vascular damage.

Break the Cycle evidence base

Break the Cycle targets current injecting drug users, encouraging them to help prevent non-injectors from beginning to inject drugs. A review of the first BTC intervention in the UK found that, among those interviewed, injecting in front of non-injectors was halved, respondents’ disapproval of initiating others was increased, injectors who participated in the intervention received fewer than half as many requests to initiate others than non-participants, and the number of people initiated by intervention participants fell, compared with baseline data.

PSI collaborated with the United Nations Reference Group on HIV/AIDS Prevention and Care among people who inject drugs in Developing and Transitional Countries to document the BTC work in Central Asia. In addition, further collaborations were carried out with UK-based researchers who created Break the Cycle to insure the quality of the BTC programme in Central Asia.

Overdose prevention and management

PSI included an overdose prevention and management component in its BTC programme in Central Asia in order to increase the attractiveness of BTC to young people who use drugs, for whom overdose is one of the main causes of morbidity and mortality. Overdose prevention and management education to young people who currently inject drugs (including distribution of naloxone to prevent death from overdose) has proven effective in preventing heroin overdose deaths. Almost all injecting heroin overdose death is caused by respiratory depression leading to cardiac arrest. Heroin overdose fatalities occur mainly after a period of abstinence. The two-week period immediately following prison release or leaving drug treatment programmes is especially dangerous. Most overdoses occur with injecting drug users present. In many overdoses, bystanders fail to call for ambulance services. This failure is primarily due to fear of the police. Untrained people

present at overdoses try a variety of methods (including ill-advised practices such as injecting saline solution) in an attempt to aid the overdose victim. Organizations considering implementing BTC should consider adding components, such as overdose prevention and management, to their programmes to make it more relevant to the lives and health of young people who use drugs.

In Break the Cycle, people who inject drugs are encouraged to adopt the following behaviours:

- Don't inject in the presence of non-injectors;
- Don't talk only about the positive effects of drugs, i.e. the high, in front of non-users or non-injectors;
- Don't assist someone with their first injection;
- Develop skills to refuse unwelcome requests to help someone learn to inject

Interventions with people who inject drugs typically use either outreach models, with the outreach worker as the expert informing the target group, or peer education in which the information is transferred by peers who should be practicing less risky behaviours. To promote BTC target behaviours, outreach workers change the outreach worker-drug user dynamic so that rather than the outreach worker operating in a superior position informing the drug user, the drug user is in the dominant position being asked questions by the outreach worker using motivational enhancement techniques, such as "motivational interviewing."

Using motivational interviewing/motivational enhancement approaches, outreach workers implementing BTC use open-ended questions to evoke revelations from the target group. Outreach workers literally interview young people who use drugs about their own injecting initiation and other injecting experiences in order to encourage thinking about the role that they, possibly inadvertently, may be having in increasing the chance that non-injectors around them might initiate injecting. These conversations also build the refusal skills of young people who use drugs who are often approached by non-injectors with unwelcome requests to help with injecting.

Benefits of Breaking the Cycle approach:

Break the Cycle builds on existing drug demand reduction programmes

Break the Cycle, working with people who inject drugs, operates in collaboration with various programmes including drug use prevention activities that target at-risk youth. The addition of BTC's injecting drug use focused work, as a supplement to youth-focused drug demand reduction activities, provides a new, holistic model for drug demand reduction with a greater chance of successfully preventing people from initiating injection of heroin or other drugs. More conventional forms of drug demand reduction – i.e. drug use prevention education activities – help young people who do not use drugs to understand the risks attached to drug use.

Countries with HIV epidemics driven by injecting drug use, for example China, Viet Nam, and Myanmar, could consider replicating BTC projects in order to reduce the number of young people initiated into injecting drug use.

Break the Cycle builds on existing HIV prevention efforts

The Break the Cycle intervention operates primarily through an outreach education model to reduce IDU assistance to others to initiate injecting. Experienced outreach workers, already working with people who inject drugs to provide HIV prevention messages and materials, used their contacts among current drug user networks to attract individuals to participate in BTC activities. These contacts allowed the projects to quickly reach a substantial proportion of injectors in the target

sites; to provide additional training to outreach staff on motivational interviewing – a core methodology used in BTC; and to add value to HIV prevention programmes.

Break the Cycle also provides health assistance to young people who use drugs

The BTC trainings also benefited the young people who use drugs who participated. Young people who use drugs were attracted to education sessions by combining them with overdose prevention education to help young people who use drugs learn how to avoid and/or manage overdose to reduce drug user morbidity and mortality. Ongoing contact with young people who inject drugs provided opportunities to motivate current users to move towards drug treatment and HIV testing. Significantly, many drug users reported a deep sense of gratitude to BTC outreach workers.

Break the Cycle builds on social codes among young people who inject drugs

Break the Cycle is not a programme externally imposed upon drug users. Rather, it builds upon existing norms and values within networks of drug users that value efforts to limit the initiation of people into injecting. The social codes of acceptable behaviour among existing young people who use drugs strongly influence the initiation of new users into injecting. The process of initiation into injecting is likely to influence an individual's future injecting practice and risk-taking behaviour. Research shows that most first-time injectors are eagerly and willingly involved in the decision to first inject, rather than being passive victims seduced into injecting drug use by people with greater experience in drug use. However, experienced drug users do not generally intend to introduce non-injectors to injecting, and many refuse when asked. The unwillingness to initiate new users represents a common social code found among experienced drug users. The BTC approach aims to reinforce this social code, and to disrupt the initiation of novices into injecting.

Pre-project planning

The following points should be considered in the planning phase for projects incorporating BTC into drug demand reduction or HIV prevention programmes.

Selection of an organization with pre-existing contact with people who inject drugs

People who inject drugs can be difficult to reach. Partnerships with existing organizations engaged in outreach service provision allow relatively rapid access to the target population. In Central Asia, PSI implemented BTC primarily through governmental and non-governmental trust points for people who inject drugs and drug treatment centers in Tashkent, Osh, Khujand, and Bishkek. Doing so enabled PSI to gain access to people who inject drugs through programmes already successfully working with the target group.

Selection of experienced outreach workers

Use of experienced and, if possible, already employed outreach workers assists in rapid implementation of the model. In Osh, the individuals selected for Break the Cycle outreach work each had more than five years of relevant experience. Furthermore, the outreach workers both lived and worked in the target districts. This ensured extensive pre-existing networks and trust did not have to be created for the Break the Cycle project. Using this model, BTC was able to be implemented with the addition of only a small number of trainings of existing outreach workers regarding how to implement the BTC programme.

Baseline studies of target behaviour

Baseline studies are important to establish appropriate indicators and as a basis from which to measure project performance. These included surveys and discussions with the target group to determine levels of injecting drug use among clients in the target group, as well as baseline levels of initiation of others to injecting. These studies were undertaken in both sites. The success of the programme will be measured based upon the programme's ability to change these indicators.

Pre-project stakeholder partnerships and advocacy

Community, government, police, and young people who use drugs support are all crucial for successful implementation of BTC. Local government bodies should be consulted when determining sites at which to work. If a pre-existing outreach network exists in the target community, it should be involved in BTC implementation. National, provincial, and district level health administration, drug control bodies, and police and relevant community bodies should be consulted during the planning phase to ensure an enabling environment. When approaching local administrations, BTC should be framed in clear terms of assisting local target groups at risk of drug use and HIV. Finally, and perhaps most importantly, local networks of young people who use drugs should be involved at every stage of the planning and implementation process of BTC. BTC builds upon existing norms within drug user networks, so it is crucial to involve young people who use drugs in order to ensure BTC is implemented in a way that will benefit both youth, by reducing initiation of injecting, and young people who use drugs, by emphasizing BTC elements such as overdose prevention and management.

Service delivery

The following points should be considered when planning service delivery incorporating the Break the Cycle approach.

BTC outreach should be implemented, wherever possible, through existing trust points

To implement BTC effectively, the programme should be run through outreach workers already providing services to young people who inject drugs in the area where they live and using people who already have trusting relationships with the target group.

Physical separation of youth services from Break the Cycle activities

It is important to keep BTC activities separated from any purely youth-oriented activities. This is important, as programmes should avoid systematically putting youth who are at risk of injecting into contact with those already injecting drugs.

The importance of target group support

Break the Cycle should only be implemented with the support of young people who use drugs in target communities. The Break the Cycle programme was supported by young people who inject drugs in target communities from the start. Initial focus groups revealed that the BTC concept reflected a pre-existing informal moral code among young people who use drugs present since the Soviet-era; which strongly discouraged existing people who inject drugs from giving non-users their first injection. Global research on IDU indicates that such norms are commonly found in IDU networks; if such notions do not already exist among drug user networks, it would be very difficult to create such norms through a BTC programme.

The importance of police support

Police support for BTC is crucial. Pre-project advocacy with police ensured police support for the PSI BTC programme in Central Asia, where Osh, Tashkent, and other target sites reported few difficulties with police. In Osh, there were occasional difficulties and harassment from new junior police officers recently transferred or employed. Ongoing training for police can help deal with this problem. It is wise to have outreach workers carry ID cards approved by local government and police, authorizing them to work with young people who inject drugs.

The importance of non-interference from drug dealers and sex worker pimps

It is very important that drug dealers and pimps not interfere in outreach activities. In Central Asia, where the programme was implemented using outreach workers already familiar with these 'gatekeepers' of the target group, no interference was reported.

The importance of client anonymity

Across Central Asia, fear of the police is one main barrier preventing young people who inject drugs from establishing contact with services. Particular efforts to ensure client anonymity should be seen as central to interventions with young people who inject drugs. The PSI Break the Cycle projects used an anonymous Unique Identifier Code (UIC) as part of a comprehensive system to track client contacts while also ensuring client anonymity, when working with at-risk and drug using populations. More information about the PSI Unique Identifier Code is available in the UIC Model in this series of publications.

Onward referrals for drug treatment, HIV testing, and other services

BTC will work best if outreach workers combine the goals of BTC with provision of additional services and referrals to services that are useful to young people who use drugs. In the BTC projects in Central Asia, outreach workers were trained to motivate young people who use drugs to utilize drug demand reduction services, to go for HIV testing, and to provide trainings to help young people who use drugs prevent and manage overdose, for example. Referral to a wide range of services makes BTC more attractive to young people who use drugs.

Client-oriented project promotion

The BTC project should be promoted by existing outreach networks and, most importantly, through word of mouth among current young people who use drugs. Outreach workers are incentivized to contact new people who inject drugs with BTC outreach by monitoring how many new contacts they make with young people who use drugs that have not been previously reached. All young people who use drugs participating in the programme were recorded by collecting UICs from each client. This completely anonymous client-oriented monitoring system made young people who use drugs more comfortable introducing their drug-using social networks to their outreach worker so more of their friends could benefit from the various aspects of the BTC programme.

See Resource CD/USB: 1, 26, 28 and 65.

Session 14. Activities

By completing this session you should have knowledge of:

- ✓ Range of possible activities that can be useful for young people who use drugs
- ✓ Developing a comprehensive activity plan/programme
- ✓ Identifying the existing skills of staff and young people
- ✓ Barriers to participation
- ✓ Maintaining participation
- ✓ What needs to be provided by other services/people to provide a comprehensive activity plan/programme



What types of activities do young people who use drugs want and need?

Remember what young people said they wanted and needed?

Examples from youth focus groups in Katmandu and Bangkok, which explored how services could be more 'youth friendly':

Focus group discussions (Bangkok, Katmandu, Kunming)

Activities to distract and to educate

- TV, movies, computers, sports
- Education: English classes, books, IT
- Vocational training: motorbike repair, handicrafts
- Interactive discussion groups, e.g. about drugs and their effects
- Recreational activities (e.g. sport, music) and gym; and training in home-based crafts for sale in markets
- Training as peer outreach workers
- Some wanted family meetings
- Leisure and fun activities, e.g. such as swimming, badminton, go to gym, play cards, climb mountain, and sports competition.
- Learn how to communicate and get along with other people
- Go to parks for group activities
- Outings



What are the benefits of a comprehensive activity programme?



Did you consider?

- Offer something to do
- To relieve boredom or difficult living situation
- Avoid risk
- Avoid drug use
- Spend time with others doing something
- Provide education and remediation
- Provide opportunities for checking on status of young people – physical and mental health, risks,
- Vocational training
-

An example?

Day	Morning 10.30 - 12.00	Afternoon 2.30 - 4.00
Monday	<i>Check in:</i> – debrief room weekend Facilitated open discussion	<i>Vocational</i> - motor bike, phone repair, handicrafts
Tuesday	<i>Nutrition and health:</i> – health topic of choice, plus preparing, cooking lunch – and taking away food for next few days. A nurse may be available and conduct a clinic/health checks	<i>Recreation and fitness</i> - at centre or elsewhere – exercise and fun (e.g. gym, sport, music, video)
Wednesday	<i>Education</i> - e.g. computers, IT, literacy, English, numeracy, getting ready for ‘education’ – activities to increase concentration and memory	<i>Managing moods</i> - mental health support for dealing with depression, anger, frustration,...
Thursday	<i>Vocational</i> - motor bike, phone repair, handicrafts – and activities to increase concentration and memory	<i>Recreation and fitness</i> - at centre or elsewhere – exercise and fun (e.g. gym, sport, music, video)
Friday	<i>Nutrition and health:</i> – health topic of choice, plus preparing, cooking lunch – and taking away food for next few days. A nurse may be available and conduct a clinic/health checks	<i>Safety for weekend</i> – reducing risk/reducing harm Facilitated open discussion

Application to your own setting:



What skills do your staff already have, in addition to their work role that could be used to develop an activities programme? (E.g. mechanical repairs, computing, art, music, singing, dance, knowing other languages, first aid, handicraft, developing a small business, electrician, building and construction trades, sport, cooking, gardening, etc.). If not known, how can you find out?

Young people are also a key resource and need to be involved in:

- Providing input for planning weekly programme
- Running/facilitating some groups – e.g. exercise, sport,

- Co-facilitating ‘check in’ and ‘reduced risk weekends’



Develop your ideal weekly programme for young people who use drugs – including who can provide what is needed, and where it can be provided (i.e. at your service or elsewhere)



Now, develop a possible weekly programme given what is available to you -- including who can provide what is needed, and where it can be provided (i.e. at your service or elsewhere)

Barriers:



What barriers do you see to young people who use drugs in participating in an activity programme?



Did you consider?

- Transport
- Any costs
- Not have appropriate clothing
- Under the influence of drugs
- Not feeling ‘comfortable’
- Shy
- Very poor self-image
- Belief that they cannot do certain activities
- Afraid
- No equipment
- Gender/sex mix of the group
- Age mix
- Religious concerns – e.g. for young women (e.g. for swimming or mixing with young men)
- Disability
- Poor basic literacy/numeracy
- Difficulty in communicating in groups
- Poor nutrition
- Sickness – e.g. breathing difficulties with asthma or respiratory infection
- Energy level of programme low – staff tired, losing interest, feeling all will relapse and no point in providing the programme, etc ... the programme is getting sick and needs rejuvenation!!



How to engage and maintain the participation of young people who use drugs?



Did you consider?

- Flexibility
- Involving them in planning and preparing
- Involving them in running/delivery/facilitating
- Getting them to the activities – i.e. pick up in bus, tuk-tuk, etc.
- Providing snacks, drinks, food
- Basing activities on what they want
- Ensuring fun
- Ensuring that activities and not like school

- Ensuring participatory approaches
- Helping them get needs met – e.g. health check, skills development, knowledge increased
- Refreshing the plan regularly
- Ensuring staff have skills to actively engage with and work with young people – know how to start conversations, an activity (e.g. cards, a competition, etc.), create fun and silly activities when people are just sitting around, bored and possibly engaging in negative conversations ('neg raving')
- Need to keep up 'energy' of activity and programme – if staff standing around, not involved, if activities do not start in time, etc... there will be no programme
- ...
- *Flexibility and choice are crucial*



What can your service provide, and what needs to be obtained from other providers?

The next session explores links and networks that need to be developed and maintained so an activity programme can be diverse and one service does not have to provide all activities.

Session 15. Essential Networks and advocacy

By completing this session you should have knowledge of:

- ✓ What a comprehensive effective harm reduction service for young people who use drugs needs to provide
- ✓ What networks with other services and people need to be developed and maintained to provide comprehensive service delivery
- ✓ Links with compulsory drug centres and other closed settings
- ✓ The need for advocacy
- ✓ Building advocacy and maintaining safety
- ✓ Importance of addressing stigma and discrimination



Reflect on your own service.... How well can you provide for the following as they relate to young people who use drugs, given existing staff, financial and facility resources?

How well do you:

- Provide a safe environment – for staff and young people
- Provide an encouraging environment
- Provide appropriate activities
- Identify and manage physical and mental health issues
- Encourage and support nutrition and wellbeing
- Assist with appropriate housing/accommodation
- Identify and meet education, training and employment needs
- Know if you are making a difference – data systems
- Respect and provide for gender, sexuality, disability issues
- Assist with IDs, Health cards, ...
- Involve families (as appropriate)
- Supervise, support and develop peer educators/youth leaders
- Provide and make available equipment (e.g. NS, other equipment of injecting, condoms, etc)
- Identify and engage key networks
- Identify, engage and link with key stakeholders
- Assist with legal issues
- Advocate for your centre/service, and young people who use drugs generally
- Recruit and maintain suitable staff
- Use acceptable IEC (i.e. acceptable to young people, their families, the community and the authorities – e.g. schools, public security)
- Assist young people in or coming from compulsory residential drug centres and other closed settings



For what you cannot provide for young people, but feel you should, could or need to – how can these be obtained? Which other services or individuals can assist? Which can provide assistance at no cost?



How can these external people, services, organizations be engaged?



What is in it for them?



How can these essential links and networks be maintained?



Group discussion MMT clients, YIDA staff, and company manager, Kunming, China

Links to compulsory drug centres and other closed settings:

Despite concerted efforts to minimise the use of compulsory residential drug centres and other closed settings, young people who use drugs are frequently placed in such settings, despite the harms that occur, rights violations, and the high relapse rates. While the capacity for a readily available, viable and effective community based treatment system is some way off, avenues for diversion from use of closed settings for young people who use drugs can be enhanced.



How might diversion of young people who use drugs be enhanced?



Did you consider?

- Developing effective working relationships with key police and public security officers, where there is a reasonable level of trust, respect and preparedness to work together
- Developing and maintaining strong effective working relationships with police and public security to ensure you know when young people have been arrested or detained
- Advocating for policy and legislative reform to enable maximum diversion from compulsory residential and other closed settings for young people who use drugs
- Developing and maintaining supportive and effective legal contacts

- Ensuring that your service can provide for reasonable conditions that may be imposed on a young person when they are released from a closed setting
- Developing and maintaining effective working relationships with key staff of compulsory drug centres and other closed settings such as prisons
- Developing and participating in a formal or informal network of service providers, key community members and representatives from compulsory residential and other closed settings to share information on who from their respective communities has entered a compulsory residential and other closed setting, and who will soon be released to enable effective support for the young person when released (always within the bounds of confidentiality and consent for information sharing)
- Developing mechanisms to enable contact with young people in compulsory drug centres and other closed settings to assist in developing support mechanisms and realistic relapse prevention plans for when they are released
- Developing effective working relationships with key community and family members of young people in compulsory drug centres and other closed settings to assist in developing support mechanisms and realistic relapse prevention plans for when they are released
- Meeting young people who use drugs on their release to demonstrate support and offering assistance to reduce chances of relapse and return to a closed setting

Advocacy for young people who use drugs:



What is advocacy and is it important?

The points below came from formal and informal discussions within Youth Vision, Nepal, and from a coordination meeting with other service providers, government authorities, police and concerned authorities.



Advocacy is actively supporting a cause and trying to get others to support it as well. It is speaking up, drawing attention to a key issue and directing decision makers towards a solution

Advocacy in General

- Addressing the barriers to harm reduction caused by the disconnect between law enforcement and the health sector
- Advocacy for removing punitive laws, policies and practices, stigma and discrimination
- Services should be physically accessible, available and affordable
- Services must be equitable and non-discriminatory with no exclusion criteria, except on medical grounds
- Access should not be determined by socio-demographic factors such as age, sex/gender
- All interventions should be offered voluntarily and occur within an enabling environment
- Advocacy with linkage (e.g. Referral) partners to provide a continuum of care

Advocacy within the organization: Often NGOs are stuck and unwilling to change the mode of service delivery. To address this they could consider:

- Meaningful participation of PUD and in policy-making and service planning

- Meaningful participation of young staff in planning and implementation of service delivery
- Mechanism established for frequent review meetings among service provider and the clients



What are some of the areas that could require an active advocacy response in relation to the needs and rights of young people who use drugs within your service?



Did you consider?

- Stigma - clients and workers
- Discrimination - clients and workers
- Violence - clients and workers
- Sex, Gender, Sexuality-based issues - clients and workers
- Lack of information in community and with politicians
- Access to treatment barriers
- Poverty
- Lack of inclusion of affected populations in decision making
- Voice of young people silenced and or not considered
- Unreasonable public security activity (even illegal activity, such as bribes, forced sex, etc...)
- Overuse of compulsory 'treatment' and incarceration, closed settings or placement in residential facilities
- Lack of access to competent legal advice and representation
-



What is currently being done in relation to advocacy for the needs and rights of young people who use drugs by your service/agency outside your service [e.g. community, key agencies, stakeholders, government]?



What means can be used to address advocacy issues?

Possibly:

- | | |
|--|------------------|
| • IEC | • Public debates |
| • Internet and web-based | • Courts |
| • In local community | • Rallies |
| • Media – newspapers, radio, TV | • Petitions |
| • Submissions to officials, and to government and NGO enquiries and investigations | • ... |



What roles do staff play?



What role do young people play?



How is safety for staff and young people provided for?



Knowing rights and getting them met can be two very different things, especially when police intervene. What can assist young people who use drugs to decrease any risks, yet maintain their dignity and rights?

Press Release:



Draft a press release to assist in generating a positive view of young people who use drugs and their needs.

An example:

Initial Draft for a press release:

Young People who Use Drugs speak out on their needs.

TTAG has been speaking with young people who use drugs to identify their specific needs and joining with them to develop meaningful services. TTAG is being assisted in this by a joining AHRN/NDARC project funded by AidsFonds Netherlands.

The young people, aged 14 to 25, have been participating in focus groups at the TTAG drop-in-centre at Mitsampan The young people were users of ya baa and ya maa and cannabis (marijuana), and, surprisingly for some, were keen to tell their stories and seek assistance to meet their needs.

Many still lived with their families and wanted their parents and siblings to get information on drug use to better understand the situation, and how they can support them to deal with their drug use-related difficulties. Some wanted to cease their drug use altogether, some wanted to avoid risks of becoming HIV positive, going to prison and being discriminated against daily. They felt they could not get access to services, and many health, education and training services did not like young people who use drugs and treated them with disrespect.

They also detailed abuse at the hands of police, even when they were trying to live drug free, obtain jobs and live quietly in the community. They said they did not like what drugs were doing to their brains and health, and wanted assistance.

Some of the things they felt could help them were both 'youth friendly' drop-in-centres and 'outreach workers. The drop-in-centre would be a safe, drug use and dealing free space where they could get the assistance they needed and wanted. They requested training in livelihood skills – for examples to be able to set up small business in their home to make handicrafts for sale, and repair such things as electrical goods, motorcycles. They wanted education, to learn English, to get accurate information about drugs and their effects, to play sports, be assisted to get adequate health care, legal advice. They also wanted discussion groups where they could explore ideas and share experiences, and to be able to bring their families along to join in.

The young people also recognised that they needed a mix of workers who were respectful and friendly, and for some of them to be people who used to use drugs. A number also wanted to become peer educators to help others. So, these young people, who daily experience discrimination, violence and lack of access to services they have a right to, do not seem to fit the typical picture in the press and other media of out of control, amoral young people bent on destruction. They seem like young people trying to grow up to lead happy lives and to help their communities.

Stigma and discrimination:



What is Stigma and discrimination?



How is it demonstrated in relation to young people who use drugs and to workers?



- Stigma is a process of forming disapproving attitudes and enforcing negative views towards an individual or group on the basis of a differential characteristic or quality of that individual or group.
- Discrimination is stigma that has been put into action; it reveals itself through unfair treatment towards people who are stigmatised. Discrimination can be defined as enacted stigma. In turn, discrimination encourages and reinforces stigma.
- Stigma and discrimination are revealed through attitudes and actions – in many cases, people may not be aware that their words or actions are stigmatizing.

Forms of stigma

- Physical stigma (fear), stigma against physical defects or dangerous diseases.
- Moral stigma condemnation, disrespect, stigma against behaviours considered to be immoral.
- Stigma can come from external sources or from self-stigma (internal sources).
- External stigma refers to experiences of being treated unfairly and differently. This discrimination may include oppression, rejection, punishment, harassment, blame or exclusion. Sometimes it can also lead to violence.
- Self-stigma (internal stigma) is the way a person feels about him/herself, e.g. feel low, putting negative view on one-self- for examples, shame, fear, look-down on oneself, fear of rejection, and discrimination...

See Resource CD/USB: 26, 28, 32, 36, 37, 54, 63, and 64.

Session 16. The Change Process

By completing this session you should have knowledge of:

- ✓ How they and their service manage change
- ✓ The process of change
- ✓ The ingredients necessary for effective change



List the potential positive behaviours young people who use drugs exhibit that you find most encouraging– e.g. business skill, care for family...



List the behaviours young people who use drugs exhibit that you find most difficult– what you see as their negative characteristics – e.g. lie, neglect responsibilities.



Explore the strategies that you use to assisting them move away from the negatives – or how to turn the negatives into positives.

Now reflect on your service and complete the table below:

<i>Good things about your current approach – what works now?</i>	<i>Not so good things about your current approach – what works less well now?</i>
<i>Good things about making a change to your approach – what could be done that could improve the current situation?</i>	<i>Not so good things about making a change to your approach – what could be difficult in making changes, or that could bring about a worse situation?</i>



Case Study: A story of change:

Sajan's story: – 25 year old worker/counsellor at a residential centre:

I grew up in Tripureshwor in Nepal. I lived in a family with conflicts around all the time. My father is deaf and dumb, but works. I went to school, completed high school at the age 13 and I started college at the age of 14. However, by age 12 I started using tobacco and cannabis, and experimented with inhaling brown sugar (heroin). By age 16, I was also orally using benzodiazepines (e.g. Valium), and by age 18 injecting brown sugar as well as using other drugs. I experimented with Set (mix of buprenorphine, diazepam and phenergan) about 12 times.

When I started using drugs my family were telling me not to use and to think about my future. At first they didn't have any idea about what I was using and were only thinking I was using alcohol and cannabis.

During my high school years, I managed to complete my work and do well. I am a very intelligent and thoughtful man and I used consider myself courageous.

I realised I needed to do something about my drug use when I was eighteen. At that time I had a strong motivation to quit all drugs and start a productive life where I could contribute something to myself and my family.

I tried to stop by doing detox at home but this did not work, so eventually I went into the Youth Vision residential rehabilitation facility. When I got there, I thought I am just going to stay there a short time and then leave.

I found it hard to stay at the treatment center. It was so weird for me and things were not getting inside me. What I found most difficult there was the daily schedule; I never had my life in such structured way or let's say I never followed the time and did things in a planned manner. But my urge to quit drugs and the encouragement from the counsellors there retained me in treatment. I started liking the schedule because it taught me a way living, living in a more manageable way and to accept my responsibilities.

Eventually, I stayed there for 3 months; I came back to the centre for daycare. However, shortly after, I was appointed as a volunteer staff member and the senior staff helped me gain counselling skills and practices. This really made me strong and I had a feeling that "I can do it." I did whatever I could to perform my duties and responsibilities given to me. I worked hard. I was promoted and now I help myself by helping others and I learned various things about drug use and its consequences.

Earlier this year Youth Vision organised a four day training to explore how to make our approach more 'youth friendly'. I attended it with 29 other people aged 20 to 38 who work with young people who use drugs, 24 of us used to use drugs and 8 are under 25 years of age.

On the second and third day we were pushed to explore how we work at the moment, why we do it, what works and what does not work so well, and, especially how this applies to young people who use drugs. We all talked about what young people who use drugs might need that is the same as for older young people who use drugs, and what is different. We also talked a lot about how difficult it was to work with the young ones and how their behaviours made us frustrated and at times a bit angry with them. One of the presenters asked us to consider the positive things about young people who use drugs, not just their negative characteristics, and pointed out how we described them in negative terms, yet our work vision says we are 'non-judgmental'. I wondered about this, and got a bit upset. I stood up and challenged the presenter, did not really agree with his response. That night some of us were de-briefing and talking about how we thought a lot of what was said about how we work, and how we could change was interesting and some really good, but we were worried that if we changed our programme might collapse and we could undo the good work we had been doing. After the de-brief I went home and worried about what was said and my reaction. I was a bit frustrated and upset.

Later, at the residential unit, I started to think more about how I worked. I noticed that when I did things in the conventional way it did not work – the young residents did not respond positively. I thought about what was presented in the training, and tried some other approaches like treating them in friendly manner, making them comfortable and not behaving like I was superior to them. To my surprise, it worked. I thought more about this, tried more things and started to see changes in the young people and I felt happier in my role. I also started to see that there were some programme rules and activities that did not seem to be useful any more like the 'encounter' approach, work therapy and the punishments.

So, as a staff, we made changes like we got rid of the 'encounters' and now manage negative behaviour by friendly, constructive approaches, and now we seem to admit more young people and they participate better. The atmosphere is more open and positive and the young residents speak up more.

We had a group today where one of the presenters from the training talked with eleven of our current young residents (aged 16 to 24) about how they see the programme. They were very talkative. They mentioned that there was a feeling of 'love and concern' in the facility, and we able to give examples when challenged. They said they had a 'voice' in programme, and could speak up about what they felt worked well and what did not work well. They said staff listened to them, tried to understand their struggles and counselled them.

I felt very proud that I have been part of the changes at Youth Vision, have offered ideas that have been listened to, seen management make big changes, and seen the positive benefit to the young people we work with.

I was very uneasy at first about all this change and thought it could have been handled better if the presenter at the training had explained things a bit more, and while it was good that he pushed us to think about what we do and how we could do it differently, he could have shown us that he understood more about how hard it was to hear these things, feel like we were being a bit criticised and not knowing how to deal with all the feelings coming up inside us. To get me to feel better about change I needed more space and time, let out my feelings, talk with others, ask more questions and be encouraged to try new approaches. Whatever – we are getting there and I will be part of future trainings when I can to share my experiences with others.

I am married now and we are expecting our first child. I am happy with my life and that I can help others. But, I am also worried – my income here is less than my expenses – I have a baby due soon, I need to help support my parents and siblings, I am studying. I need to try to do extra jobs, but I get tired and stressed. Luck I can control myself, so I do not pass on my stress to those in my care. I also worry about the funding for our programme –as we made changes, and have seen positive results ...



What are your reactions to this story? Do you see yourself in it in any way?

Process of Change:

This is a model of how people might change. How might it apply to your service?



 How ready are you in relating to making useful changes to your way of working?

 How ready are your co-workers in relating to making useful changes to your way of working?

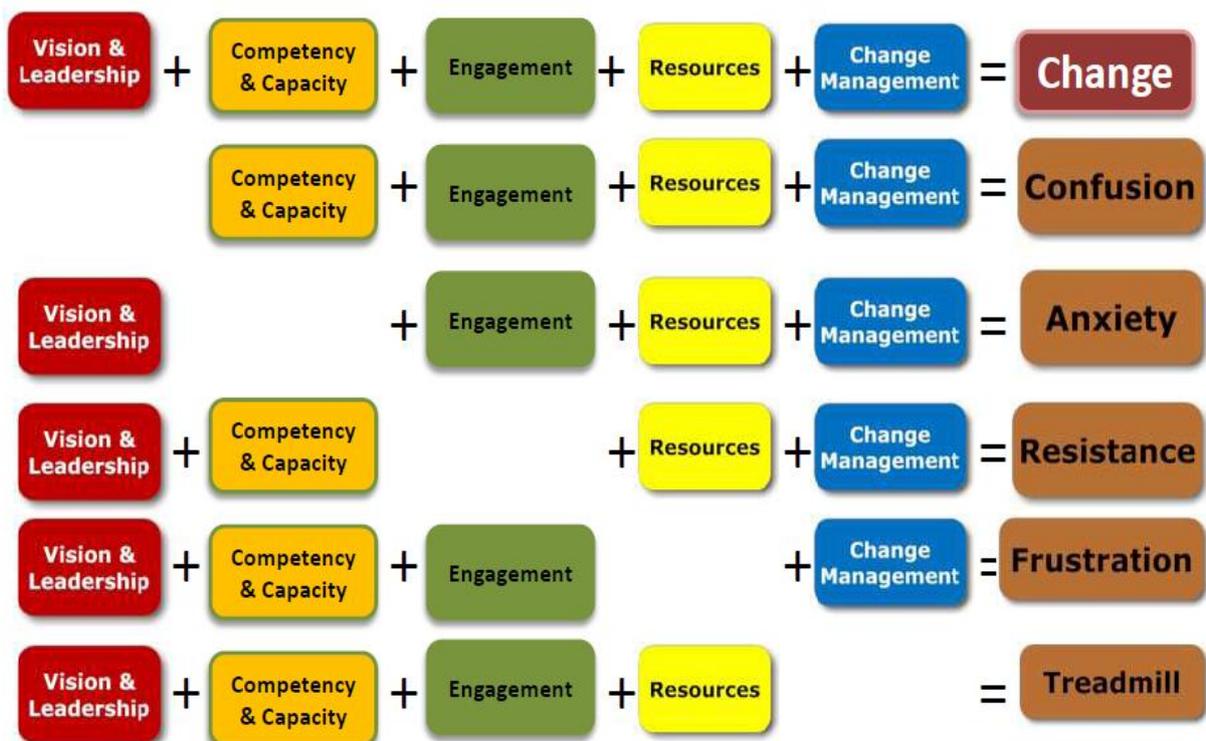
 How ready are management in relating to making useful changes to your way of working?

 What is in place to sustain the programme when there is funding/financial or other stress (e.g. low morale, anxiety about the future)?

Active Ingredients of Systems Change:

 This diagram shows the important components of making a change in an organization. In small groups, consider the diagram, and reflect on what is happening in your service. What is present and what is missing? What can be done to ensure that all ingredients are in place and effective?

The Active Ingredients of Systems Change



Annexes

Annex 1: Worksheets containing questions for each Session:	154
Annex 2 : Contents of resource CD/USB:	173

Annex 1: Worksheets containing questions for each Session:

Session 1: Youth Friendly Services I



Why does meeting the specific needs of young people who use drugs matter?



What is similar, what might be different between a 16 year old who injects versus a 30-year-old person who injects drugs?



For Santosh:

- What might Santosh get from his drug use that he would see as useful or beneficial?
- What are his strengths - what we know, and what we might want to find out about?
- What are his risk factors - what we know, and what we might want to find out about?
- What does he need?
- What are his rights?



What could happen for Santosh?

- Who could assist him?
- What could assist him?
- Different if female?
- Different if aged 27?
- Different if not from Kathmandu?
- Different if from a middle class family, with father a businessman?
- Different if lived in a rural area?



What are considered to be the developmental tasks of adolescence?



How does this list fit for China, Nepal, Thailand, Lao PDR, Viet Nam, Pakistan, Australia.....?



Are the tasks different for rural and urban adolescents, males and females, those with disabilities or those not solely heterosexual?

Session 2: Youth-Friendly Services II



What has shaped adult services?



Do youth require a different approach totally, mixed, or the same as for adults?



What are the barriers for young people in accessing services in your area?



What can assist in services becoming more 'youth friendly'?

Session 3: Harm Reduction



What is Harm Reduction?



Why should harm reduction be available for young people who use drugs?



What evidence is there for a harm reduction approach within your service?



What evidence is there for a harm reduction approach within your country?



Are harm reduction interventions available for young people under 25 years of age? Under 18 years of age?



Why is it crucial to use a human rights approach to harm reduction for young people who use drugs?



How to meet these and other needs and provide enhanced 'youth friendly harm reduction' in your setting?



What is essential?



What is desirable?



What needs to be done in your service to provide a board range of youth friendly harm reduction?

Session 4: NSP, Outreach, Drop-in-Centres, Safety

NSP:



What about young people under 25 years of age? Are there any barriers to them accessing a NSP in your service/country? Under 18 years of age? [Note there may be some legal barriers to any NSP provision in your country]



Isn't it better to stop people from using drugs, rather than giving them needles?



If clean needles and syringes are easily available, won't this encourage people to start injecting drugs or to use more drugs?



If clean needles and syringes are easily available, will that make it less likely that a person will enter treatment for their drug use?



How will you manage your relationship with the community and law enforcement?



How will you assist clients to dispose of equipment safely?

Outreach:



What is "outreach"?



Why outreach?



Are there any specific outreach issues for young people under 25 years of age?



What are equipment essentials for an Outreach Worker to carry in their bag?

Drop-in-Centres:



Why are drop-in-centres useful for young people who use drugs?

Overdose or 'too high' in unsafe area.



What do we learn from this story?



What are the essentials to assist the safety of workers and young people use drugs and others with them?



What are some important considerations when working in injecting environments – out or indoors – were young people inject?



What are important considerations when on ‘outreach’? For example when visiting ‘shooting galleries’, at night, near dealers, etc...?



Other strategies?

Risk and safety:



For clients and staff how do we ensure?

- Safety
- Hopefulness/optimism
- A sense of purpose
- A sense of movement
- Productivity
- Fun
- A sense of self
- A drug-free environment
- Order/ boundaries
- A learning environment
- A therapeutic environment
- Staff and young people’s mental health and wellbeing



Reflect on your work setting – what risk and safety issues come to mind?



What measures are in place to address these issues?



What measures need to be in place to address these issues?

Session 5: Drugs, Withdrawal, Overdose, OST



Where do the harms from the use of drugs come from:



What are some of the drugs commonly used by the young people you work with? What are their major effects and side effects?

Withdrawal:



What are some symptoms that are experienced by most people who use drugs when they withdraw - regardless of which drug they are dependent on?



Think of some things a young drug user experiencing withdrawals should do to try and stay healthy and more comfortable.

Overdose:



How could you tell if a person was overdosing on opioids?

- How could you tell if a person was overdosing on methamphetamine?
- How you tell if someone was overdosing on benzodiazepines?
- Make sure you consider whether you are assisting with an overdose or someone being 'too high'.



What would you do if you found a person you suspected was overdosing on a drug?

OST:



What medications are commonly used to treat opioid addiction and what are the differences between them?



What might be some goals and benefits of OST?

Session 6: BBIs, HIV, HCV, HBV, TB, STIs

HIV:



How is HIV transmitted?



What might help a young person who is HIV positive manage their disease?

HCV:



How is Hepatitis C transmitted?



What might help a young person who has Hepatitis C manage their disease?

HBV:



How is Hepatitis B transmitted?



What might help a young person who has Hepatitis B manage their disease?



What could you do to reduce the spread of blood borne infections such as HIV and Hepatitis B and C in the young people you work with?

TB:



How is TB transmitted?



What might help a young person who has TB manage their disease?

STIs:



What advice could you give to a young person about reducing their risk of catching an STI?

Session 7: Health and Nutrition

 What are some of the barriers to maintaining the health and wellbeing of the young people who use drugs that you come in contact with?

Diet:

 What do you think a healthy diet would be for the young people you come into contact with who use drugs?

 How can you and the other outreach workers and centres help improve the diet of the young people who use drugs you come in contact with?

Young Women:

 What might be some issues of concern for young women who use drugs?

 In addition to addressing concerns about drug use and related behaviours, how do young women who are pregnant, trying to get pregnant or breast feeding need to adapt their diet to keep themselves and baby healthier?

Exercise:

 Why is exercise important for a young person who uses drugs, and what are some exercises you think they could easily do?

Sleep:

 What are some reasons sleep is important in maintaining health?

 What are some difficulties you think the young people who use drugs you come into contact with may have with getting good sleep?

 How do you think the young people who use drugs you work with could try to improve the amount and quality of sleep they get?

Skin and Veins:

 What functions do you think the skin and veins have in our body?

 How do you think the skin and veins of a young person who uses drugs get damaged?

 How do you think a young person who uses drugs could keep healthy skin and veins?

Oral hygiene/Dental:

 What are some common problems with the teeth and mouth that you see or may see in the young people who use drugs?

 What are some ways using drugs might negatively impact on the dental health of a young person?

 What could you recommend to a young person who uses drugs to try and improve their dental care and oral health?

Sexual and Reproductive Health:

 What does 'safe' sex involve?

Drugs and Sex:

 What are the effects of the drugs you commonly see used by young people on sex and sexual function?

Session 8: Mental Health and Wellbeing



What might it feel like to be:

- Sad – depressed and hopeless?
- Frightened – fearful?
- Anxious – stressed?
- Paranoid – feeling people after you, out to hurt you?
- Seeing things that others cannot see?
- Hearing things that others cannot hear?
- Focus on mood/feelings, thoughts, behaviour from the observer and the sufferer's perspective.



What might lead you to think that a young person who uses drugs might have the following mental health problems?

Have depression?

Have an anxiety disorder?

Be psychotic?



How can we tell if mental health difficulties become a mental health disorder (as defined by mental health professionals)?



What drugs can affect your mental health, and how?



What can you do to assist a young person who uses drugs and who also has mental health concerns?

Session 9: Basic Counselling:



Confidentiality – why is it a fundamental issue, especially for young people who use drugs?



What are some of the main ‘helping processes’ in counseling?



What are some important Counsellor attitudes?



Non-verbal communication – what are some important examples that could assist/decrease counsellor effectiveness?



What are some important considerations in goal setting with young people who use drugs?



What are some of the possible challenges when counselling young people who use drugs, and how might you respond?

Session 10: Motivational Enhancement



Why is enhancing motivation a most important part of working with young people who use drugs in bringing about positive change?

If viewing the video, it could be helpful to consider:

- Why words like 'bad' or 'negative' not used by the worker?
- What is the worker attempting to do each time he summaries the conversation so far?
- How does the worker present the predicament to the young person (i.e. how does he present the dilemma re 'good and less good' things about cannabis use, and the potentially 'good and less good' things about change?
- Why does the worker NOT really explore the many issues raised by the young person?
- How would you adapt this approach to your own 'style' of relating to young people, and your work setting and role?



Practice: In groups of three (3) practice the approach (1 Counsellor, 1 Young Person, 1 Observer)

Session 11: Group Work



Why use Group counseling?



What is the role of the group counselor/facilitator?



What are some useful topics for groups with young people who use drugs?



What might be some typical problems during group counselling sessions, and how might you deal with them?



Review the groups included in UNESCAP Tool Kit 5 – Group Counselling. Do any of these groups seem useful in your setting?

List of groups:

1. Getting to know you – ice breaker and trust development
2. Something like me – ice breaker and trust development
3. Keeping the faith – trust development
4. Blind walk – trust development
5. Why people do what they do – Teacher Somjai
6. Dice/wheel of emotions
7. Emotion card
8. Skills in managing emotions
9. Self control – this bicycle provokes thinking
10. Being careful/aware not to make inappropriate decisions
11. Obstacles in life
12. How to prevent relapse
13. Refusal skills – relapse prevention
14. Successful refusal – relapse prevention
15. A very good mother – family relationships
16. Love letter – family relationships
17. Sympathy for your mother – family relationships
18. My father – family relationships
19. My house – family relationships
20. Took and Tui – Two-way communication
21. Drawing a picture following instructions: Two-way communication
22. Polite talk – respectful communication
23. Hunt the killer
24. Group story telling
25. Roads and lanes – stress management
26. Meditation to reduce stress
27. Breathing to reduce stress
28. Developing relationships in the family
29. Final activity



Do you know of other groups that could be useful in your setting?

Session 12: Relapse Prevention



Thinking back on your work with young people in this area:



What do you think might be some of the feelings, moods and memories that could be related to the return to substance use by a young person?



What might be some of the relationship cues related to the return to substance use by a young person?



What might be some specific situational cues related the return to substance use by a young person; e.g., smells, places, videos, etc?



Relapse Prevention is not just an activity for the young person. Who else needs to be involved?



What needs to be targeted?



Choose one or more of the case studies below of young people who use and develop a realistic Relapse Prevention Plan:

Session 13: Building Young Leaders



What do young people who use drugs think leaders should be like?



How to identify potential leaders?



What skills do they need?



How to develop these skills in the identified leaders/peer educators? How to help keep youth leaders and peer educators safe and continuing to grow and develop?



When to 'let go' (knowing when a peer/youth leader is ready to move on and leave the role of peer educator/leader)?

GLIMU and Break the Cycle



Consider each approach, which builds youth leaders and peer educators. Select one that is more suitable your setting, and consider how it could be implemented and any risks in doing so.

Session 14: Activities



What types of activities do young people who use drugs want and need?



What are the benefits of a comprehensive activity programme?



What skills do your staff already have, in addition to their work role, that could be used to develop an activities programme? (e.g. mechanical repairs, computing, art, music, singing, dance, knowing other languages, first aid, handicraft, developing a small business, electrician, building and construction trades, sport, cooking, gardening, etc.). If not known, how can you find out?



Develop your ideal weekly programme for young people who use drugs – including who can provide what is needed, and where it can be provided (i.e. at your service or elsewhere)



Now, develop a possible weekly programme given what is available to you – including who can provide what is needed, and where it can be provided (ie at your service or elsewhere)



What barriers do you see to young people who use drugs in participating in an activity programme?



How to engage and maintain the participation of young people who use drugs?



What can your service provide, and what needs to be obtained from other providers?

Session 15: Essential Networks and Advocacy



Reflect on your own service.... How well can you provide for the following as they relate to young people who use drugs, given existing staff, financial and facility resources?

For example, how to create or provide for:

- A Safe environment – for staff and young people
- An Encouraging environment
- Appropriate Activities
- Identifying and managing Physical health issues
- Nutrition and Wellbeing encouraged and supported
- Identifying and managing Mental health issues
- Appropriate housing/accommodation
- Identifying and meeting Education, Training and Employment needs
- Knowing if you are making a difference – Data systems
- Respecting and providing for Gender issues
- Respecting and providing for Sexuality issues
- Respecting and providing for Disability issues
- IDs, Health cards,
- Family involvement (as appropriate)
- Supervision, support and development of peer educators/youth leaders
- Provision, availability and use of Equipment (e.g. NS, other equipment of injecting, condoms, etc..)
- Key networks identified and engaged
- Key stakeholders identified, linked and engaged
- Legal issues addressed
- Advocacy for young clients, service, and young people who use drugs generally
- Staffing
- Acceptable IEC (i.e. acceptable to young people, their families, the community and the authorities – e.g. schools, public security)
- Young people in or coming from compulsory residential drug centres and other closed settings



For what you cannot provide for young people, but feel you should, could or need to – how can these be obtained? Which other services or individuals can assist? Which can provide assistance at no cost?



How can these external people, services, organizations be engaged?



What is in it for them?



How can these essential links and networks be maintained?



How might diversion of young people who use drugs be enhanced?

Advocacy:



What is advocacy and why is it important?



What are some of the areas that could require an active advocacy response in relation to the needs and rights of young people who use drugs within your service?



What is currently being done in relation to advocacy for the needs and rights of young people who use drugs by your service outside your service [e.g. community, key agencies, stakeholders, government]?



What means can be used to address advocacy issues?



What roles do staff play?



What role do young people play?



How is safety for staff and young people provided for?



Knowing rights and getting them met can be two very different things, especially when police intervene. What can assist young people who use drugs to decrease any risks, yet maintain their dignity and rights?



Draft a press release to assist in generating a positive view of young people who use drugs and their needs.

Stigma and Discrimination:



What is stigma and discrimination?



How is it demonstrated in relation to young people who use drugs and to workers?

Session 16: The Change Process



List the potential positive behaviours young people who use drugs exhibit that you find most encouraging – e.g. business skill, care for family...



List the behaviours young people who use drugs exhibit that you find most difficult– what you see as their negative characteristics – e.g. lie, neglect responsibilities.



Explore the strategies that you use to assisting them move away from the negatives – or how to turn the negatives into positives.

Now reflect on your service and complete the table below:

Good things about current your – what works now?	Not so good things about current your approach – what works less well now?
Good things about making a change to your approach – what could be done that could improve the current situation?	Not so good things about making a change to your approach – what could be difficult in making changes, or that could bring about a worse situation?

A story of change:



What are your reactions to this story? Do you see yourself in it in any way?

Process of Change:



How ready are you in relating to making useful changes to your way of working?



How ready are your co-workers in relating to making useful changes to your way of working?



How ready are management in relating to making useful changes to your way of working?



What is in place to sustain the programme when there is funding/financial or other stress (e.g. low morale, anxiety about the future)?

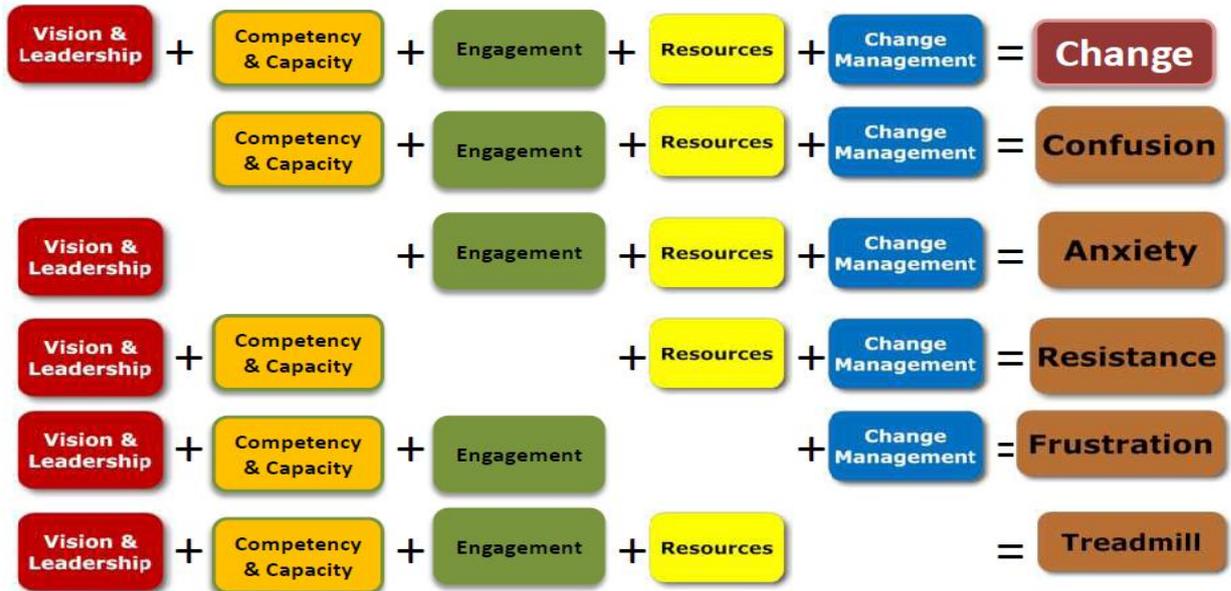
Active Ingredients of Systems Change:



This diagram shows the important components of making a change in an organization. In small groups, consider the diagram, and reflect on what is happening in your service. What is

present and what is missing? What can be done to ensure that all ingredients are in place and effective?

The Active Ingredients of Systems Change



Annex 2: Contents of resource CD/USB:

1	Break the Cycle - PSI
2	Cannabis and mental health guidelines - NCPIC
3	Through a Harm Reduction Lens - IHRA
4	Cleaning used syringes - AIVL
5	Convention on the Rights of the Child - UN
6	Convention on the Rights of the Child – right to be heard - UN
7	CPR Guide
8	Depression and young people - Youth Beyondblue
9	Drug use and related problems among very young people (under 15 yr) - EMCDDA
10	Harm Reduction – evidence, impacts, challenges - EMCDDA
11	Drugs and vulnerable groups of young people - EMCDDA
12	Evidence for harm reduction – Neil Hunt
13	HIV and drug use – good practice guide - Alliance
14	Handy Hints - AIVL
15	Out of harm’s way: IDU and harm reduction - Red Cross
16	HCV: youth and health worker support kit - Hepatitis NSW
17	Oral health – opioids and HCV - AIVL
18	HIV Counselling and Testing for Youth: Manual for providers: Training Guide - FHI
19	HIV Counselling and Testing for Youth: Manual for providers - FHI
20	Howard, Arcuri, Hunt. A situation assessment and review of the evidence for interventions for the prevention of HIV/AIDS among occasional, experimental and young injecting drug users.
21	Harm reduction and human rights - IHRA
22	Psychostimulants: management of acute behavioural disturbances – police - National Drug Strategy, Australia
23	Men-streaming in sexual and reproductive health and HIV - IPPF
24	Essential skills in mental health care (Crabb and Razi) - Ghana
25	Opioid Overdose - Lifeline - Manchester
26	Peer and Outreach education for improving the sexual health men who have sex with men: reference manual - UNESCO, Bangkok
27	Overdose prevention and response - OSI
28	Evidence-based guidelines for youth peer education - FHI
29	PPT: Howard: Structural determinants and an assets approach to achieving good outcomes for young people, Moscow 2003
30	PPT: Howard: Evidence for interventions for young, vulnerable populations to prevent HIV/AIDS, Dublin, 2004
31	Not just a phase - a guide to the participation of children and young people in health services – RCPCH, UK
32	Re-engaging students in education - Youth Affairs Network, Qld
33	Safer injecting - AIVL
34	Overdose Prevention- SCARE ME - Chicago Recovery Alliance

35	HIV/AIDS among men who have sex with men and transgender populations in South-East Asia - WHO SEARO
36	Looking for more: a review of social and contextual factors affecting young people's sexual health – Couch et al. ARCSHS
37	Understanding and reducing stigma related to men who have sex with men and HIV - UNAIDS
38	Stress and HCV - HCV Australia
39	UNESCAP: Building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: an overview and discussion paper
40	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 1: Introduction, case studies and videos
41	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 2: Assessment and Action Planning
42	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 3: Stages of Change and Motivational Interviewing
43	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 4: Individual Counselling
44	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 5: Group Counselling
45	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 6: Family Counselling
46	UNESCAP: a toolkit for building capacity for community-based treatment and continuing care of young drug users in the Greater Mekong Subregion: 7: Relapse Prevention and Planning
47	UNESCAP: Young people and substance use: Introduction
48	UNESCAP: Young people and substance use: 1: Understanding substance use
48	UNESCAP: Young people and substance use: 2: Prevention: principles and strategies for intervention
50	UNESCAP: Young people and substance use: 3 treatment and continuing care: principles and strategies for intervention
51	What is Harm Reduction – Mandarin - IHRA
52	What is Harm Reduction - IHRA
53	Global consultation on adolescent friendly health services: a consensus statement - WHO
54	Adolescent friendly services – an agenda for change - HO
55	Antiretroviral therapy for HIV infection in adults and adolescents – 2010 revision - WHO
56	HIV counselling and testing - WHO, SEARO
57	HIV prevention and care among drug uses - WHO, SEARO
58	Adolescent Job Aid: SRH Part 1 - WHO
59	Adolescent Job Aid: SRH Part 2 -WHO
60	Adolescent Job Aid: SRH Part 3 - WHO
61	Youth friendly services: annotated guide to web resources - FHI
62	Why overdose matters for HIV - OSI
63	Young people most a risk of HIV - FHI
64	Youth friendly services: a manual for service providers - Engender Health
65	GLISU - Luciano Colonna
66	YouthR.I.S.E Peer Education Manual

