Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION ONE

Introduction, Case Studies and Videos

United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

ST/ESCAP/2444

UNITED NATIONS PUBLICATIONS
Sales No. E.07.11.F.20

ISBN: 978-92-1-120515-2

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area, or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The opinions, figures and estimates set forth in this publication are the responsibility of the authors and should not necessarily be considered as reflecting the views or carrying the endorsement of the United Nations. Mention of firm names and commercial products does not imply the endorsement of the United Nations.

This publication has not been formally edited prior to its issuance by the Health and Development Section, Emerging Social Issues Division, ESCAP. It may be reproduced or reprinted for non-profit use, with due acknowledgement to ESCAP.

Contents

Section One

Introduction, Case Studies and Videos *13*

1. Introduction *14*

2. The five case studies and four videos *23*

3. The videos *32*

Acronyms

AA	Alcoholics Anonymous
ADHD	attention deficit hyperactivity disorder
CNS	central nervous system
GHB	gammahydroxybutyrate
GMS	Greater Mekong Subregion
HDS	Health and Development Section
HIV	human immunodeficiency virus
IDU	injecting drug user
LSD	lysergic acid diethylamide
MDA	methylenedioxyamphetamine
NSP	needle and syringe programme
OARS	Open ended questions, Affirmation, Reflective listening, and Summarizing
OD	overdose
PSI	Population Services International
RL	role lettering
STI	sexually transmitted infection
YIDA	Yunnan Institute for Drug Abuse

Preface

This Tool Kit was developed by ESCAP as part of the project "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion". The Tool Kit aims to provide "how to do it" guides for assessment of individual, group and family counselling interventions that can be applied in community or residential settings. It uses relevant subregional examples, accessible web-based resources and templates.

It is hoped that the techniques illustrated in the Tool Kit will assist you to work with young people, their families and communities to deal with substance use-related difficulties. However, the Tool Kit is NOT a textbook on counselling, and does not attempt to replace face-to-face workshops that try to develop counselling skills in participants.

Counselling of young drug users can involve participation from a number of trained people, from specialized professional psychologists, psychiatrists, doctors and social workers, to peer counsellors and peer educators who can offer "basic counselling". The professionals are usually experienced in working with cases that are more difficult and can provide an approach that is more "in depth". Nevertheless, not all young people need such a level of intervention, or they are not yet ready to engage with these professionals. Therefore, they can benefit from basic counselling provided by someone they trust. This may be sufficient, or it might help them realize that they are in need of more specialized interventions and the person providing the basic counselling can link them with the professionals, and even accompany them if they are anxious or afraid.

Young people respond well to **peer counsellors** and **peer educators**. Such peers can act as good "role models", and have great insight into the lives of young people from similar backgrounds. Some of them might have previously been drug users, and young people can view them as coming from or living in similar situations to them, and having "recovered" from drug problems similar to those faced by the young people.

Teachers, community leaders, police, compulsory residential treatment centre staff also provide basic counselling and support. At times, all the types of "non-specialized" counsellors can encourage and support young people experiencing drug use-related difficulties to seek necessary assistance from "specialists". This can include specialist attention for serious mental and physical health, and family and abuse issues.

This Tool Kit is expected to be of use to both those professionally trained, perhaps as a "refresher", and those who need the skills to provide basic counselling to young people experiencing drug use-related difficulties. Those using the Tool Kit to facilitate the training of people from varying backgrounds and of different ages and experience can use the sections that will be of most use in preparing their trainees for the settings within which they will provide basic counselling. Those using the Tool Kit as a self-directed learning package may need some guidance from counsellors with more experience.

The assessment and family interventions are somewhat more specialized, as are some of the more advanced techniques of individual counselling. However, for those working with young people in community or residential settings, whatever their role, it is hoped that they may learn some useful techniques or approaches that can be adapted to assist individual young people, groups of young people, their families and their communities.

The Tool Kit comprises seven sections, a CD of useful forms for screening, assessment and follow-up, and a CD with four videos made by participating project partners.

The seven Sections are:

1. Introduction, Case Studies and Videos

2. Assessment and Action Planning, Re-test/Follow-up Questionnaire and General Treatment Principles

3. Stages of Change and Motivational Interviewing

4. Individual Counselling

5. Group Counselling

6. Family Counselling

7. Relapse Prevention Planning

The four Videos are:

1. "Noy Story" – Vientiane Youth Center for Health and Development, Lao Women's Union – Lao People's Democratic Republic

2. "Never too late to change: Payu's Story" – Tulakarn Chalermprakiat Hospital of the Institute for Juvenile and Family Justice and Development – Thailand

3. "New Working Process of Nonthaburi Provincial Court: Juvenile and Family Division" – Thailand

4. "Seeking the way back" – the Yunnan Institute for Drug Abuse (YIDA) – China

Acknowledgements

ESCAP developed this Tool Kit to address needs identified in the early stages of the project "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion". The project is being implemented by the Health and Development Section (HDS), Emerging Social Issues Division, ESCAP.

Generous funding for the project was received from the Bureau for International Narcotics and Law Enforcement Affairs, U.S. Department of State.

Initial work for Phase II of the project, from where the Tool Kit comes, was undertaken by Janet Maychin Wong, formerly of HDS.

The Tool Kit was prepared by the HDS consultant for the project, John Howard, Director, Clinical Services, Training and Research, Ted Noffs Foundation, Sydney, Australia.

Feedback on the draft of the Tool Kit was offered by the project partners: the Yunnan Institute for Drug Abuse, Yunnan Province, China; the Vientiane Youth Center for Health and Development, Lao People's Democratic Republic; the Institute for Juvenile and Family Justice Development, Thailand; and the Department for Social Evils Prevention, of the Ministry of Labour, Invalids and Social Affairs, Viet Nam.

From HDS, Preeyamas Mayura assisted in translating materials from Thai to English, Marco Roncarati undertook editing of the manuscript and Ployparn Khunmuang coordinated the finalization of the publication.

Ms. Catherine Tan prepared the graphic design of the publication.

ESCAP project summary

Despite progress in certain spheres, young people of the Greater Mekong Subregion (GMS) face numerous challenges associated with rapid social and economic changes. Many find it hard to avoid temptation to experiment with drugs. A number slip into drug use and delinquency, often at particular risk of acquiring HIV. There is also the risk of young people engaging in crime and being victimized in sexual abuse and exploitation.

The treatment of young people who have developed drug dependency and drug-related problems in programmes originally designed for adults is problematic. Young people have different psychological, social and cognitive developmental needs from adults. They deserve different and specialized treatment interventions that address their developmental needs and that build on their developmental potential. The predominant use of incarceration and/or "compulsory treatment" has often proved to be unsuccessful, resulting in an unacceptably high relapse rate; it can also worsen social exclusion, stigma and discrimination.

The project "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion" represents commitment to an active search for effective and culturally-appropriate treatment and rehabilitation for young drug users. It is based on the conviction that giving up on young drug users would constitute a violation of basic human rights. The project has focused on contributing towards meeting the serious need for community-based treatment and rehabilitation of young drug users in the GMS.

The Target Groups of the project are young people experiencing problematic drug use, their families and schools, community health and other workers with youth, and residential rehabilitation staff. Policy makers will also be targeted in Phase III of the project.

Phase I (2002-2004) in addition to documenting existing capacity, sought to do the following:

1. Develop NGO and community capacity to plan and deliver prevention, treatment, rehabilitation and continuing care services for young people with drug use-related difficulties as an alternative to existing programmes and juvenile detention centres.

2. Identify, advocate for and document "good practices" in drug use prevention, treatment and continuing care and the enhancement of protective factors.

3. Promote intra- and inter-country exchanges of experiences.

4. Produce a training guide: "Young people and substance use: prevention, treatment and rehabilitation".

From field visits for Phase I of the project and the development of the training guide, it became obvious that one of the greatest impediments to expanding the capacity for community-based treatment was the lack of a skilled and confident workforce. In some locations there was almost an absence of counselling skill development, or only brief workshops held occasionally. Many in the field requested information on counselling in an easy to understand and practise format. In addition, there were few relevant, culturally-appropriate textbooks readily available in local languages or useful in local settings.

Phase II (2005-2006) emphasized building capacity for community-based treatment, field testing selected interventions and producing this Tool Kit for use in community settings and compulsory or voluntary residential treatment facilities. To achieve its aims, Phase II included:

1. A subregional meeting to evaluate Phase I and introduce Phase II of the project, including the development of a baseline against which to measure progress.

2. Field visits to conduct interviews and focus group discussions with young drug users, family members, school staff, community health service providers and/or community members.

3. The identification of information for knowledge and skills development, including resource materials, for the development of the Tool Kit.

4. Subregional workshops, which included sessions on developing performance indicators to facilitate evaluation, facilitating identification of and reviewing learning to date, reviewing progress, introducing the draft Tool Kit and sharing ideas, identifying commonalities and differences, and offering suggestions for the review of the Tool Kit.

5. Conducting training workshops in each country to explain the Tool Kit, with a view to drawing out views for its local adaptation.

Phase III (2007-2008) will facilitate an expansion of the approach to build capacity for community-based treatment and rehabilitation, share learning and focus more on how policy change could reinforce and provide stronger support for the approach.


A TOOL KIT

Section One

Introduction, Case Studies and Videos

This section introduces the Tool Kit and presents five case studies that are used throughout the kit to illustrate various aspects of working with young people and their families experiencing substance use-related difficulties.

1. Introduction

From field visits for the UNESCAP project "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion", it became obvious that one of the greatest impediments to expanding the capacity for community-based treatment was the lack of a skilled and confident workforce. In some locations there was almost an absence of counselling skill development, or only brief workshops held occasionally. Many in the field requested information on counselling in an easy to understand and practise format. In addition, there were few relevant, culturally appropriate textbooks readily available in local languages or useful in local settings.

The "Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion" project has a **focus on young people under 25 years of age**, their families and carers and communities. In a number of countries young drug users are placed in compulsory detoxification, treatment or rehabilitation centres. Most of these centres accommodate people of all ages, and there are few that are for young people only. While there have been attempts to provide separate accommodation for young people (for example, under 18 years of age) in the centres that accommodate all age groups, for most daily activities young residents are in the company of older ones. This raises concerns for the safety and welfare of these young people, and for those working with them, to assist them to develop skills to lead drug-free, less problematic lives. These concerns will shape how you deliver counselling and other activities that best fit for a community or compulsory treatment centre for example.

Thus, one hears the question: ***"How can we use these approaches and techniques in closed settings, such as compulsory residential treatment centres?"*** The interventions contained in this Tool Kit can be applied in any setting, but there must be modifications made to ensure the safety of young people and workers such as peer educators and peer counsellors. In compulsory residential treatment facilities, it is very important that confidentiality be taken very seriously. 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. It is very important to consider these issues and adjust your approach accordingly.

The group counselling approach works well in residential facilities, as it does in the community. In fact, most of the groups included in Section Five were developed for use in residential treatment facilities. Family counselling offered in residential treatment facilities use much the same techniques as are used in the community. However, safety and confidentiality concerns may require more careful attention.

This Tool Kit attempts to provide "how to do it" guides for assessment, individual, group and family counselling interventions that can be applied in community or residential settings. It tries to use relevant regional examples, accessible web-based resources and templates. It is NOT a textbook on counselling, and does not attempt to replace face-to-face workshops that attempt to develop counselling skills in participants.

1.1. Who does counselling?

When working with drug users it is very useful to have a mix of backgrounds. At times, highly trained professionals such as psychologists, psychiatrists, doctors and social workers may be needed to provide specialized interventions. These professionals are experienced in working with more difficult cases and can provide a more "in depth" approach. However, not all young people require this level of intervention, or are not yet ready to engage with these professionals. Thus, they can benefit from basic counselling provided by some they trust. This may be enough, or it may help them understand that they need more specialized interventions and the person providing the "basic counselling" can link them with a psychologist, for example, and even accompany them if they are scared or anxious.

Young people are known to respond well to **peer counsellors and peer educators**, some of whom may be ex-drug users, as they see that

they come from or live in similar situations to them, and may have had drug problems like them but "recovered". They also provide good "role models", and have great insight into the lives of young people from similar backgrounds. **They are living proof that rehabilitation is possible**. Ex-drug users also gain a lot for themselves by doing something for others experiencing difficulties similar to those they experienced.

Teachers, community leaders, police, compulsory residential treatment centre staff also provide basic counselling and support. At times, all the types of "non-specialized" counsellors can encourage and support young people experiencing drug use-related difficulties to seek necessary assistance from "specialists". This can include specialist attention for serious mental and physical health, family and abuse issues.

Whereas they may have caused great suffering due to their drug habit, recovering drug users now become part of the solution instead of part of the problem. By remaining abstinent and helping others, they prove that drug dependence is treatable. And after rehabilitation, by becoming productive members of the community, they help a great deal in removing the stigma that excludes former drug users from the mainstream of society.

1.2. Support for counsellors

Most "counsellors" need what is often called **"clinical supervision"**; that is, supervision of their work by other counsellors who are more experienced. This is recommended for all who use this Tool Kit. If such supervision is not available to you, it is recommended that you join with peers who are also providing counselling, and form a "peer supervision group" where you discuss difficulties and success with each other, share ideas and challenge each other. Supervision is very important for ex-drug users providing counselling, as they may become "triggered" to return to drug use if they become overwhelmed by the problems experienced by the young people they are counselling and are not receiving enough support themselves.

It is clear that "counselling interventions" rarely work in isolation. They need to be supported by others: family, peers, teachers, community leaders, employers, and so on. Peer educators and peer counsellors can provide much needed support to young people as they try to remain free from drug use and related problems, and reduce the difficulties they have been experiencing.

1.3. Engaging young people, families and community

Many factors will have an impact on whether or not you can engage a young person, their family and supports in trying to resolve difficulties. These can include:

- The cultural background, age, religion, gender, etc., of both the client(s) and the counsellor;
- The location of the young person – e.g., isolated rural village, town and city;
- Where you are providing counselling – e.g., in the community or in a compulsory residential centre;
- If city, slum or middle-call area;
- Whether the counsellor was a drug user in the past;
- The reputation of your agency/service;
- Whether potential clients trust your service;
- The "mix" of staff – e.g., ages, training, religions, ethnic backgrounds;
- Training staff have received – e.g., prior to employment and/or subsequently;
- The mix of clients attending your service/agency;
- The resources you or your agency have both internally and those who can be drawn on for assistance or referral;
- Hours of operation of your service;
- The "spaces" where counselling can take place – e.g., private rooms, outdoors, in the family home, in a compulsory residential centre;
- Ease of transport/access to your service.

This Tool Kit follows the typical structure of a counselling intervention. That is, it starts with screening and assessment, and then moves through assessing stage of change and action planning. Ideas for individual,

group and family counselling, brief interventions and relapse prevention planning are then provided.

Many young people and/or their families can be very resistant to change. They may be what are called "pre-contemplators" (not even thinking about change) or "contemplators" (thinking about change but not taking any action). It is hoped that the techniques illustrated in the Tool Kit will assist you to work with young people, their families and communities who are ready to makes changes in their lives, as well as those who are not so ready to be involved in dealing with their substance use-related difficulties.

Deciding how to start the process of engaging with compulsory residential centres, communities and young people and families in both compulsory centres and the community can be difficult. Over the course of the project various methods have been tried. What follows is a listing of some of the approaches taken by the project partners in China (Yunnan Province), Lao People's Democratic Republic, Thailand and Viet Nam. However, it appears best to try a mixture of methods and not just rely on one. In addition, some approaches will work best in some settings, but not at all in other settings. Some may be culturally inappropriate and others may seem too intrusive. Careful discussion with key community leaders will assist in determining which approaches are best for which groups.

1.3.1. Engaging with communities:

- Having discussions with youth and family friendly community leaders;
- Having discussions with local elected or appointed leaders (e.g., village headmen, mayors, politicians, party chairpersons);
- Having discussions with local police chiefs;
- Having discussions with leaders and members of mass organizations (e.g., youth, veterans and women);
- Having discussions with youth and family friendly local public security officers;
- Having discussions with community health centre staff about services to young people and their families;

- Having discussions with local school, vocational training and university administrators;
- Having discussions with local religious leaders;
- Starting off with non-threatening activities;
- Offering to hold some "community activity", for instance an anti-drugs event, such as a drama, concert, creative art or song contest involving young people and their families. Of course, "drugs" may not be the issue you want to address, but it may be a "legitimate" entry point;
- Not starting by appearing to know "all the answers", but asking sensible questions, seeking advice and starting to give information on what you have found from your work with young people.

1.3.2. Engaging with families:

- Holding an information session for parents on "drug issues in the community", and trying to make contact with parents who are worried about their sons/daughters;
- Meeting parents who have sons/daughters in compulsory residential centres and offering assistance, such as helping with transport to visit their son/daughter, and offering assistance to their son/daughter while in the centres;
- Asking for approval to visit their sons/daughters in the compulsory centres to offer assistance;
- Starting to introduce families with young people in the compulsory centres or who are using drugs in the community to each other to begin to facilitate a family-to-family support group. Keep the initial group small enough to assist trust and group cohesion, and to consolidate a "core group" of families;
- Offering to support them and their sons/daughters when they return from the compulsory centres;
- Identifying families with "at risk" young people (i.e., those who are starting to try drugs, staying out late, being defiant, stealing from home, not attending school, etc.) who are worried and could benefit from some assistance;
- Starting a separate family-to-family support group for parents of "at risk" young people, or inviting them to join with the parents of young people in the compulsory centres;

- Asking young people in the compulsory centres for approval to make contact with their families in the community to offer assistance, and to move, if possible, towards the family feeling more supported and thus ready to have their son/daughter return home earlier.

1.3.3. Engaging with young people:

In compulsory residential centres:

- Ensuring that you have developed a good working relationship, characterized by mutual trust and respect, with the managements and administrators of the compulsory residential centre;
- Ensuring that you abide by the rules of the centre and do not breach trust by bringing in or taking out items or letters that are against the centre's rules or policies;
- Ensuring that centre staff are alerted to any possible risk to individuals or the centre (e.g., drugs in the centre, violence about to occur, damage/riots planned);
- Making clear how your staff and peer educators will be supervised, and what their duties and roles are;
- Maintaining regular contact and meetings with centre administration to resolve any difficulties and keep two-way communication active;
- Using peer educators to offer some group activities – e.g., a drama, concert, sport or creative activities – to introduce what you can offer;
- Meeting with young people whose families have given approval from the community;
- Identifying and developing peer educators in the centres, who will benefit themselves from the training and, hopefully, assist other residents;
- Starting with the young women if the centre contains both males and females, as in some centres the young males will then join in the activities;
- Offering to contact the parents/families of young people from target communities to encourage them to support their sons/daughters, visit, and send food or other necessary items;

- Offering realistic assistance to young people leaving the centre, such as assistance in obtaining employment or getting some training or work experience, recreational and leisure activities, counselling, accommodation assistance if they cannot return home, introduction to a drop-in or youth centre, links to youth friendly doctors, etc.

In the community:

- Using peer educators to offer some group activities – e.g., a drama, concert, sport or creative activities – to introduce what you can offer;
- Holding an information session for young people on "drug issues in the community", and trying to make contact with those who are worried about their drug use or who are "at risk";
- Meeting young people who have brothers/sisters in compulsory residential centres and offering assistance such as helping with transport to visit their brothers/sisters;
- Starting to introduce young people who have brothers/sisters in the centres or whose brothers/sisters are using drugs in the community to each other to begin to facilitate a youth-to-youth support group;
- Offering to support them and their brothers/sisters when they return from the centres;
- Identifying "at risk" young people (i.e., those who are starting to try drugs, staying out late, being defiant, stealing from home, not attending school, etc.) who are worried and could benefit from some assistance;
- Starting a separate peer-to-peer support group for young people being released from centres;
- Keeping the initial groups small enough to assist trust and group cohesion, and to consolidate a "core group" of active young people;
- Having peer educators train more peer educators or 'helpers' to spread the workload;
- If not from a youth centre, linking with a local youth centre to assist in providing regular "fun" activities at times that suit young people. Do not exclude more marginal, vulnerable and drug using

young people; they, and those who are trying to give up drug use, are *the* target groups. If young people using drugs are involved in centre activities, insist that they not come too drug affected, and do not bring, sell or distribute drugs at the centre. Use peer educators to ensure that the centre rules are clear and enforced.

In addition to the materials gained during the field visits to China (Yunnan Province), Lao People's Democratic Republic, Thailand and Viet Nam, much of the material in this Tool Kit comes from or has been adapted from the following primary sources:

1. Mika Niskanen (2005) Various resources made available by Mr Niskanen from Counselling Workshops conducted under UNODC auspices during 2005 when Mr Niskanen, a psychotherapist, was working with UNAIDS in Vientiane, Lao People's Democratic Republic;
2. Ministry of Health – Jamaica, VCT Programme, Youth.now (2004) *Adolescent Decision-Making Counselling Protocol*. Downloadable from the Family Health International website: http://www.fhi.org/en/Youth/YouthNet/Publications/YouthInfoNet/YIN15.htm#CounsProtocol (the manual is located in Youth InfoNet No: 15 May 2005, Program Resource No. 3);
3. Ted Noffs Foundation (2006) Various assessment and treatment tools. Obtainable from: Ted Noffs Foundation (2006) Youth Substance Assessments A-B, C, D and various other assessment and treatment tools. Obtainable from: howardj@noffs.org.au;

4a. Department of Juvenile Observation and Protection (2004a) *Manual for Rehabilitation and Treatment Activities for Children and Young People in Juvenile Training Centres* Department of Juvenile Observation and Protection, Office of Juvenile Justice System Development. Bangkok, Thailand;

4b. Department of Juvenile Observation and Protection (2004b) *Manual for Rehabilitation Activities for Young People at Risk of Drug Use, Drug Users and Drug Addicts.* Department of Juvenile Observation and Protection, Office of Juvenile Justice System Development. Bangkok, Thailand;

5. UNDCP (2000) *Drug Counsellor's Handbook: a Practical Guide for everyday Use.* UNDCP, Nairobi, Kenya. Downloadable from website: http://www.unodc.org/unodc/en/report_2000-05-01_1.html;

6. UNESCAP (2005) *HIV Prevention among Young People: Life Skills Training Kit.* http://www.unescap.org/esid/hds/resources/publications.asp;
7. WHO (2003) *Brief Intervention for Substance Use: a Manual for use in Primary Care* (Draft Version 1.1). Downloadable from website: http://www.who.int/substance_abuse/activities/assist/en/index.html;
8. Materials from PSI, Kunming.

2. The five case studies and four videos

The following case studies are used to illustrate the many factors associated with the development of substance use by a young person, and the many interventions that are necessary to be delivered in a coordinated way in order to attempt to bring about a positive outcome. They are fictional cases developed during the field work. Most of the case studies are taken from the UNESCAP (2005) resource: Young People and Substance Use: Prevention, treatment and rehabilitation – the training manual developed from Phase I of the project "Reducing drug use and delinquency among youth in the Greater Mekong Subregion", and adapted.

Case studies

2.1. Noy's story

Noy is a 16 year-old high school student in a small town. His father has a small car and motorcycle repair business. He has an older sister aged 18, a younger brother aged 13 and a younger sister aged 11. Noy has been a good student, but over the past year has begun to get bored with school and family life. He watches TV and sees the fun young people have in discos and bars in the big cities.

About six months ago, while riding his bicycle around town one evening, he saw some of the older boys from his school hanging around beer halls near the river. They called him over, talked with him for a while and then asked him for some money. They said they would get him beer if he gave them money. He gave them the money as he wanted to drink beer. They

returned, gave him beer and they went to a quiet area near the river and talked. They told him about the fun they had with girls when they went to the beer halls and clubs. Noy was getting drunk and excited. He had been thinking about girls for many months and wondered what sex would be like.

Over the next few months he met up with the same group of older boys and drank with them. They introduced him to some girls. Noy had sex with some of them. Some of the girls asked him for money, as did the older boys. He used all his school money and began to steal small items, such as gems from his family. A few months ago, his older friends introduced him to *ya baa* (a form of methamphetamine). He liked the effect, felt excited and sexy. He began to use *ya baa* more often. Sometimes he came to school feeling very tired after using *ya baa* the night before. At other times he was excited and not able to sit still as he had used *ya baa* that day. He also began to sell *ya baa* to school friends.

His parents are worried about him. They ask him what is wrong. His father has even threatened to beat him and send him to his grandparents in a village 80 km away. His teachers have also become worried about him. His grades are falling. He day-dreams most of the time and looks tired. He has started to feel that people are watching him all the time. Occasionally, he hears voices talking to him but cannot see anyone. He also gets irritable when his teachers ask him what is wrong. He says that he feels like hitting someone or smashing doors and cars.

The teachers called his parents to the school and told them about his falling grades and changed behaviour. His sister spends a lot of time at a local youth centre where she is training as a volunteer peer leader. The centre has a youth health centre and gives information on reproductive health. She suggests Noy go to the centre with her and talk to the health workers or some peer leaders.

Risk factors – the risks/negative things in Noy's life:

- Older peers;
- Likes the effects of beer and *ya baa;*
- Likes sex;
- Father getting angry;
- School grades dropping;
- Not going to school;
- Starting to hear voices and is paranoid.

Protective factors – the protective/positive things in Noy's life:

- Noy is intelligent;
- Teachers like him;
- Sister wants to help;
- Father loves him – although he is angry;
- Youth centre – if he goes;
- Can make friends easily.

What is important in helping Noy?

- Keeping him connected to his community;
- Helping him to give up *ya baa;*
- Noy needs an STI check and sexual health, including HIV, information;
- Getting him back to school;
- Encouraging him to study again;
- Encouraging him to join some non-drug, fun activities;
- Linking Noy to the youth centre and some peer volunteers;
- Helping his father – education and some parenting skills;
- Supporting his sister who cares so much for him;
- Making sure his younger brother and sister are safe;
- Working with the authorities to ensure that under-age youth are not frequenting bars;
- Creating some more fun activities within the community;
- Encouraging peer outreach workers to make contact with the young people frequenting the bars and possibly having unsafe sex;
- Encouraging the police to enforce the laws, especially with regard to the young people frequenting the bars and drinking in public.

2.2. Nung's story

Nung is 14 years old. Her peers at school think she is very quiet. She is an excellent student who gets high marks in all subjects. But, when she is praised for her work, she thinks she does not deserve the praise and says her work is not good enough.

Her best friend, Som, has noticed that she has become more withdrawn in the past couple of weeks. Nung had also asked Som the other day if she has ever tried methamphetamine or heard of Valium (diazepam). Recently she was offered some methamphetamine on the way home from school. She did not buy it, but has been wondering whether this might help her feel better. She has never used drugs before. Some of the girls give her a hard time by calling her "witch" and "weirdo" because she likes to read fantasy books about life on other planets and in strange far away galaxies. One day she even found a dead rat in her locker. She told the teacher who said it was difficult to find the culprits and subsequently nothing was done about this. She was in the drama team but recently stopped attending because she feels lethargic and does not see much point in being part of the team.

Nung lives at home with her mother. She loves her mother, but finds that her mother is often sad these days. Her mother has started taking Valium prescribed by her doctor. Some afternoons when Nung comes home, she finds her mother intoxicated from drinking alcohol and taking Valium. When she is in this state her mother says things to her like, "I wonder why I keep living" and "It's not really worth it". Her mother's depression is affecting Nung. Recently, she took one of the Valium tablets that her mother takes, just to see what it was like. She did not really enjoy it. She got sleepy and later had a headache. But, she also felt that it was something different to do and she liked the dreamy feeling she had before she got the headache. Since then she has used her mother's medication a few more times, but not regularly.

Nung has also started feeling depressed. On weekends when she is at home, she stays in bed most of the day. She is not reading as much as she used to and has stopped going to the library. She has started wondering if anyone would miss her if she were dead.

She sees her father every fourth weekend. Her mother and father have been divorced for four years. They used to argue constantly and now do not speak to each other. Nung's mother often tells her that her father is a bad man. Her father works as a manager in a big export company. She enjoys her visits with her father. It is their special time together and they talk a lot about different kinds of things. Nung has been giving more thought to moving in with her father. She has not asked him because she thinks that his new wife may not be happy with the idea. They have two young children and there is not enough space. She wants to ask him but she knows that she will be extremely disappointed if her father said "no". She does not get along well with her father's new wife. Nung thinks that she is always criticizing her. She overheard them arguing over Nung's influence on the two younger children.

Her only real friend is Som. Nung thinks that Som is nice. Som and her family are warm and accepting of Nung. She stays with them some weekends and enjoys the close relationship they have with one another. Her other 'friends' are the 'pills' she has begun to use more frequently. She steals them from her mother when her mother is too drunk or intoxicated from taking too many pills.

2.3. Minh's story

Minh 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 three 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 Minh. But, Minh does

not want anyone to know about it. He wants people to think he likes girls and is "tough".

Minh 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.

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

He lives on and off with his mother and father in their State-owned house. Minh's parents argue constantly and when they get intoxicated, the fighting escalates. When Minh'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, Minh was assaulted by his father when he defended his mother. Minh has a younger brother aged 13 years and a sister aged eight years, and he is protective of them. When he is at home and his parents start fighting, Minh takes his siblings into his bed and they sleep with him.

Minh'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 Minh's bad behaviour. Minh 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 two children if she visited.

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

Minh 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 Minh was suspended three times from his local school, twice for fighting with other students and once for throwing a desk at a teacher. Minh 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 one or two subjects. In his old school, he did six or seven subjects. The principal of the school in the detention centre is helping him to gain entry into a similar school in the community. Minh 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 Minh'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 are in custody with him. Like Minh, two of them are trying to never use heroin. The others are using drugs whenever they can get them in the detention centre. All of them 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 Minh 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. Minh 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 could employ Minh as a dealer. Although he is uncomfortable with these suggestions, he sees them as an easy way of making money.

2.4. 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 drug users 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. He has been given information on substance use,

safe sex, HIV and hepatitis by friends and some outreach workers from an NGO. Choi, also 18, is a friend and is worried that he might end up like him. But, he thinks, are there any better alternatives?

2.5. Choi's story – a friend of Zhong

Choi 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 local drug users and dealers and those involved in crime for the past year. He has 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.

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. However, 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 injecting drug users (IDUs), and been now given information on safe sex, HIV and hepatitis. He became very concerned when one of the workers at the drop-in-centre who is an ex-drug users and who underwent treatment at the therapeutic community in the city told him that 70 per cent of those in the treatment centre are HIV-positive and 40 per cent 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 by any other means.

3. The Videos

3.1. The video ***"Noy Story"*** presents the first case (Noy) in a dramatic format, and hopes to illustrate how substance use by a young person develops and how various members of Noy's community can assist him with his substance use-related difficulties; teacher, police, family, youth centre, doctor, monk, peer educators and peers. This video was developed and produced in Lao People's Democratic Republic by young staff and peer educators from the Vientiane Youth Center for Health and Development.

3.2. The video ***"Never too late to change: Payu's Story"*** from Thailand illustrates how a specialized service, Tulakarn Chalermprakiat Hospital, which has a residential, therapeutic community programme for young substance users, can assist while the young person is in residential treatment and then support them to implement the skills they have learned when back in their community and attempting to avoid relapse. It also illustrates how a specialized service (i.e., Tulakarn) has re-oriented its services

to provide a greatly expanded "outreach" and "community development" role to assist in "relapse prevention" of those treated at the hospital. It also demonstrates the greater support provided to the families of the young people, developing community and peer leaders, planning community development activities and strengthening the whole community to address the drug use of young community members. Thus, like Noy Story, it shows that you can "treat" some young drug users in the community without using residential placement or prison. The video was developed and produced by staff of the Tulakarn Chalermprakiat Hospital of the Institute for Juvenile and Family Justice and Development and members of the Baan Somdej community in Bangkok. The content of this video is described below.

3.3. The third video, again from Thailand, illustrates how the courts can support community-based treatment. The Chief Judge and the Associate Judges of the Juvenile and Family Court of Nonthaburi Province developed and produced ***"New Working Process of Nonthaburi Provincial Court: Juvenile and Family Division"*** to demonstrate the role and functions of the Juvenile and Family Court, the roles of the Associate Judges and the Community Network to divert young drug offenders from custody, and how they are assessed, supported and treated in the community.

3.4. The fourth video is from China – the Yunnan Institute for Drug Abuse (YIDA). It is titled ***"Seeking the way back"*** and illustrates the work coordinated by YIDA and peer educators from the Population Services International (PSI) Drop-in-centre in Kunming with young people while they are residing at a Compulsory Detoxification and Rehabilitation Centre and their journey back to their families and the community. It highlights the difficult work of recovering from drug dependence for the young person, their family and those working with them.

"Never too late to change" – Payu's Story

By Amorn Virapongse, International Consultant, Tulakarn Chalermprakiat Hospital

Payu is the youngest son of Muma Jun. He is 16 years old and has two older brothers (one in his thirties) and one older sister. Payu lives at home with his mother, as his siblings have left home and started their own families. One older brother is still a drug user, and Payu was never really very close to any of them due to the large age differences. His father died when Payu was a toddler and he has very few memories of him. Payu loves his mother very much, but as she is very shy and gentle, he spends most of his spare time with his friends and so listens to them more than to his mother.

There is a lot of drug dealing and using in his slum community. Even though there is much police and other law enforcement authority drug suppression and seizure activity, there are still many drug users and dealers, which make many families in the community uneasy.
Payu felt lonely and bored at home with not much to do. His friends frequently suggested he use *ya baa* with them and finally he did. First, he just wanted to know how it felt, as his friends talked about it so much. Eventually he became 'hooked' and started to ask for money, and even steal it, from his mother to buy the drugs he wanted and needed to "feel happy". When he was caught he was lucky as he was a minor and apprehended during a lenient time in law enforcement which encouraged young users to enter treatment to avoid being sent to a correctional facility. Payu and his mother chose the Tulakarn Chalermprakiat Hospital because their neighbours and participated in a support network programme with the hospital and talked favourably about it.

Payu entered the four month treatment programme (a therapeutic community) with the intention of ceasing his drug use due to his mother's pleading. He felt sorry for his mother and did not want to see her in tears again. He was also tired of hiding and running from the police. During his time at Tulakarn he participated in all activities with curiosity. The attention, caring and encouragement of the staff helped him a lot. At Tulakarn he participated in their drug-free environment, group

work, individual and family counselling, vocational skill training and recreational activities. He enjoyed the time in family therapy and other activities with his mother, and this helped him to understand her more. He left Tulakarn with a strong intention not to return to drug use.

When he returned to his community, not much had changed. His friends were using drugs, and there was still not much to do at home. His strong will was threatened and reduced, but he remained drug-free and sought work.

In his community there are many small factories (e.g., flute making, mask making, and making and sewing jeans). Payu chose to try to obtain work in a leather bag factory. Mr Sama-ae is the owner and has an intimate and deep understanding of drugs and drug users and the difficulties they face while trying to remain drug-free after treatment. He was trained in sewing leather while in prison and after his release he and his wife worked in a factory that received leather from a much larger factory and made leather bags on contract. After saving enough money they started their own small factory and now have many local and export contracts. Mr Sama-ae employs many young people from the community who have been drug users or who are disabled in some way, and he and his wife are very supportive and kind to them. When Mama Jun brought Payu to apply for a job he was more than willing to accept him.

Payu then lived a happy enough and drug-free life for a while. Over time, he started to spend more time with his old friends. He thought he was strong enough to refuse drugs, but he was not and used again (a lapse). Mr Sama-ae noticed the change in his behaviour and talked to Payu about it. Payu admitted that he had used drugs again and Mr Sama-ae discussed what to do with Payu's mother and the Tulakarn staff who were providing follow-up support in the community. They decided to work more closely with the community leaders to tackle the drugs and other issues in their community. Tulakarn staff planned, with the community leaders and other members, the setting up of a community network and developing more activities for the young people and their families.

The Tulakarn staff also suggested to Mama Jun to be calm as lapses are very common for drug users. They advised her to talk with Payu more often and suggested to Payu that he enrol in the "Diploma Programme" sponsored by the hospital, and continue his education via the evening and weekend classes. They also persuaded Payu to join in many community activities, and asked him to ask his friends to also join the creative and sporting activities that had begun.

Payu enrolled in the Diploma Programme and there he met Fon who used to sniff glue, had been apprehended by the police but allowed to be "treated" in the community by the Tulakarn Outreach and Follow-Up staff. Fon's mother is a drug dealer and physically abusive towards Fon. Fon's boyfriend is a drug user and dealer. When Tulakarn staff made a visit to Payu, they found Fon in a very low mood. They consoled Fon and encouraged her not to relapse. They asked Fon to join in any of the activities she liked. She did this and Payu and Fon helped each other to stay drug-free and to study together. In addition to the Tulakarn staff, community and religious leaders also provided support and encouragement in many ways.

Finally, Payu completed his Diploma with congratulations from everyone. His journey has not ended, but he is now better supported to continue to achieve his goals, feels supported in his community, and the community feels supported and encouraged by Tulakarn and its staff.

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

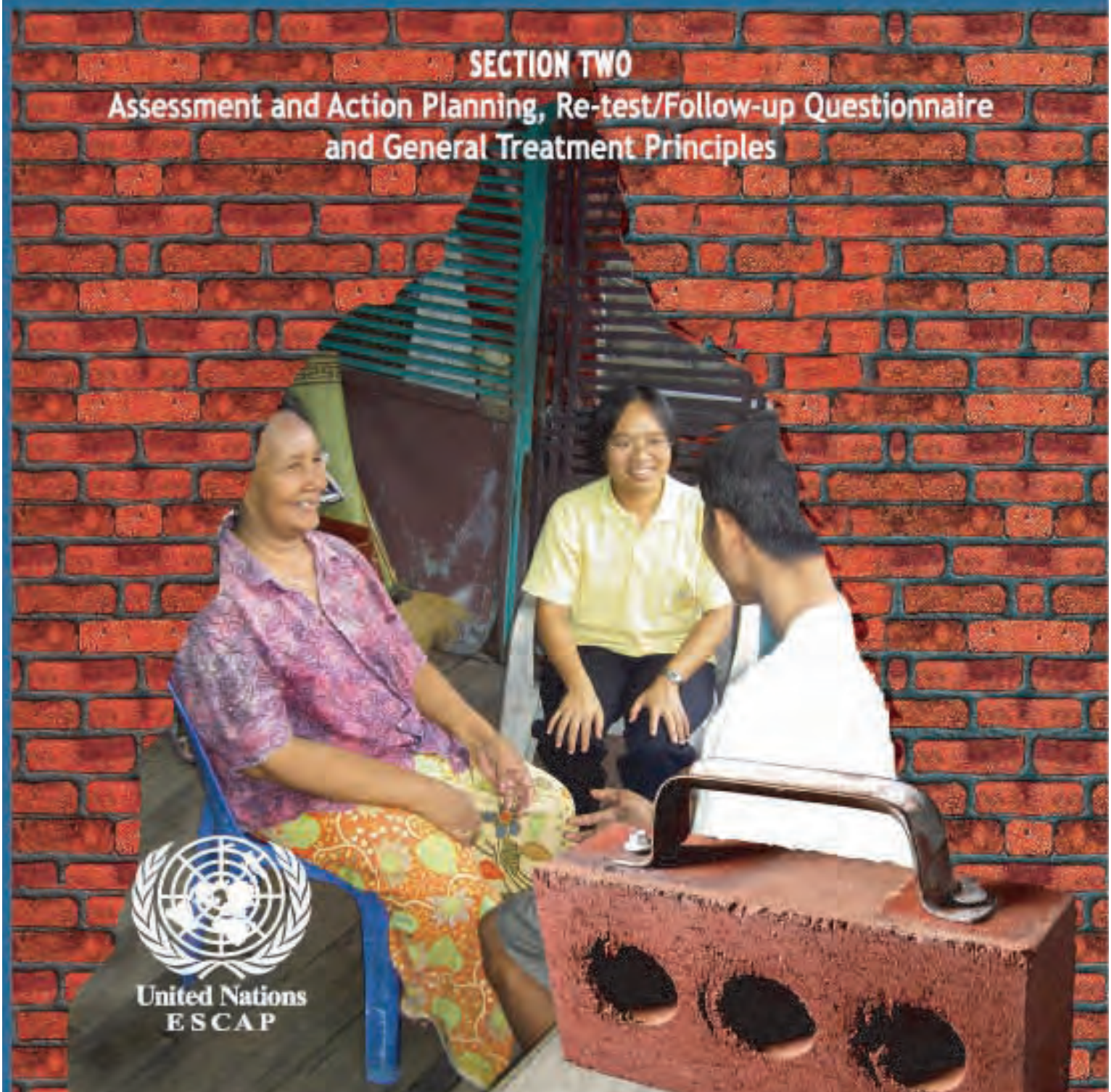
Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION TWO

Assessment and Action Planning, Re-test/Follow-up Questionnaire and General Treatment Principles



United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Two

Assessment and Action Planning, Re-test/Follow-up Questionnaire and General Treatment Principles *5*

1. Assessment and action planning *6*

2. Assessment screen *14*

3. Specific assessment tools for use as necessary: *27*
Example 1. Noy *38*
Example 2. Nung *60*
Example 3. Zhong *78*
Example 4. Choi *93*

4. Follow-up Assessment *116*

5. Specific follow-up assessment tools for use as necessary *123*

6. General treatment principles *131*


A TOOL KIT

Section Two

Assessment and Action Planning, Re-test/Follow-up Questionnaire and General Treatment Principles

This section discusses the role and importance of assessment, a brief assessment screening tool and some specialized assessment tools, such as for mental and physical health. The importance of action planning is illustrated and a format for developing an action plan after assessment is presented.

1. Assessment and action planning

Substance use is not an isolated activity. There are many areas that need to be assessed to better understand how a young person developed their drug use and related difficulties, to assist in treatment planning.

Main points to consider for assessments:

Area for consideration	Details
Personal details of young substance user	Age, gender, ethnicity, income, education, type of accommodation, peers, type of support from family and community, family structure and family life, education/employment history.
Substance use experience	Reasons for substance use, and if these have changed over time, how and when substance use was initiated, method of use and changes over time, frequency of use, dosage, cost of drug(s), peers with whom drugs used, history of any treatment.
Effects of substance use requiring attention	Immediate care: any serious health risks, the need for withdrawal management with or without medication. Infections. Less immediate care: e.g., ongoing respiratory problems, general lack of energy and motivation.
Education, training and employment	Level of formal and in formal education and any needs. Work/employment history. Skills, training needed.
Health – mental and physical	General information on physical and mental health, any current concerns, HIV and hepatitis status, any history of trauma and abuse.
Risk behaviour	Injecting drug use, sharing injecting equipment, unsafe sex.
Criminal activity	Information of any involvement with crime, including stealing, spending time in custody.
Leisure pursuits	Preferred activities, details of interaction with peers, social skills.

Strengths	Positive aspects of character and abilities, interpersonal skills.
Personal views	Needs and wants as expressed by the young substance user.

1.1. Assessment

Most of this section comes from two sources referenced in the previous section: Ted Noffs Foundation (2006); UNDCP (2000). The UNDCP (2000) resource is a most helpful guide to counselling in general and has an excellent chapter on assessment, which comprises much of the following, with adaptations.

What is Assessment?
(Based on UNDCP, 2000, and adapted)
Assessment is a first, and ongoing, step in treatment and rehabilitation. It is the process we use in the first few meetings with the young person ('intake') to identify and evaluate their general situation, including his/her strengths, weaknesses, problems and needs in order to develop a treatment plan and recovery goals. Your challenge in the assessment stage is to learn about your client's life, to help them tell their story by asking useful questions, and to help him/her to understand the value of counselling. There may be many pressures in the client's life that have led to his/her drug problem. You need to learn as much as you can about this background before you can presume to judge. It is not helpful to make the client feel guilty. Assessment is critical for you to determine what specific treatment will help to develop relapse prevention goals and make the necessary life style changes to reach those goals.

1.1.1. Your objectives in the assessment interview

- To help the young people, and their family if possible, tell their story of how they think the 'problem' (drug use) developed.
- To gather information about the client's social, physical and mental health, and work history.
- To engage and motivate to engage in treatment, if assessed as necessary.

- To learn about the factors that led to the use of drugs by the client.
- To identify the client's existing emotional, personal or economic needs that may require immediate attention and care.
- To make the necessary arrangements that will address these needs.
- To identify client strengths (i.e., what is NOT problematic, what is potentially supportive and useful in their life).
- To collect information required by the centre/service for administrative purposes.
- (e.g., home contact information or the person/institution that referred the client to your service, data required for research or reporting requirements).
- To provide information to the client about how you will work with him/her, the centre/service treatment philosophy and programme structure.

As mentioned in Section One, in compulsory residential treatment facilities, it is very important that **confidentiality** be taken very seriously. If a young person feels strong emotions during assessment, 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 undertake an assessment 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 participate in the assessment. Some snacks and drinks may also reduce tension and assist in developing some trust.

1.1.2. The assessment process

Assessing a client at intake is a very delicate step in treatment and rehabilitation because clients are very often depressed, anxious, suspicious and confused. Even those who appear calm and positive are normally hiding their feelings; they will need a

lot of encouragement and support to talk about delicate personal problems. Young people, especially, often come as coerced clients; i.e., they are referred and pushed by others such as parents, teachers, police, the courts, etc.

After breaking the ice by showing that you care about the client's feelings, you can start filling in the assessment form(s).

You may not be able to complete a full assessment during the first meeting. The various parts of the client's file can be filled in during successive counselling sessions after you have established feelings of trust and confidence between you and the client. The file allows for continuous record-keeping even during the rehabilitation phase. Feel free to use additional information sheets to record major events (lapses and relapses as well as important achievements) for as long as you stay in touch with the client.

While some clients may arrive with the expectation that you can help them, others will simply resist and test your understanding of the drug problem. Some may see you as a negative authority figure, part of a system that has never helped them before. Your job as a counsellor is to approach all new clients with compassion, no matter how hostile or difficult they may be. Negative clients or addicts who have been forced to join treatment by a spouse/partner, their parents, a doctor or a legal institution may resist by refusing to answer any of your questions.

You can respond to this attitude with empathy by saying, for example: *"I can understand your feelings about having to come here today, but these things can and do happen to anybody, in any family. Problems are there to be solved and we shall try to do it together. But first, I would really like to learn more about you."*

A common tactic used by clients is rationalization. They may try to justify their drug abuse by blaming it on friends, other members of the family or on society at large.

A questionnaire with a good set of questions is an important tool for you to gather a complete history from each of your clients. However,

the client may be scared of questionnaires. Therefore it is better to start the interview informally without the questionnaire rather than putting it between you and the client.

During the first intake interview, limit your questions to the following issues alone: whether the client is appropriate for admission to your service; and, if not, what alternative services might be more appropriate. Emphasize that full confidentiality is ensured.

Your job is to hold a mirror up to the client by helping him/her to tell you his/her life story. Then, as you talk about the story with the client, you can help him/her to accept the challenge of counselling and treatment.

1.1.3. Personal, emotional and social life story ('psycho-social history')

Apart from basic information such as name, address, age, gender, etc., you will need to know whom the client is living with; their roles and attitudes toward the client; and whether any other member of the family has a drug use/abuse problem. It is also important to know about any close friends, relatives and other significant people who may have an influence on your client. You need to assess to what degree the client's family and other relationships have been harmed by your client's drug use. It is important for you to know what triggered your client to join a treatment programme. Is it because the spouse/partner has left? Has he/she recently been arrested by the police? Is he/she scared about the probability of losing his/her job? Is he/she being driven out of home by the parents? Or is it because of the death of a close friend by overdose? All these are common reasons evoked by substance users to join a treatment programme.

Many young substance users, particularly those who are being forced into treatment, naturally may tend to deny or dismiss the harm caused by their substance use. The client may claim that everything is alright. Maintaining your compassionate attitude, you can probe into the following areas:

- *Are you maintaining a job? Tell me about how you make a living.*
- *Do you have debts? Please tell me about them.*
- *Have you had to sell your own valuables or those belonging to other members of the family to purchase drugs?*
- *Have you had any trouble with the police? Tell me about that.*

Confronted with his/her own replies, it becomes quite difficult for him/her to keep denying having serious problems with drugs. It also becomes difficult for him/her to look for scapegoats who would be responsible for the above problems because all these consequences are client-centred as a result of serious addiction:

- How motivated is he/she to recover from their substance use and related difficulties?
- What are his/her expectations of your services?
  Here, you may seize this opportunity to ask your client about priorities.

It is important for you to help your clients talk through these issues so that they will be able to start taking responsibility for their problems.

The first meeting will be successful if you can help the client to:

- Recognize and admit that he/she has a problem with drug use;
- Agree to voluntarily accept counselling and treatment;
- Understand that while drugs may appear to help him/her to feel better and cope with problems, drug use can be a negative destructive force in his/her life;
- Understand that he/she will need to work very hard and cooperate with you if he/she really wants to solve his/her problems. Assure the client that through counselling, healthier, safer ways to meet and overcome many of his/her problems can be learned.

During the assessment, your job is to hold a mirror up to the client by helping him/her to tell you his/her life story. Then, as you talk about the story with the client, you can help him/her to accept the challenge of counselling and treatment. The client needs to know that it will be hard work, but it will be worth the struggle and you will be there to help.

1.1.4. Substance use history

It is important to ask:

- *How, and under what circumstance was drug use initiated and what types of drugs are used?*
- *How long has he/she been using each of them?*
- *The amount used as dosage in the past, recently, as well as the present dose?*
- *Which substance is perceived by your client as his/her main problem?*
- *How does he/she take the drug? Is he/she inhaling, smoking or injecting the drug or drugs?*
- *If injecting, is it done alone or in the company of friends with sharing of needles?*
- *Is he/she cleaning or sterilizing the syringe before and after use?* (Hepatitis and HIV infection are real threats to people who use syringes to inject drugs into their veins. The client may not care about his/her health risk at first, but in the process of counselling and rehabilitation he/she may recover a desire to care for his/her health.)

Your client may have followed other treatment programmes in the past. It is interesting to learn about the frequency and duration of his/her abstinence episodes for each drug of abuse. You may even enquire about previous treatments the client has tried and how he/she perceives these approaches to treatment. But most important, your client will probably need your assistance to discover the exact causes of his/her past relapses.

People relapse for different reasons – one person can relapse for various reasons in different circumstances. Generally speaking,

each has got his/her weak points or 'personal triggers' that lead to relapse. This information will be very important during the rehabilitation and relapse prevention phase.

1.1.5. Work history

Holding and maintaining a job is a major contributing factor in rehabilitation and relapse prevention. Encourage the client to talk about his/her work history:

- *Does the client have a work history, current occupation or job?*
- *If he/she is unemployed, why and when did he/she leave the last job? How long has he/she been able to maintain past jobs (average length of time)?*
- *How many past jobs did he/she leave voluntarily and for what reasons?*
- *In how many cases had he/she been dismissed and for what reasons?*
- *What are his/her employable skills, educational qualifications?*
- *If the client still has a job, what is his/her performance level, regularity, punctuality, productivity, and use of sick leave?*
- *How are his/her relationships with co-workers, supervisors?*
- *What are the promotion prospects?*

When you feel you have gathered enough information on the client's situation you will be able to make a first assessment of the client's needs in terms of withdrawal management/detoxification, crisis intervention, rehabilitation, individual, family and/or group counselling, group or other complementary and supportive services. The client may be referred to another service or admitted to a centre providing rehabilitation counselling.

With many of your clients, it is possible to help them recover the sources of personal strength in their own traditions – to find the path to recovery in responsibility to family, community, elders and ancestors.

To facilitate the counselling process you will need to propose precise rehabilitation goals and define specific tasks to be undertaken by the client and his/her family in order to attain the decided and agreed goals.

1.1.6. Special considerations for female clients (gender issues)

Young women who have drug problems may find it particularly difficult to reveal their health and personal problems at intake. There may be religious or cultural reasons for this. They are likely to feel shame and many other mixed emotions; and they may expect to be treated badly. On the other hand, clinicians, administrative officers and counsellors must be knowledgeable about, supportive of, and sensitive to the specific needs of women under treatment.

For the best results, female counsellors should usually assess female clients. If this is not possible, male counsellors should be cautious about discussing sexual health and related matters with a female client. These questions can be discussed, if possible, at another meeting with a female counsellor, health worker or a doctor (through a referral).

2. Assessment Screen

In the next part of this section a brief screening and assessment tool is presented, with additional questions for specific concerns (such as mental health and family functioning) following. The questionnaire is based on tools developed by the Ted Noffs Foundation, (2005) and UNDCP (2000). It is important to note that an initial assessment screen should be short, but meaningful. Thus, the young person does not feel as if the experience has been too 'intrusive' or overwhelming. Only enough data to make the necessary decisions should be collected. Fuller assessment can be undertaken later. Usually, the first decisions to be made are whether the young person requires urgent medical attention, or a residential or medically supervised withdrawal. History of drug use, problems associated with drug use, and physical and mental health concerns are primary.

It also must be stressed that questionnaires are only a part of an assessment; engagement, rapport building, observation are all part of the **assessment process**. Never just fill out a questionnaire and believe that an

assessment has been undertaken. Let the young person know why you are asking the questions, and encourage them to answer in their own words and not just tell you what they think you might want to hear.

Also, some questions may not suit some cultures and need to be adapted or removed.

Be sure to decide **what you need to know to make the best decision** on what treatment is most suitable for the young person, and the questions needed to find this out. Include in the list of substances/drugs those used in your country. The lists in the screening questionnaire cover a wide range.

Try to complete the assessment where the young person feels most comfortable. This may be in a clinic room, or in an outside space, such as a garden. Make sure the young person feels comfortable, understands your role, why the assessment is being undertaken, what types of questions will be asked and confidentiality. Let them take their time in telling their story in their own words. Comfort them if they become distressed, and let them settle before asking the next questions and before they leave you after the assessment is completed. Explain any issues of confidentiality to them.

The following sections provide a sample assessment screening questionnaire and then some specific questionnaires to screen for physical and mental health concerns and family functioning. Then case examples are given to illustrate how to use these tools in your work. **Not all questions might be needed in your work setting, and language would have to be changed to be more appropriate for your setting and culture.** Likewise, the names used for various drugs would need to be changed and some removed as they may not be available where the young people come from.

Feel free to adapt the questionnaires to better fit your work setting, culture, client group. They are only examples to guide you in your work.

Sample Screening and Assessment Questions

Name: _____ Date of Birth: _____

Address: _____

Marital status:
Single ___ Married ___ Separated ___ Divorced ___ Other _____

Currently living with: _____
Family address (if different): _____

_____

Referred by: _____

1. I would like to ask you about your use of alcohol, tobacco and other substances because many of them can affect your health. Have you **ever used** any of the following substances, and if so how often?

Substance	YES ✔	Age first used	How often?	Last used
Tobacco				
Alcohol				
Cannabis (marijuana, hash, hash oil)				
Tranquillisers/sleeping pills (e.g., benzodiazepines)				
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)				

Cocaine				
Designer drugs (e.g. , Ecstasy, Special K, Ketamine, GHB, MDA, etc.)				
Opioids (e.g., heroin, methadone, morphine, codeine)				
Hallucinogens (e.g., LSD, magic mushrooms)				
Inhalants (e.g., glue, petrol, paint)				
Steroids				
Other medicines (specify)				
Other (specify)				

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✔, substance(s) of most concern to young person.***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask 'was it on a doctor's prescription?'. For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note, local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

2. In the last **three months**, **how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco			
Alcohol			
Cannabis (marijuana, hash, hash oil)			
Tranquillisers/sleeping pills (e.g., benzodiazepines)			
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)			
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)			
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

3. **Why** did you first use each substance you have used, and, if you continued to use any of them, why did you continue to use?

Substance	First use	Why continue (if did)
Tobacco		
Alcohol		
Cannabis (marijuana, hash, hash oil)		
Tranquillisers/sleeping pills (e.g., benzodiazepines)		
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)		
Cocaine		
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)		
Opioids (e.g., heroin, methadone, morphine, codeine)		
Hallucinogens (e.g., LSD, magic mushrooms)		
Inhalants (e.g., glue, petrol, paint)		
Steroids		
Other medicines (specify)		
Other (specify)		

4. Have you been **worried or concerned** about your use of any substance? Yes __ No __ If yes, which one(s) and why?

Substance	Why worried or concerned?

5. Have you ever been able to **stop or reduce** your use of any of the substances you have used? Yes __ No __ If yes, which substances, for how long did you cease/reduce use, why did you cease/reduce, and how did you manage to cease /reduce use?

Substance	How long?	Why?	How managed?

6. Have you regretted what you did when high or intoxicated on any of the substances you used at any time in the last 3 months?
   Never ___ Once or twice ___ Frequently ___ All the time ___

7. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems		
b. Money problems		
c. Problems with work/school		
d. Problems with people, e.g., family, partner, friends		
e. Serious physical health problems, e.g., weight loss/chest pains		
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid		
g. Become violent or aggressive		
h. Serious accidents		
i. Overdosed? If yes, how many times?		

8. Has a friend or relative or anyone else ever expressed concern about your use of any drug? Yes ___ No ___

9. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

If the person ever tried any of these by injection, probe:
If any answer to question 9 is <u>Yes</u>, continue with Question 10.
If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

10. Why did you decide to inject again? .....

11a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

11b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

12. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time	
Most of the time	
Some of the time	
None of the time	

13. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	
Pharmacists/Chemists	
Friends	
Other	

Do not proceed beyond this point in the first interview if client appears uncomfortable or hostile to the assessment process.

14. Does your boy/girlfriend use drugs? Yes __ No __ If yes, what?

.....

15. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex			
Every time			
Often			
Sometimes			
Rarely			
Never			

16. With whom have you had sex in the last year?

Only females	
Only males	
Both females and males	
No sex	

17. Level of Education: Primary __ Secondary __ College/University __
Additional training _____

18. Work History: Do you hold a job? Yes ___ No ___
If yes, what is the job? _____

19. How do you feel about your job?
Good ___ Satisfactory ___ Bad ___ Very bad ___

20. Do you always fulfil your work responsibilities? _____

21. Describe your relationships with co-workers: _____

22. Describe your relationship with your supervisor: _____

23. What is the probability that you will be able to keep your current job?
Very Good __ Good __ Don't know __ At risk __ Unlikely ___

24. Employability if unemployed:
Very Good __ Good __ Satisfactory __ Bad __ Very bad __

25. Employment goals *(note any new skills needed to achieve these goals):*
a. _____

b. _____

c. _____

26. Do you have daily responsibility for children, other family members, household or property? Yes ___ No ___

27. Neighbourhood/community attitude towards client:
Good ___ OK ___ Bad ___ Very bad ___

28. Client's interests and hobbies prior to drug use:
_____

_____

29. What are the client's interests and hobbies now?
_____

30. Client's Goals:
_____

_____

31. Clients Motivation to Follow Treatment/Rehabilitation:
Very Good __ Good __ Satisfactory __ Bad __ Very bad __

32. Strengths identified:
_____

Assessment Summary *(overall case description and comments using the following headings)***:**

- **Presentation**
- **Substance use history**
- **Family situation and issues**
- **Significant relationships**
- **Mental health – past/present including medication**
- **Physical health concerns and medication**
- **Trauma history**
- **Risk behaviour** ***(e.g., injecting, sexual)***
- **Educational/vocational** ***(achievements, difficulties, aspirations, challenges)***
- **Criminal activity and any current court matters**
- **Previous treatment**
- **Strengths**
- **Leisure activities**
- **Initial Action Plan Recommendations**

Staff signature: _____

Case Manager: _____

3. Specific assessment tools for use as necessary:

Brief Mental Health Screen

Physical Health Screen

Family Assessment Screen

Brief Mental Health Screen

1. In the **last 3 months** have you had any **significant** problems with (please ✔ either YES or NO for each question a-i).

		YES ✔	NO ✔
a	Feeling very trapped, lonely, sad, blue, depressed or hopeless about the future?		
b	Having no energy and losing interest in work, school, friends, sex or other things you cared about?		
c	Remembering, concentrating, making decisions, or having your mind go blank?		
d	Feeling very shy, self-conscious, or uneasy about what people thought or were saying about you?		
e	Thoughts that other people did not understand you or appreciate your situation?		
f	Feeling easily annoyed, irritated, or having trouble controlling your temper?		
g	Thoughts of ending your life?		
h	Have you attempted to end your life in the **last 3 months**?		
i	Have you <u>ever</u> attempted to end your life? →If yes answer questions below →If no go to Question 5		

2. If you have ever attempted to end your life, (please list)
   a. How many times? ..... Means used: ……...
   b. How old at first attempt? ..... Means used: ……
   c. How old at last attempt? ..... Means used: ……

3. In making the attempt(s) to kill yourself did you: *(✔ one or more)*

Just want to stop the pain/anger/frustration	
Want to stop the pain but I did not care if I died	
Want to die	
Did not know what else to do	
Other	

4. Thinking back to your most serious attempt, how likely was it that you could have died?
   Not at all __ A little __ Somewhat likely __ Likely __ Very likely __

5. Have you ever seen a mental health professional *(e.g., psychologist/psychiatrist/social worker/school counsellor)*?
   Yes __ No __ If yes, what for? .....

6. Were you ever given a diagnosis; e.g., anxiety, depression, or psychosis *(e.g., schizophrenia or other)*?
   Yes (please specify) .....…….. No ___

7. Are you currently taking any psychiatric medication? Yes ___ No ___
   If yes, please specify and list all medications:

Antipsychotic	Anticonvulsant/Mood Stabiliser
Antidepressant	Other

8. Are you currently using any other prescribed medication(s)?
   Yes ___ No ___
   If yes, what for? ……

9. Do you have any chronic health problems *(e.g., asthma, diabetes, etc.)*?
   Yes ___ No ___
   If yes, what? .....

10. Have you had any major health problems *(e.g., major accidents, surgery, etc.)*? Yes ___ No ___
    If yes, what? .....

11. Many people have lived through or witnessed a very stressful and traumatic event. Have you experienced or witnessed any of the following?

Serious accident *(e.g., car, fire)*	__
Physical assault by someone you know *(e.g., domestic violence, mugged)*	__
Sexual assault by someone you know	__
Combat/war zone	__
Life threatening illness	__
Natural disaster *(e.g., fire, flood, earthquake)*	__
Physical assault by stranger	__
Severe/ongoing emotional/verbal abuse	__
Sexual assault by stranger	__
Torture	__
Other Specify	

Physical Health Screen

A good physical assessment can be effectively done by a counsellor who has some basic training. This does not have to be done by a doctor or nurse, if they are not available in your daily work.

Observation:

- Body hygiene and clothes: Is he/she clean? ___
- Face: How does the client look? In reasonably good shape? ___
  Poor shape? ___
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck? ___
- Dehydration: Does the client have dry skin, dry lips and tongue, and/or sunken eyes? ___
- Pallor: Is he/she pale? ___
- Jaundice: Do the whites of his/her eyes look yellow? ___
- Mouth/lips: Are there whitish patches? Are there bad teeth? ___

*Have you had any of the following during the **last year**? (✔)*

General	Yes	No	Comment
Fatigue/energy loss			
Poor appetite			
Weight loss/underweight			
Weight gain/overweight			
Trouble sleeping			
Fever			
Night sweats			
Swollen glands			
Jaundice			
Bleeding easily			

Bruising easily			
Teeth problems			
Eye/vision problems			
Ear/hearing problems			
Allergies			
Injecting related problems			
Overdose			
Abscesses/infections			
STIs			
Hepatitis B/C			
Cardio/respiratory			
Persistent cough			
Coughing up phlegm			
Coughing up blood			
Wheezing			
Sore throat			
Shortness of breath			
Chest pains			
Heart flutters/racing			
Genito-urinary			
Painful urination			
Loss of sex urge			
Unusual discharge from penis/vagina			
Rash on or around penis/vagina			

Gynaecological (females)			
Irregular period			
Miscarriage			
Abortion			
Musculo-skeletal			
Joint pains/stiffness			
Broken bones			
Muscle pain			
Neurological			
Headaches			
Blackouts			
Tremors (shakes)			
Numbness/tingling			
Dizziness			
Fits/seizures			
Difficulty walking			
Head injury			
Forgetting things			
Gastro-intestinal			
Nausea			
Vomiting			
Stomach pains			
Constipation			
Diarrhoea			

Any specific health assessments necessary?

Family Assessment Screen

Answered by: _____

Relationship to the Young Person: _____

1. Who in the family is the Young Person closest to? _____

2. Why is this? _____

3. The following are a number of statements about families *(Family Assessment Device – General Functioning Scale – short)*. Please read carefully and decide how well it describes your family. **SA** = strongly agree, **A** = agree, **D** = disagree, **SD** = strongly disagree.

	SA ✔	A ✔	D ✔	SD ✔
Planning family activities is difficult because we misunderstand each other				
In times of crisis we can turn to each other for support				
We cannot talk to each other about the sadness we feel				
Individuals are accepted for what they are				
We avoid discussing our fears and concerns				
We can express feelings to each other				
There are lots of bad feelings in the family				
We feel accepted for what we are				
Making decisions is a problem for our family				
We are able to make decisions about how to solve problems				
We don't get along well together				
We confide in each other				

4. What issues have there been for your family – now or in the past? (e.g., domestic violence, physical, emotional or sexual abuse): _____

_____

_____

5. What impact do you think this has had and on whom? _____

_____

_____

6. What is expected of the children/young people in the family and how is it enforced? _____

_____

_____

7. Is it effective? _____

8. What activities do the children/young people engage in when not at home?

_____

9. What are the strengths in the family? _____

_____

_____

10. What things could be improved in the family? _____

_____

11. What would need to change for it to happen? _____

_____

_____

12. What things about the young person do you want to see continue?

_____

_____

13. What things do you think the young person needs to work on (change)? _____

_____

14. When do you think the young person began to go off track? _____

_____

15. Do you know why? _____

16. Would you be willing to attend a group to meet with some of the other parents experiencing similar difficulties? _____

17. Who in the family would be willing to attend for at least one family session with your young person? _____

Some examples of assessments using the screening and assessment tools:

Noy
Nung
Zhong
Choi

Screening and Assessment: Noy

Name: Noy Southamavong Date of Birth: 23 June 1990

Address: _____

Marital status: Single X Married __ Separated __ Divorced __ Other _____

Currently living with: both parents, older sister and younger brother and sister

Family address (if different):

_____

_____

Referred by: Mother, sister and teachers.

1. I would like to ask you about your use of alcohol, tobacco and other substances because many of them can affect your health. Have you **ever used** any of the following substances, and if so how often?

Substance	YES ✔	Age first used	How often?	Last used
Tobacco	✔	*14*	*4/7 days*	*Yesterday*
Alcohol	✔	*14*	*4/7 days*	*Last week*
Cannabis (marijuana, hash, hash oil)	✔	*16*	*4/7 days*	*Last week*
Tranquillisers/sleeping pills (e.g., benzodiazepines)				
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)	✔	*16*	*3/7 days*	*Yesterday*
Cocaine				
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)				
Opioids (e.g., heroin, methadone, morphine, codeine)				
Hallucinogens (e.g., LSD, magic mushrooms)				
Inhalants (e.g., glue, petrol, paint)				
Steroids				
Other medicines (specify)				
Other (specify)				

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✔, substance(s) of most concern to young person.***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask "was it on a doctor's prescription?". For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note, local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

2. In the last **three months, how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco	✔	*4/7 days*	*3 per day*
Alcohol	✔	*4/7 days*	*6 bottles of beer*
Cannabis (marijuana, hash, hash oil)	✔	*4/7 days*	*5 "joints"*
Tranquillisers/sleeping pills (e.g., benzodiazepines)			
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)	✔	*2-3/7 days*	*4 bongs*
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)			
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

3. **Why** did you first use each substance you have used, and, if you continued to use any of them, why did you continue to use?

Substance	First use	Why continue (if did)
Tobacco	*Curious*	*Friends use*
Alcohol	*Curious/ pressure from friends*	*Like it*
Cannabis (marijuana, hash, hash oil)	*Curious/ pressure from friends*	*Fun, like it*
Tranquillisers/sleeping pills (e.g., benzodiazepines)		
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)	*Pressure from friends*	*Made me feel sexy and see things*
Cocaine		
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)		
Opioids (e.g., heroin, methadone, morphine, codeine)		
Hallucinogens (e.g., LSD, magic mushrooms)		
Inhalants (e.g., glue, petrol, paint)		
Steroids		
Other medicines (specify)		
Other (specify)		

4. Have you been **worried or concerned** about your use of any substance? Yes X No __ If yes, which one(s) and why?

Substance	Why worried or concerned?
Ya baa	*Making me see and hear things others do not, people angry at me, stealing from home, going "crazy"*
Cannabis	*Not so much fun anymore*
Tobacco	*Coughing sometimes in morning*

5. Have you ever been able to **stop or reduce** your use of any of the substances you have used? Yes __ No X If yes, which substances, for how long did you cease/reduce use, why did you cease/reduce, and how did you manage to cease/reduce use?

Substance	How long?	Why?	How managed?

6. Have you regretted what you did when high or intoxicated on any of the substances you used at any time in the last 3 months?
   Never ___ Once or twice ___ Frequently ___ All the time X
   – Having sex without condoms and stealing.

7. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems	*No*	
b. Money problems	*Yes*	*All*
c. Problems with work/school	*Yes*	*Ya baa, cannabis and alcohol*
d. Problems with people, e.g., family, partner, friends	*Yes*	*All*
e. Serious physical health problems, e.g., weight loss/chest pains	*No*	
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid	*Yes*	*Ya baa and cannabis*
g. Become violent or aggressive	*Yes*	*Ya baa and alcohol*
h. Serious accidents	*No*	
i. Overdosed? If yes, how many times?	*No*	

8. Has a friend or relative or anyone else ever expressed concern about your use of any drug? Yes X No ___ ***Family, teachers and friends.***

9. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

If the person ever tried any of these by injection, probe:
If any answer to question 9 is <u>Yes</u>, continue with Question 10.
If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

10. Why did you decide to inject again? .....

11a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

11b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

12. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time	
Most of the time	
Some of the time	
None of the time	

13. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	
Pharmacists/Chemists	
Friends	
Other	

Do not proceed beyond this point in the first interview if client appears uncomfortable or hostile to the assessment process.

14. Does your boy/girlfriend use drugs? Yes X No _ If yes, what? .....

15. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex			
Every time			
Often			
Sometimes			
Rarely		X	
Never			

16. With whom have you had sex in the last year?

Only females	X
Only males	
Both females and males	
No sex	

17. Level of Education: Primary ___ Secondary X College/University ___
Additional training _____

18. Work History: Do you hold a job? Yes X No __
If yes, what is the job? _____

19. How do you feel about your job?
Good ___ Satisfactory X Bad ___ Very bad ___

20. Do you always fulfil your work responsibilities? ***No.***

21. Describe your relationships with co-workers: ***Good and bad.***

22. Describe your relationship with your supervisor: ***Getting bad – he is my father.***

23. What is the probability that you will be able to keep your current job?
Very Good ___ Good ___ Don't know ___ At risk X Unlikely ___

24. Employability if unemployed:
Very Good ___ Good ___ Satisfactory ___ Bad ___ Very bad ___

25. Employment goals *(note any new skills needed to achieve these goals):*
Get own business one day – small factory, or become a teacher.

26. Do you have daily responsibility for children, other family members, household or property? Yes __ No X

27. Neighbourhood/community attitude towards client:
Good __ OK X Bad __ Very bad __

28. Client's interests and hobbies prior to drug use:
Music, soccer, reading.

29. What are the client's interests and hobbies now?
Same, and dancing and playing music.

30. Client's Goals:
Find out if I am crazy;
Get on better with family;
Get back to being a good student;
Be happy;
Have a girlfriend;
Get off drugs – I think.

31. Clients Motivation to Follow Treatment/Rehabilitation:
Very Good ___ Good X Satisfactory ___ Bad ___ Very bad ___

Possible individual goals:
Drug counselling;
Mental health check;
School adjustment;
Medical check up – physical and mental health, STI, HIV.

Possible Family goals:
To get family settled again and be happy.

32. Strengths identified:
Intelligent, friendly, family concern, concern of teachers.

Brief Mental Health Screen: Noy

1. In the **last 3 months** have you had any **significant** problems with (please ✔ either YES or NO for each question a-i).

		YES ✔	NO ✔
a	Feeling very trapped, lonely, sad, blue, depressed or hopeless about the future?	✔	
b	Having no energy and losing interest in work, school, friends, sex or other things you cared about?	✔	
c	Remembering, concentrating, making decisions, or having your mind go blank?	✔	
d	Feeling very shy, self-conscious, or uneasy about what people thought or were saying about you?	✔	
e	Thoughts that other people did not understand you or appreciate your situation?	✔	
f	Feeling easily annoyed, irritated, or having trouble controlling your temper?	✔	
g	Thoughts of ending your life?		✔
h	Have you attempted to end your life in the **last 3 months?**		✔
i	Have you <u>ever</u> attempted to end your life? →If yes answer questions below →If no go to Question 5		✔

2. If you have ever attempted to end your life, (please list)
   a. How many times? ..... Means used: ……
   b. How old at first attempt? ..... Means used: ……
   c. How old at last attempt? ..... Means used: ……

3. In making the attempt(s) to kill yourself did you: *(✔ one or more)*

Just want to stop the pain/anger/frustration	
Want to stop the pain but I did not care if I died	
Want to die	
Did not know what else to do	
Other	

4. Thinking back to your most serious attempt, how likely was it that you could have died?
   Not at all __ A little __ Somewhat likely __ Likely __ Very likely __

5. Have you ever seen a mental health professional *(e.g., psychologist/psychiatrist/social worker/school counsellor)*?
   Yes __ No X If yes, what for? .....

6. Were you ever given a diagnosis; e.g., anxiety, depression, or psychosis *(e.g., schizophrenia or other)*?
   Yes (please specify) .....…….... No X

7. Are you currently taking any psychiatric medication? Yes __ No X
   If yes, please specify and list all medications:

Antipsychotic	Anticonvulsant/Mood Stabiliser
Antidepressant	Other

8. Are you currently using any other prescribed medication(s)?
   Yes __ No X
   If yes, what for? .....

9. Do you have any chronic health problems *(e.g., asthma, diabetes, etc.)*?
   Yes __ No X
   If yes, what? ……

10. Have you had any major health problems *(e.g., major accidents, surgery, etc.)*? Yes __ No X
    If yes, what? ……

11. Many people have lived through or witnessed a very stressful and traumatic event. Have you experienced or witnessed any of the following?

Serious accident *(e.g., car, fire)*	__
Physical assault by someone you know *(e.g., domestic violence, mugged)*	X
Sexual assault by someone you know	__
Combat/war zone	__
Life threatening illness	__
Natural disaster *(e.g., fire, flood, earthquake)*	__
Physical assault by stranger	X
Severe/ongoing emotional/verbal abuse	__
Sexual assault by stranger	__
Torture	__
Other Specify ……	

Physical Health: Noy

Observation:

- Body hygiene and clothes: Is he/she clean? X
- Face: How does the client look? In reasonably good shape? X
  Poor shape? X
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck? No
- Dehydration: Does the client have dry skin, dry lips and tongue, and/or sunken eyes? No
- Pallor: Is he/she pale? No
- Jaundice: Do the whites of his/her eyes look yellow? No
- Mouth/lips: Are there whitish patches? Are there bad teeth? No

*Have you had any of the following during the **last year**? (✔)*

General	Yes	No	Comment
Fatigue/energy loss	✔		
Poor appetite		✔	
Weight loss/underweight		✔	
Weight gain/overweight		✔	
Trouble sleeping	✔		
Fever		✔	
Night sweats		✔	
Swollen glands		✔	
Jaundice		✔	
Bleeding easily		✔	
Bruising easily		✔	
Teeth problems		✔	
Eye/vision problems		✔	
Ear/hearing problems		✔	

Allergies		✔	
Injecting related problems		✔	
Overdose		✔	
Abscesses/infections		✔	
STIs			?
Hepatitis B/C		✔	
Cardio/respiratory			
Persistent cough		✔	
Coughing up phlegm	✔		
Coughing up blood		✔	
Wheezing		✔	
Sore throat	✔		
Shortness of breath		✔	
Chest pains		✔	
Heart flutters/racing		✔	
Genito-urinary			
Painful urination		✔	
Loss of sex urge		✔	
Unusual discharge from penis/vagina		✔	
Rash on or around penis/vagina		✔	
Gynaecological (females)			
Irregular period			
Miscarriage			
Abortion			
Musculo-skeletal			
Joint pains/stiffness		✔	
Broken bones		✔	

Muscle pain		✔	
Neurological			
Headaches	✔		
Blackouts		✔	
Tremors (shakes)		✔	
Numbness/tingling		✔	
Dizziness		✔	
Fits/seizures		✔	
Difficulty walking		✔	
Head injury		✔	
Forgetting things	✔		
Gastro-intestinal			
Nausea		✔	
Vomiting		✔	
Stomach pains		✔	
Constipation		✔	
Diarrhoea		✔	

Family Assessment Screen: Noy

Answered by: Mother

Relationship to the Young Person: Mother

1. Who in the family is the Young Person closest to? ***Mother.***

2. Why is this? ***We used to talk a lot – he was first son.***

3. The following are a number of statements about families *(Family Assessment Device – General Functioning Scale – short)*. Please read carefully and decide how well it describes your family. **SA** = strongly agree, **A** = agree, **D** = disagree, **SD** = strongly disagree.

	SA ✔	A ✔	D ✔	SD ✔
Planning family activities is difficult because we misunderstand each other		✔		
In times of crisis we can turn to each other for support		✔		
We cannot talk to each other about the sadness we feel	✔			
Individuals are accepted for what they are		✔		
We avoid discussing our fears and concerns				
We can express feelings to each other			✔	
There are lots of bad feelings in the family		✔		
We feel accepted for what we are		✔	✔	
Making decisions is a problem for our family			✔	
We are able to make decisions about how to solve problems		✔		
We don't get along well together		✔		
We confide in each other			✔	

4. What issues have there been for your family – now or in the past? (e.g., domestic violence, physical, emotional or sexual abuse):
Husband working long hours to build up business, my parents have not been very supportive, but my husband's have been. We used to be quite happy and I think we all got along very well. But, lately, since Noy has been using drugs and stealing things have become very tense and my husband gets angry a lot and Noy is never at home much. When he is grumpy and difficult and has been stealing from us.

5. What impact do you think this has had and on whom?
It has made us all tense and scared and we argue a lot.

6. What is expected of the children/young people in the family and how is it enforced?
We expect all the children to do their chores. We give them some small money each week when their complete their chores.

7. Is it effective? ***Usually.... but not now with Noy.***

8. What activities do the children/young people engage in when not at home?
Sport, music, hanging around with friends.

9. What are the strengths in the family?
Our love for each other.. we have had hard times but come through them.

10. What things could be improved in the family?
For Noy to stop using drugs and come back to us.

11. What would need to change for it to happen?
Noy to stop using drugs.

12. What things about the young person do you want to see continue?
His music and studies... and the way he can make us laugh when he is OK and not using drugs.

13. What things do you think the young person needs to work on (change)?
    His friends and drug use… and getting back into doing his school work.

14. When do you think the young person began to go off track?
    6 months ago.

15. Do you know why?
    No... he just seemed to get bored at school and started to wander around by himself and then met up with these drug using kids.

16. Would you be willing to attend a group to meet with some of the other parents experiencing similar difficulties?
    Yes.

17. Who in the family would be willing to attend for at least one family session with your young person?
    All of us.

Assessment Summary: Noy

Presentation: *Noy, who was referred by his sister and teachers, presents himself as an intelligent 16-year-old with a short (3 month), but problematic history of use of ya baa, cannabis and alcohol. He is not dependent on any of these drugs, but has become a regular user of ya baa, cannabis, alcohol and tobacco. He and his family and teachers are worried about his change in behaviour, declining school performance and mental health. He reports experiencing paranoia, and visual and auditory hallucinations, which appear to be associated with his use of ya baa. Noy also appears to be mildly depressed. Noy was very cooperative during the assessment, and while concerned about his mental health and situation could engage in eye contact and smile appropriately.*

***Substance use history*:**
Noy reported the following history for the past 3 months:
Tobacco: about 4 days per week, 3 cigarettes per day.
Alcohol: about 4 days per week, 6 bottles of beer per day.
Cannabis: about 4 days per week, 5 "joints" per day.
Ya baa: 2-3 days per week, about 4 "bongs".
He is most concerned about his use of ya baa as he believes it has negatively affected his moods and behaviour, his mental and physical health, his family and his school work.

Family situation and issues:
Loves and is loved by his family, but there is conflict evident. His father is frustrated and angry about his drug use and his sister has tried to encourage him to seek assistance.

Significant relationships:
Family. Noy reports no girlfriend, but he has been with a number of girls casually.

Mental health – past/present including medication:
Noy reported visual and auditory hallucinations associated with his drug use, and there were some signs of depression in his presentation, history and from the mental health screen.

Physical health concerns and medication:
Some coughing in the morning probably associated with his tobacco and other drug use. Needs STI and HIV check.

Trauma history:
Has been physically assaulted by someone he knows and strangers.

Risk behaviour (e.g., injecting, sexual):
Noy reported some unprotected sexual activity.

Educational/vocational (achievements, difficulties, aspirations, challenges):
Noy is in his 4th year of secondary education. He reports that he was a very good student, had good relationships with teachers and fellow pupils, but this has deteriorated of late. He would like to own his own business or be a teacher.

Criminal activity and any current court matters:
Underage drinking and stealing from home. Has not been arrested or charged by police.

Previous treatment:
None.

Strengths:
Intelligent, friendly, caring, people like him.

Leisure activities:
Soccer, music, reading.

Initial Action Plan Recommendations:
Noy could benefit from:
1. *Individual counselling with Mr Ting;*
2. *Joining activities at the Youth Centre;*
3. *A full medical examination – physical (including STI and HIV check after pre-test counselling) and mental health;*
4. *Receiving information on the effects of drugs.*

His family appear willing to be involved in family counselling and are supportive of him, as are his teachers, a local police officer and monks from the temple near his house.

After engagement with Mr Ting:

1. *Family counselling: to be provided by Mme Siamphone, then parent-to-parent support group.*

2. *Group counselling: with Mr Ting, and then with peer educators.*

3. *Liaise with monks at temple to provide support and religious instruction.*

Date: 23 February 2007 *Staff signature: .....*
Case Manager: Mr Ting

Screening and Assessment: Nung

Name: Nung Date of Birth: 6 May 1992

Address: _____

Marital status: Single _X_ Married ___ Separated ___ Divorced ___ Other _____

Currently living with: Mother

Family address (if different):

_____

_____

Referred by: School

1. I would like to ask you about your use of alcohol, tobacco and other substances because many of them can affect your health. Have you **ever used** any of the following substances, and if so how often?

Substance	YES ✔	Age first used	How often?	Last used
Tobacco				
Alcohol				
Cannabis (marijuana, hash, hash oil)				
Tranquillisers/sleeping pills (e.g., benzodiazepines)	✔	*13*	*4 or 5 times*	*Last week*
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)				

Cocaine				
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)				
Opioids (e.g., heroin, methadone, morphine, codeine)				
Hallucinogens (e.g., LSD, magic mushrooms)				
Inhalants (e.g., glue, petrol, paint)				
Steroids				
Other medicines (specify)				
Other (specify)				

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✓, substance(s) of most concern to young person.***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask "was it on a doctor's prescription?". For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note, local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

2. In the last **three months, how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco			
Alcohol			
Cannabis (marijuana, hash, hash oil)			
Tranquillisers/sleeping pills (e.g., benzodiazepines)	✔	*4-5 times*	*1 pill*
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)			
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)			
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

3. **Why** did you first use each substance you have used, and, if you continued to use any of them, why did you continue to use?

Substance	First use	Why continue (if did)
Tobacco		
Alcohol		
Cannabis (marijuana, hash, hash oil)		
Tranquillisers/sleeping pills (e.g., benzodiazepines)	*See what it was like*	*To feel different – I feel dreamy and a little bit happy*
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)		
Cocaine		
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)		
Opioids (e.g., heroin, methadone, morphine, codeine)		
Hallucinogens (e.g., LSD, magic mushrooms)		
Inhalants (e.g., glue, petrol, paint)		
Steroids		
Other medicines (specify)		
Other (specify)		

4. Have you been **worried or concerned** about your use of any substance? Yes _X_ No _X_ If yes, which one(s) and why?

Substance	Why worried or concerned?
Valium	*Not sure if should worry or not*

5. Have you ever been able to **stop or reduce** your use of any of the substances you have used? Yes ___ No _X_ If yes, which substances, for how long did you cease/reduce use, why did you cease/reduce, and how did you manage to cease/reduce use?

Substance	How long?	Why?	How managed?

6. Have you regretted what you did when high or intoxicated on any of the substances you used at any time in the last 3 months? Never _X_ Once or twice ___ Frequently ___ All the time ___

7. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems		
b. Money problems		
c. Problems with work/school	✔	*Valium*

d. Problems with people, e.g., family, partner, friends		
e. Serious physical health problems, e.g., weight loss/chest pains		
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid		
g. Become violent or aggressive		
h. Serious accidents		
i. Overdosed? If yes, how many times?		

8. Has a friend or relative or anyone else ever expressed concern about your use of any drug? Yes _X_ No ___ ***My friend Som.***

9. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

   If the person ever tried any of these by injection, probe:
   If any answer to question 9 is <u>Yes</u>, continue with Question 10.
   If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

10. Why did you decide to inject again? .....

11a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

11b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

12. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time	
Most of the time	
Some of the time	
None of the time	

13. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	
Pharmacists/Chemists	
Friends	
Other	

Do not proceed beyond this point in the first interview if client appears uncomfortable or hostile to the assessment process.

14. Does your boy/girlfriend use drugs? Yes ___ No _X_ If yes, what? .....

15. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex	✔	✔	✔
Every time			
Often			
Sometimes			
Rarely			
Never			

16. With whom have you had sex in the last year?

Only females	
Only males	
Both females and males	
No sex	✔

17. Level of Education: Primary __ Secondary _X_ College/University ___
Additional training _____

18. Work History: Do you hold a job? Yes ___ No_X_ **Student**
If yes, what is the job? _____

19. How do you feel about your job?
Good ___ Satisfactory ___ Bad ___ Very bad ___

20. Do you always fulfil your work responsibilities? _____

21. Describe your relationships with co-workers: _____

22. Describe your relationship with your supervisor: _____

23. What is the probability that you will be able to keep your current job?
Very Good ___ Good ___ Don't know ___ At risk ___ Unlikely ___

24. Employability if unemployed:
Very Good ___ Good ___ Satisfactory ___ Bad ___ Very bad ___

25. Employment goals *(note any new skills needed to achieve these goals):*
N/A

26. Do you have daily responsibility for children, other family members, household or property? Yes ___ No _X_

27. Neighbourhood/community attitude towards client:
Good _X_ OK _X_ Bad ___ Very bad ___

28. Client's interests and hobbies prior to drug use:
Playing with friends, reading drama – visiting Dad.

29. What are the client's interests and hobbies now?
Same.

30. Client's Goals:
Be happy.

31. Clients Motivation to Follow Treatment/Rehabilitation:
Very Good ___ Good _X_ Satisfactory ___ Bad ___ Very bad ___

32. Strengths identified:
Concern for mother, has a friend (Som), was good at drama, good student.

Brief Mental Health Screen: Nung

1. In the **last 3 months** have you had any **significant** problems with (please ✔ either YES or NO for each question a-i).

		YES ✔	NO ✔
a	Feeling very trapped, lonely, sad, blue, depressed or hopeless about the future?	✔	
b	Having no energy and losing interest in work, school, friends, sex or other things you cared about?	✔	
c	Remembering, concentrating, making decisions, or having your mind go blank?	✔	
d	Feeling very shy, self-conscious, or uneasy about what people thought or were saying about you?	✔	
e	Thoughts that other people did not understand you or appreciate your situation?	✔	
f	Feeling easily annoyed, irritated, or having trouble controlling your temper?		✔
g	Thoughts of ending your life?	✔	
h	Have you attempted to end your life in the **last 3 months**?		✔
i	Have you <u>ever</u> attempted to end your life? →If yes answer questions below →If no go to Question 5		✔

2. If you have ever attempted to end your life, (please list)
   a. How many times? ..... Means used: .....
   b. How old at first attempt? ..... Means used: .....
   c. How old at last attempt? ..... Means used: .....

3. In making the attempt(s) to kill yourself did you: *(✔ one or more)*

Just want to stop the pain/anger/frustration	
Want to stop the pain but I did not care if I died	
Want to die	
Did not know what else to do	
Other	

4. Thinking back to your most serious attempt, how likely was it that you could have died?
   Not at all __ A little __ Somewhat likely __ Likely __ Very likely __

5. Have you ever seen a mental health professional *(e.g., psychologist/psychiatrist/social worker/school counsellor)*?
   Yes ___ No ___ If yes, what for? .....

6. Were you ever given a diagnosis; e.g., anxiety, depression, or psychosis *(e.g., schizophrenia or other)*?
   Yes (please specify) ..... No _X_

7. Are you currently taking any psychiatric medication? Yes ___ No _X_
   If yes, please specify and list all medications:

Antipsychotic	Anticonvulsant/Mood Stabiliser
Antidepressant	Other

8. Are you currently using any other prescribed medication(s)?
   Yes ___ No _X_
   If yes, what for? .....

9. Do you have any chronic health problems *(e.g., asthma, diabetes, etc.)*?
   Yes ___ No _X_
   If yes, what? ……

10. Have you had any major health problems *(e.g., major accidents, surgery, etc.)*? Yes ___ No _X_
    If yes, what? ……

11. Many people have lived through or witnessed a very stressful and traumatic event. Have you experienced or witnessed any of the following?

Serious accident *(e.g., car, fire)*	__
Physical assault by someone you know *(e.g., domestic violence, mugged)*	__
Sexual assault by someone you know	__
Combat/war zone	__
Life threatening illness	__
Natural disaster *(e.g., fire, flood, earthquake)*	__
Physical assault by stranger	__
Severe/ongoing emotional/verbal abuse	__
Sexual assault by stranger	__
Torture	__
Other Specify ……	

Physical Health: Nung

Observation:

- Body hygiene and clothes: Is he/she clean? ✔
- Face: How does the client look? In reasonably good shape? ✔
  Poor shape? —
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck? No
- Dehydration: Does the client have dry skin, dry lips and tongue, and/or sunken eyes? No
- Pallor: Is he/she pale? No
- Jaundice: Do the whites of his/her eyes look yellow? No
- Mouth/lips: Are there whitish patches? Are there bad teeth? No

*Have you had any of the following during the **last year**? (✔)*

General	Yes	No	Comment
Fatigue/energy loss	✔		
Poor appetite		✔	
Weight loss/underweight		✔	
Weight gain/overweight		✔	
Trouble sleeping		✔	
Fever		✔	
Night sweats		✔	
Swollen glands		✔	
Jaundice		✔	
Bleeding easily		✔	
Bruising easily		✔	
Teeth problems		✔	
Eye/vision problems		✔	

Ear/hearing problems		✔	
Allergies		✔	
Injecting related problems		✔	
Overdose		✔	
Abscesses/infections		✔	
STIs		✔	
Hepatitis B/C		✔	
Cardio/respiratory			
Persistent cough		✔	
Coughing up phlegm		✔	
Coughing up blood		✔	
Wheezing		✔	
Sore throat		✔	
Shortness of breath		✔	
Chest pains		✔	
Heart flutters/racing		✔	
Genito-urinary			
Painful urination		✔	
Loss of sex urge		✔	
Unusual discharge from penis/vagina		✔	
Rash on or around penis/vagina		✔	
Gynaecological (females)			
Irregular period		✔	

Miscarriage		✔	
Abortion		✔	
Musculo-skeletal			
Joint pains/stiffness		✔	
Broken bones		✔	
Muscle pain		✔	
Neurological			
Headaches	✔		*When used mum's pills*
Blackouts		✔	
Tremors (shakes)		✔	
Numbness/tingling		✔	
Dizziness		✔	
Fits/seizures		✔	
Difficulty walking		✔	
Head injury		✔	
Forgetting things		✔	
Gastro-intestinal			
Nausea		✔	
Vomiting		✔	
Stomach pains		✔	
Constipation		✔	
Diarrhoea		✔	

Assessment Summary: Nung

Presentation: *Nung, referred by her school teachers, presented himself as a sad 14-year-old. She talked quietly with her head down – rarely looking at the assessor. She was confused as to why she had been referred. Nung has used some of her mother's anti-anxiety medication (diazepam), but only a few times. She does not appear to have a drug problem, and her issues are more to do with bullying at school, confusion over whether to live with her mother or father and worries about her mother's health. Nung has thought about ending her life, but has not acted on these thoughts. She requires referral to a child and adolescent psychologist or counsellor to assist her with her situation at school and home. Her mother probably requires referral to a mental health or substance use service for assessment after a review by her local doctor.*

Substance use history:
Nung reported the following history for the past 3 months:
Tranquillisers: 4 or 5 times ever, and once last week.

Family situation and issues:
Nung comes from a family where her parents divorced about 4 years ago. Her father has remarried and has 2 children to that marriage. Nung visits her father occasionally and likes him very much, but has problems with his new wife. Nung lives with her mother, who appears to suffer from depression, but would like to live with her father.

Significant relationships:
Father, mother and friend from school – Som.

Mental health – past/present including medication:
Possible depression.

Physical health concerns and medication:
Nil noted.

Trauma history:
Nil noted.

Risk behaviour (e.g., injecting, sexual):
Nil noted.

Educational/vocational (achievements, difficulties, aspirations, challenges):
Nung is in her 2nd year of secondary education. She reports that she is a very good student, had good relationships with teachers but not fellow pupils. She likes drama and reading.

Criminal activity and any current court matters:
None.

Previous treatment:
None.

Strengths:
Intelligent, caring, drama.

Leisure activities:
Reading.

Initial Action Plan Recommendations:
Nung could benefit from:
1. *Referral to a Child and Adolescent Psychiatrist, Psychologist or Counsellor;*
2. *Individual counselling with an appropriate therapist;*
3. *Referral of mother to a mental health and/or substance use service;*
4. *Being involved with supportive peers in some group recreational activities – such as drama.*

Date: 29 January 2007 *Staff signature: .....*
Case Manager: Ms Amorn

Screening and Assessment: Zhong

Name: Zhong Date of Birth: 14 February 1988

Address: _____

Marital status: Single _X_ Married ___ Separated ___ Divorced ___ Other _____

Currently living with: Family

Family address (if different):

_____

_____

Referred by: Outreach workers

1. I would like to ask you about your use of alcohol, tobacco and other substances because many of them can affect your health. Have you **ever used** any of the following substances, and if so how often?

Substance	YES ✔	Age first used	How often?	Last used
Tobacco	✔	*13*	*Daily*	*Today*
Alcohol	✔	*14*	*5/7 days a week*	*Yesterday*
Cannabis (marijuana, hash, hash oil)				
Tranquillisers/sleeping pills (e.g., benzodiazepines)				

Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)				
Cocaine				
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)				
Opioids (e.g., heroin, methadone, morphine, codeine)	✔	*18*	*Once*	*Two months ago*
Hallucinogens (e.g., LSD, magic mushrooms)				
Inhalants (e.g., glue, petrol, paint)				
Steroids				
Other medicines (specify)				
Other (specify)				

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✔, substance(s) of most concern to young person.***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask 'was it on a doctor's prescription?'. For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note, local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

2. In the last **three months, how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco	✔	*Daily*	*20 a day*
Alcohol	✔	*5/7 days a week*	*6 bottles of beer*
Cannabis (marijuana, hash, hash oil)			
Tranquillisers/sleeping pills (e.g., benzodiazepines)			
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)			
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)	✔	*Once*	*Small amount*
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

3. **Why** did you first use each substance you have used, and, if you continued to use any of them, why did you continue to use?

Substance	First use	Why continue (if did)
Tobacco	*Peers*	*Used to it – dependent*
Alcohol	*Curious, peers wanted me to*	*Like it*
Cannabis (marijuana, hash, hash oil)		
Tranquillisers/sleeping pills (e.g., benzodiazepines)		
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)		
Cocaine		
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)		
Opioids (e.g., heroin, methadone, morphine, codeine)	*Curious*	*Did not like it – make me sick*
Hallucinogens (e.g., LSD, magic mushrooms)		
Inhalants (e.g., glue, petrol, paint)		
Steroids		
Other medicines (specify)		
Other (specify)		

4. Have you been **worried or concerned** about your use of any substance? Yes _X_ No ___ If yes, which one(s) and why?

Substance	Why worried or concerned?

5. Have you ever been able to **stop or reduce** your use of any of the substances you have used? Yes ___ No _X_ If yes, which substances, for how long did you cease/reduce use, why did you cease/reduce, and how did you manage to cease/reduce use?

Substance	How long?	Why?	How managed?

6. Have you regretted what you did when high or intoxicated on any of the substances you used at any time in the last 3 months?
Never ___ Once or twice ___ Frequently _X_ All the time ___
- Unprotected sex with sex workers.

7. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems	✔	*Alcohol*
b. Money problems		
c. Problems with work/school		
d. Problems with people, e.g., family, partner, friends		
e. Serious physical health problems, e.g., weight loss/chest pains		
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid		
g. Become violent or aggressive		
h. Serious accidents		
i. Overdosed? If yes, how many times?		

8. Has a friend or relative or anyone else ever expressed concern about your use of any drug? Yes ___ No X

9. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

If the person ever tried any of these by injection, probe:
If any answer to question 9 is <u>Yes</u>, continue with Question 10.
If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

10. Why did you decide to inject again? .....

11a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

11b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

12. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time	
Most of the time	
Some of the time	
None of the time	

13. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	
Pharmacists/Chemists	
Friends	
Other	

Do not proceed beyond this point in the first interview if client appears uncomfortable or hostile to the assessment process.

14. Does your boy/girlfriend use drugs? Yes _X_ No ___ If yes, what? .....

15. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex			
Every time			
Often			
Sometimes			
Rarely		✔	✔
Never			

16. With whom have you had sex in the last year?

Only females	✔
Only males	
Both females and males	
No sex	

17. Level of Education: Primary ___ Secondary _X_ College/University___
Additional training _____

18. Work History: Do you hold a job? Yes ___ No _X_
If yes, what is the job? _____

19. How do you feel about your job?
Good ___ Satisfactory ___ Bad ___ Very bad ___

20. Do you always fulfil your work responsibilities? _____

21. Describe your relationships with co-workers: _____

22. Describe your relationship with your supervisor: _____

23. What is the probability that you will be able to keep your current job?
Very Good ___ Good ___ Don't know ___ At risk ___ Unlikely ___

24. Employability if unemployed:
Very Good ___ Good ___ Satisfactory _X_ Bad ___ Very bad ___

25. Employment goals *(note any new skills needed to achieve these goals):*
Maybe driving a taxi – not sure.

26. Do you have daily responsibility for children, other family members, household or property? Yes ___ No _X_

27. Neighbourhood/community attitude towards client:
Good ___ OK ___ Bad _X_ Very bad ___

28. Client's interests and hobbies prior to drug use:
TV, sport.

29. What are the client's interests and hobbies now?
TV, video games.

30. Client's Goals:
May be get a job, be happy and get on with family.

31. Clients Motivation to Follow Treatment/Rehabilitation:
Very Good ___ Good ___ Satisfactory _X_ Bad ___ Very bad ___

32. Strengths identified:
Intelligent, has resisted a great deal of temptation and pressure to be involved in crime and continuing heroin use.

Family Assessment Screen: Zhong

Answered by: Zhong

1. Who in the family is the Young Person closest to? ***No one.***

2. Why is this? ***They argue all the time.***

3. The following are a number of statements about families *(Family Assessment Device – General Functioning Scale – short)*. Please read carefully and decide how well it describes your family. **SA** = strongly agree, **A** = agree, **D** = disagree, **SD** = strongly disagree.

	SA ✔	A ✔	D ✔	SD ✔
Planning family activities is difficult because we misunderstand each other		✔		
In times of crisis we can turn to each other for support			✔	
We cannot talk to each other about the sadness we feel	✔			
Individuals are accepted for what they are			✔	
We avoid discussing our fears and concerns		✔		
We can express feelings to each other	✔			
There are lots of bad feelings in the family	✔			
We feel accepted for what we are			✔	
Making decisions is a problem for our family		✔		
We are able to make decisions about how to solve problems				
We don't get along well together	✔			
We confide in each other			✔	

4. What issues have there been for your family – now or in the past? (e.g., domestic violence, physical, emotional or sexual abuse):
   Moving to new house. Losing friends.

5. What impact do you think this has had and on whom?
   All of us.

6. What is expected of the children/young people in the family and how is it enforced?
   To help around the house and give some money to parents if working – Father yells.

7. Is it effective? ***No.***

8. What activities do the children/young people engage in when not at home?
   TV.

9. What are the strengths in the family?
   Mother and father have always worked hard.

10. What things could be improved in the family?
    Father being so angry.

11. What would need to change for it to happen?
    For him/her to accept reality – we had to move, and to stop drinking.

12. What things about the young person do you want to see continue?
    I want to get back to being someone – a job and happy life.

13. What things do you think the young person needs to work on (change)?
    New friends and a job.

14. When do you think the young person began to go off track?
    When we moved house.

15. Do you know why?
    Loss of some friends and father starting to drink.

16. Would you be willing to attend a group to meet with some of the other parents experiencing similar difficulties?
    Don't think my father would go.

17. Who in the family would be willing to attend for at least one family session with your young person?
    Me and mum.

Assessment Summary: Zhong

Presentation: *Zhong, who was referred by the Outreach Team, is an 18-year-old 'at risk' for problematic drug use due to his unemployment and associating with dependent heroin users, people who steal and sex workers. To date his drug use is minimal, and this is a credit to his resilience. Zhong is experiencing re-location problems – village demolished and family relocated to State housing near by. He appears to have no physical or mental health difficulties, but could benefit from a family intervention, assistance with employment and more information on the negative effects of drugs and unprotected sex.*

Substance use history:
Zhong reported the following history for the past 3 months:
Tobacco: daily use, about 20 cigarettes per day.
Alcohol: about 5 days per week, 6 bottles of beer per day.
Heroin; once and only a small amount.
He says he is not worried about his use of any of these substances, but that he could be influenced by his drug using and sex working peers.

Family situation and issues:
The forced re-location of his family has caused significant stress for all of them. Both parents apparently work hard, but father may have a problem with his alcohol use.

Significant relationships:
Family. Zhong reports no girlfriend, but he has been with a number of girls casually.

Mental health – past/present including medication:
None noted.

Physical health concerns and medication:
Needs STI and HIV check.

Trauma history:
None noted.

Risk behaviour (e.g., injecting, sexual):
Involvement with dependent drug users and sex workers, unprotected sexual activity.

Educational/vocational (achievements, difficulties, aspirations, challenges):
Zhong completed 4 years of secondary education. He has been encouraged to become a taxi driver, but is unsure of this or what he would really like to do.

Criminal activity and any current court matters:
Zhong reports that he has been involved in selling stolen goods. Has not been arrested or charged by the police.

Previous treatment:
None.

Strengths:
Friendly, people like him, good communicator, does not want to end up in prison or dead from drug use.

Leisure activities:
'Hanging around'.

Initial Action Plan Recommendations:
Zhong could benefit from:
1. *Individual counselling with Y from the Outreach Team;*
2. *Joining activities at the Drop-in Centre;*
3. *A full medical examination – including STI and HIV check after pre-test counselling;*
4. *Receiving information on the effects of drugs;*
5. *Explore training and employment options.*

After engagement with a counsellor:
1. *Try to engage Zhong's parents for Family Counselling: to be provided by X.*

2. *Group counselling: with peer educators.*

Date: 17 March 2007 *Staff signature: .....*
Case Manager: Mr Yang

Screening and Assessment: Choi

Name: Choi Date of Birth: 3 January 1988

Address: living with friends at _____

Marital status: Single X Married __ Separated __ Divorced __ Other _____

Currently living with: girlfriend and other friends

Family address (if different): Choi came to K city from S village 3 years ago. He has limited contact with his family and has not seen them for one and a half years.

Referred by: Peer outreach workers

1. I would like to ask you about your use of alcohol, tobacco and other substances because many of them can affect your health. Have you **ever used** any of the following substances, and if so how often?

Substance	YES ✔	Age first used	How often?	Last used
Tobacco	✔	*12*	*Daily*	*Today*
Alcohol	✔	*13*	*5/7 days*	*Yesterday*
Cannabis (marijuana, hash, hash oil)	✔	*15*	*5/7 days*	*Yesterday*
Tranquillisers/sleeping pills (e.g., benzodiazepines)				
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)	✔	*17*	*Twice*	*One hit*
Cocaine				

Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)				
Opioids (e.g., heroin, methadone, morphine, codeine) and opium	✔	*16*	*Daily at times*	*Twice per day*
Hallucinogens (e.g., LSD, magic mushrooms)				
Inhalants (e.g., glue, petrol, paint)				
Steroids				
Other medicines (specify)				
Other (specify)				

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✔, substance(s) of most concern to young person.***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask 'was it on a doctor's prescription?'. For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note, local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

2. In the last **three months, how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco	✔	*Daily*	*30 cigarettes*
Alcohol	✔	*5/7 days*	*10 bottles of beer, some spirits*
Cannabis (marijuana, hash, hash oil)	✔	*5/7 days*	*25 "cones"*
Tranquillisers/sleeping pills (e.g., benzodiazepines)			
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)			
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)	✔	*Daily*	*Two hits per day*
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

3. **Why** did you first use each substance you have used, and, if you continued to use any of them, why did you continue to use?

Substance	First use	Why continue (if did)
Tobacco	*Curious, parents used*	*Like it, dependent on it*
Alcohol	*Peers and curious*	*Like it, like the feeling*
Cannabis (marijuana, hash, hash oil)	*Peers and curious*	*Like it, like feeling out of it and "trippy"*
Tranquillisers/sleeping pills (e.g., benzodiazepines)		
Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)		
Cocaine		
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)		
Opioids (e.g., heroin, methadone, morphine, codeine)	*Curious, peers, wanting to escape reality*	*Free of pain, no worries, dreamy*
Hallucinogens (e.g., LSD, magic mushrooms)		
Inhalants (e.g., glue, petrol, paint)		
Steroids		
Other medicines (specify)		
Other (specify)		

4. Have you been **worried or concerned** about your use of any substance? Yes ___ No ___ If yes, which one(s) and why?

Substance	Why worried or concerned?
Heroin	*Dependent on it, worried about HIV and going to prison*

5. Have you ever been able to **stop or reduce** your use of any of the substances you have used? Yes _X_ No ___ If Yes, which substances, for how long did you cease/reduce use, why did you cease/reduce, and how did you manage to cease/reduce use?

Substance	How long?	Why?	How managed?
Heroin	*4 months*	*Afraid of police*	*Friends gave me pills and alcohol*
Heroin	*5 months*	*Afraid of police*	*Clinic gave me methadone*

6. Have you regretted what you did when high or intoxicated on any of the substances you used at any time in the last 3 months?
Never ___ Once or twice ___ Frequently _X_ All the time ___
- Stealing and getting into trouble with people, losing job.

7. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems	✔	*All*
b. Money problems	✔	*All*
c. Problems with work/school	✔	*All*
d. Problems with people, e.g., family, partner, friends	✔	*All*
e. Serious physical health problems, e.g., weight loss/chest pains	?	*Heroin*
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid	✔	*Heroin and cannabis*
g. Become violent or aggressive	✔	*alcohol*
h. Serious accidents		
i. Overdosed? If yes, how many times?	✔	*Twice – did not care of him lived or died*

8. Has a friend or relative or anyone else ever expressed concern about your use of any drugs? Yes _X_ No ___ ***Some friends and outreach workers.***

9. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

If the person ever tried any of these by injection, probe:
If any answer to question 9 is <u>Yes</u>, continue with Question 10.
If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

10. Why did you decide to inject again? ***liked the fast effect, got ALL of my drugs into me.***

11a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	✔
6-10 times	
More than 10 times	

11b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	✔

12. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time ..... *alcohol and cannabis*	✔
Most of the time	
Some of the time	
None of the time	

13. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	✔
Pharmacists/Chemists	✔
Friends	✔
Other	

Do not proceed beyond this point in the first interview if client appears uncomfortable or hostile to the assessment process.

14. Does your boy/girlfriend use drugs? Yes _X_ No ___
If yes, what? ***– Heroin.***

15. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex			
Every time			
Often			
Sometimes		✔	
Rarely	✔		
Never			

16. With whom have you had sex in the last year?

Only females	✔
Only males	
Both females and males	
No sex	

17. Level of Education: Primary___ Secondary _X_ College/University___
Additional training _____

18. Work History: Do you hold a job? Yes ___ No _X_
– Was working part-time in a kitchen.
If yes, what is the job? _____

19. How does you feel about your job?
Good ___ Satisfactory ___ Bad ___ Very bad ___

20. Do you always fulfil your work responsibilities? _____

21. Describe your relationships with co-workers: _____

22. Describe your relationship with your supervisor: _____

23. What is the probability that you will be able to keep your current job?
    Very Good ___ Good ___ Don't know ___ At risk ___ Unlikely _____

24. Employability if unemployed:
    Very Good __ Good __ Satisfactory __ Bad _X_ Very bad __

25. Employment goals *(note any new skills needed to achieve these goals):*
    Any job I can get into some training course.

26. Do you have daily responsibility for children, other family members, household or property? Yes ___ No _X_

27. Neighbourhood/community attitude towards client:
    Good __ OK __ Bad __ Very bad _X_

28. Client's interests and hobbies prior to drug use:
    Being a "kid", riding my bike, watching TV, playing sport.

29. What are the client's interests and hobbies now?
    Not many – but like table tennis at the drop-in centre.

30. Client's Goals:
    Stop heroin use;
    Get a job;
    Be happy.

31. Clients Motivation to Follow Treatment/Rehabilitation:
    Very Good ____ Good ____ Satisfactory _X_ Bad ____ Very bad _____

32. Strengths identified:
    Appears to want to do something with his/her life, has "detoxed" twice, has engaged with outreach workers and drop-in centre.

Brief Mental Health Screen: Choi

1. In the **last 3 months** have you had any **significant** problems with (please ✔ either YES or NO for each question a-i).

		YES ✔	NO ✔
a	Feeling very trapped, lonely, sad, blue, depressed or hopeless about the future?	✔	
b	Having no energy and losing interest in work, school, friends, sex or other things you cared about?	✔	
c	Remembering, concentrating, making decisions, or having your mind go blank?	✔	
d	Feeling very shy, self-conscious, or uneasy about what people thought or were saying about you?	✔	
e	Thoughts that other people did not understand you or appreciate your situation?	✔	
f	Feeling easily annoyed, irritated, or having trouble controlling your temper?	✔	
g	Thoughts of ending your life?	✔	
h	Have you attempted to end your life in the **last 3 months**?	✔	
i	Have you <u>ever</u> attempted to end your life? →If yes answer questions below →If no go to Question 5	✔	

2. If you have ever attempted to end your life, (please list)
   a. How many times? ..... once Means used: *overdose on heroin*
   b. How old at first attempt? .... Means used: *overdose on heroin*
   c. How old at last attempt? ..... Means used: .....

3. In making the attempt(s) to kill yourself did you: (✔ *one or more*)

Just want to stop the pain/anger/frustration	
Want to stop the pain but I did not care if I died	✔
Want to die	
Did not know what else to do	
Other	

4. Thinking back to your most serious attempt, how likely was it that you could have died?
   Not at all __ A little __ Somewhat likely __ Likely __ Very likely __

5. Have you ever seen a mental health professional *(e.g., psychologist/ psychiatrist/social worker/school counsellor)*?
   Yes ___ No _X_ If yes, what for? .....

6. Were you ever given a diagnosis; e.g., anxiety, depression, or psychosis *(e.g., schizophrenia or other)*?
   Yes (please specify) ..... No _X_

7. Are you currently taking any psychiatric medication? Yes____ No_X__
   If yes, please specify and list all medications:

Antipsychotic	Anticonvulsant/Mood Stabiliser
Antidepressant	Other

8. Are you currently using any other prescribed medication(s)?
   Yes ___ No _X_
   If yes, what for? .....

9. Do you have any chronic health problems *(e.g., asthma, diabetes, etc.)*?
   Yes ___ No _X_
   If yes, what? .....

10. Have you had any major health problems *(e.g., major accidents, surgery, etc.)*? Yes ___ No _X_
    If yes, what? But I am worried that I might have HIV or hepatitis as I have shared needles and had unprotected sex.

11. Many people have lived through or witnessed a very stressful and traumatic event. Have you experienced or witnessed any of the following?

Serious accident *(e.g., car, fire)*	___
Physical assault by someone you know *(e.g., domestic violence, mugged)*	___
Sexual assault by someone you know	___
Combat/war zone	___
Life threatening illness	___
Natural disaster *(e.g., fire, flood, earthquake)*	___
Physical assault by stranger	___
Severe/ongoing emotional/verbal abuse	___
Sexual assault by stranger	___
Torture	___
Other Specify	

Physical Health: Choi

Observation:

- Body hygiene and clothes: Is he/she clean? Fair
- Face: How does the client look? In reasonably good shape? Poor shape? ✔
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck? **– forearms** ✔
- Dehydration: Dry skin, dry lips and tongue, and/or sunken eyes? No
- Pallor: Is he/she pale? ✔
- Jaundice: Do the whites of his/her eyes look yellow? No
- Mouth/lips: are there whitish patches? No. Are there bad teeth? ✔

*Have you had any of the following during the **last year**?* (✔)

General	Yes	No	Comment
Fatigue/energy loss	✔		
Poor appetite	✔		
Weight loss/underweight	✔		
Weight gain/overweight		✔	
Trouble sleeping	✔		
Fever		✔	
Night sweats			
Swollen glands	✔		
Jaundice		✔	
Bleeding easily			
Bruising easily	✔		
Teeth problems	✔		
Eye/vision problems		✔	

Ear/hearing problems		✔	
Allergies		✔	
Injecting related problems	✔		*Hard to find vein – sores take a long time to heal*
Overdose	✔		*Twice this year*
Abscesses/infections	✔		
STIs	✔		
Hepatitis B/C	✔		
Cardio/respiratory			
Persistent cough		✔	
Coughing up phlegm	✔		*smoking related*
Coughing up blood		✔	
Wheezing		✔	
Sore throat		✔	
Shortness of breath		✔	
Chest pains		✔	
Heart flutters/racing		✔	
Genito-urinary			
Painful urination	✔		*sometimes*
Loss of sex urge		✔	
Unusual discharge from penis/vagina		✔	
Rash on or around penis/vagina		✔	
Gynaecological (females)			
Irregular period			
Miscarriage			

Abortion			
Musculo-skeletal			
Joint pains/stiffness		✔	
Broken bones		✔	
Muscle pain		✔	
Neurological			
Headaches	✔		
Blackouts		✔	
Tremors (shakes)		✔	
Numbness/tingling		✔	
Dizziness	✔		
Fits/seizures		✔	
Difficulty walking		✔	
Head injury		✔	
Forgetting things	✔		
Gastro-intestinal			
Nausea	✔		
Vomiting		✔	
Stomach pains	✔		
Constipation	✔		
Diarrhoea	✔		

Assessment Summary: Choi

Presentation: *Choi, who was referred by the Peer Outreach Team, is an 18-year-old who is dependent on heroin again. He is a poly substance user: tobacco, alcohol, cannabis and heroin. He has experimented with amphetamines. He reported that he began his use of alcohol at age 13, cannabis at age 15 and heroin at 16, having tried opium first. He has experienced two significant withdrawals with two periods of abstinence, but relapsed each time. The first time he withdrew with the assistance of his friends and "pills" of some form and alcohol. The second time the X community clinic assisted his withdrawal with methadone. His family is disrupted and he lives with his girlfriend and other friends in crowded, sub-standard accommodation. He appears quite depressed at times and has contemplated killing himself. After his latest overdose he reported that he thought that he did not care if he lived or died.*

He has had some work experience as a kitchen hand, but has no clear career/ employment goals, bus is happy to do some training. He has been involved in some criminal activity and unprotected sex. He is afraid that he may be HIV+ and have hepatitis. He is also very afraid of being sent to the compulsory treatment centre or to prison. His general health appears poor.

Despite him saying that he was afraid of the police and that is why he had come to seek assistance, Choi was most cooperative during the assessment and appears genuine in his desire to change his life and cease drug use. He requires a medical examination (and HIV and STI testing), and residential or supervised withdrawal management in the community, with a referral for assessment for placement on a methadone programme. If unable to access a methadone programme, he requires intensive counselling and support. It is essential that the outreach workers maintain contact with him, and staff at the drop-in centre continue to engage, motivate and support him.

Substance use history:
Choi, who has used illegal drugs since he was 15, reported the following history for the past 3 months:
Tobacco: daily use, about 30 cigarettes per day.
Alcohol: about 5 days per week, 10 bottles of beer per day and some spirits (whisky).

Cannabis: about 5 days per week, 25 "cones" per day. He likes the feeling of being "stoned".
Heroin; daily, two hits per day. He says heroin keeps him free of pain and worries. He says he is worried about his use of any of these substances, and has had many drug use-related difficulties (legal, financial, employment, health, psychological and interpersonal). He has overdosed twice.

Family situation and issues:
Choi came to the city from a rural area some 3 years ago and only has irregular contact with his family, last seeing them one and a half years ago. He lives with his girlfriend and friends.

Significant relationships:
Girlfriend and other drug using friends.

Mental health – past/present including medication:
Choi's mental health appears to be poor. He exhibits some signs of depression and mental distress (concentration difficulties, being fearful, being easily irritated and angered), he has had no treatment and is not on any medication for this.

Physical health concerns and medication:
Choi did not present as being in good health. He requires a full medical examination and needs an STI and HIV check. He also requires supervised withdrawal management, as well as attention to abscesses caused via unsafe injecting practices and poor overall health.

Trauma history:
None noted.

Risk behaviour (e.g., injecting, sexual):
Involvement with dependent drug users and sex workers, unprotected sexual activity, IDU.

Educational/vocational (achievements, difficulties, aspirations, challenges):
Choi completed 3 years of secondary education. He has been encouraged to become a motorcycle mechanic, but is unsure of this or what he would really like to do.

Criminal activity and any current court matters:
Choi reports that he has been involved in some theft and damage to public property. Has been cautioned by the police.

Previous treatment:
Nothing major, but much involvement in street fighting.

Strengths:
Wanting to do something with his life, has engaged with outreach workers.

Leisure activities:
Playing table tennis at the drop-in centre.

Initial Action Plan Recommendations:
Choi could benefit from:

1. *Supervised withdrawal (detox) in a community residential setting;*
2. *A full medical examination – including an STI and HIV check after pre-test counselling.*

After withdrawal, the following could be considered:

3. *Referral for assessment for a methadone programme;*
4. *Psychological assessment by Ms Lou;*
5. *Individual counselling with Y from the Outreach Team;*
6. *Joining activities at the Drop-in Centre;*
7. *Receiving information on the effects of drugs;*
8. *Introduction to NA or other self-help or peer-to-peer support group;*
9. *Explore training and employment options.*

If this does not work, he may need referral to the compulsory treatment centre.

Date: 15 March 2007 *Staff signature: …….....*
Case Manager: Mr Yang

ACTION PLAN: Choi

Goal 1	Withdrawal management	Commenced:	17.03.06
		Completed:	
		Signed:	
Action Enter community residential "detox" when a bed is available Have assessment for methadone programme		Who? Counsellor, me and staff at "clinic" How will I know it is achieved? I will not be craving and I will feel better Who will notice the change? Me and everyone	

After completion of the "detoxification", Choi's Action Plan as follows:

ALERTS: Choi has completed a residential withdrawal management (detoxification)		
	Action Plan Goals	Status:

Goal 1	Participate in Counselling/Group	Commenced:	
		Completed:	
		Signed:	
Action Join in group activities at the drop-in centre Stay awake and being attentive in any group discussions (sit up in seat and do not lounge about) Listening and contributing constructively to discussions Attempting to answer questions fully and honestly (in more than just a few words) Contributing to the best of my ability		Who? Me and Outreach and Peer Workers How will I know it is achieved? I will be getting involved Who will notice the change? I will.	
Goal 2	To demonstrate my willingness to participate in the programme	Commenced:	
		Completed:	
		Signed:	
Action Discuss with counsellor Obey the drop-in centre rules		Who? Me with the help of my counsellor and other outreach and drop-in centre staff	
Goal 3	Continue to explore my drug and alcohol issues	Commenced:	
		Completed:	
		Signed:	
Action Manage cravings The 4 D's Distract Myself Deep Breath Drink Something Delay Continue assessment Discuss in counselling Discuss in relapse prevention sessions/groups Begin relapse prevention worksheet Complete assessment for methadone		Who? Counsellor and me How will I know it is achieved? I will be more open about my drug and alcohol issues, had assessment for methadone Who will notice the change? I will and so will staff	

Goal 4	To be able to start to name my emotions in order to monitor my moods	Commenced:	
		Completed:	
		Signed:	
Action Refer to feelings sheets Take an active interest in noticing how I feel		Who? counsellor and me How will I know it is achieved? I will be able to name what is going on for me	
Goal 5	Vocational and Educational	Commenced:	
		Completed:	
		Signed:	
Action Make an appointment with Voc Ed person Have a Vocational/Educational Assessment Begin work placement or training Skill development: being able to access internet Set up an e-mail account on the internet; have basic computer/word processing skills (i.e., being able to write a letter)		Who? Employment agency How will I know it is achieved? When working or in training Who will notice the change? I will, and staff	
Goal 6	Support People	Commenced:	
		Completed:	
		Signed:	
Action Make a list of who is important in my life Identify who is a positive influence in my life Maintain contact with support people in my life I can do this by: phone calls, letters, e-mail and visits		Who? Staff and me How will I know it is achieved? I will have the level of contact that I need	

Goal 7	Relapse prevention	Commenced:	
		Completed:	
		Signed:	
Action Make a clear relapse prevention plan for stopping/ managing my use of alcohol, cannabis and heroin		Who? Counsellor, staff and me How will I know it is achieved: I will have a definite plan, and feel more stable and less prone to thinking about and wanting to use Who will notice the change? Me, everyone	
Goal 8	Family Work	Commenced:	
		Completed:	
		Signed:	
Action Counsellor to meet with me and my family when I am more settled. Have people in family to be able to trust me again.		Who/By when: counsellor and me. How will I know it is achieved: I will be getting along better with my family. Who will notice the change? **We will all notice the change**	

4. Follow-up Assessment

To determine effectiveness of treatment, a much shorter version of the original assessment can be administered three (3) months after the cessation of treatment. The brief re-assessment follows. It includes questions on substance use during the three months after the cessation of treatment, risk behaviours (injection drug use related and sexual behaviour), mental and physical health and family functioning, in addition to questions about employment and problems associated with any continued substance use.

Thus, an agency can quickly gain self-report impact data to demonstrate whether there has been change in key indices:

- Reduction/cessation of use of various substances;
- Reduction in BBV and STI risk behaviour;
- Reduction in drug use-related problems;
- Improvement in mental health;
- Improvement in physical health;
- Improved family functioning;
- Increase in employment.

Follow-up Assessment Questions

To be administered 3 months after cessation of treatment.

Name:_____ Date of Birth:_____

Address:_____

Marital status: Single ___ Married ___ Separated ___ Divorced ___ Other _____

Currently living with: _____

For "How Often" please record as follows: 0 = None, 1 = Daily, 2 = More than weekly but not daily, 3 = Weekly, 4 = Less often. ***Indicate with ✔, substance(s) of most concern to young person***

Note: *Some of the substances listed may be prescribed by a doctor (such as amphetamines, sedatives, pain medications), so ask "was it on a doctor's prescription?". For prescription medications, interviewers should code only those substances taken for reasons other than prescribed by a doctor unless the substance was taken more frequently or at higher doses than prescribed. Also note that local names for legal or illegal may vary from place to place and country to country.*

If all answers are negative, probe: not even once, just to try it? **If after probing it is still "no" to all items, stop the interview.**

1. In the last **three months, how often** have you ever used any of the following substances, and **how much** (quantity) did you use in a typical session?

Substance	YES ✔	How often?	How much?
Tobacco			
Alcohol			
Cannabis (marijuana, hash, hash oil)			
Tranquillisers/sleeping pills (e.g., benzodiazepines)			

Amphetamine type stimulants (e.g., speed, methamphetamine, Ice, Crystal, Shabu, base, ADHD medications (e.g., methylphenidate – Ritalin)			
Cocaine			
Designer drugs (e.g., Ecstasy, Special K, Ketamine, GHB, MDA, etc.)			
Opioids (e.g., heroin, methadone, morphine, codeine)			
Hallucinogens (e.g., LSD, magic mushrooms)			
Inhalants (e.g., glue, petrol, paint)			
Steroids			
Other medicines (specify)			
Other (specify)			

2. Have you been **worried or concerned** about your use of any substance? Yes ___ No ___ If yes, which one(s) and why?

Substance	Why worried or concerned?

3. During the past three months, have you had any of the following problems because of your use of substances?

Problem	Yes/No	Which Substance(s)
a. Legal/criminal problems		
b. Money problems		
c. Problems with work/school		
d. Problems with people, e.g., family, partner, friends		

e. Serious physical health problems, e.g., weight loss/chest pains		
f. Serious psychological problems, e.g., anxiety, depression, hallucinations, trouble sleeping, forgetting things, feeling paranoid		
g. Become violent or aggressive		
h. Serious accidents		
i. Overdosed? If yes, how many times?		

4. Has a friend or relative or anyone else ever expressed concern about your use of any drugs? Yes ___ No ___

5. Have you ever used any of the following substances by injection?
   a. Amphetamine type stimulants ☐ Last time ……..
   b. Cocaine ☐ Last time ……..
   c. Opioids ☐ Last time ……..
   d. Medications ☐ Last time ……..
   e. Other …… ☐ Last time ……..

   If the person ever tried any of these by injection, probe:
   If any answer to question 9 is <u>Yes</u>, continue with Question 10.
   If <u>No</u>, go to Question 14, if client appears comfortable enough with the questions.

6a. How often, in the last 3 months, have you cleaned needles or syringes before re-using them?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

6b. How often, in the last 3 months, have you shared or re-used other equipment *(e.g., filters, spoons)*?

Haven't injected in last 3 months	
Have not ever re-used equipment	
Have not re-used in the last 3 months	
One time	
2-5 times	
6-10 times	
More than 10 times	

7. In the last month, how often were you under the influence of drugs or drunk when you were about to inject?

No use in the last month	
All of the time ..... *alcohol and cannabis*	
Most of the time	
Some of the time	
None of the time	

8. From where do you usually get your needles and syringes?

Needle and syringe programme *(buses/outlets)*	✔
Pharmacists/Chemists	✔
Friends	✔
Other	

9. Does your boy/girlfriend use drugs? Yes _X_ No ___
   If yes, what? _____
10. How often have you used a condom when you had sex with another person in the past 3 months?

	Regular Partner	Casual Partner	Client *(paid sex)*
No penetrative sex			
Every time			
Often			
Sometimes			
Rarely			
Never			

11. With whom have you had sex in the last year?

Only females	
Only males	
Both females and males	
No sex	

12. Work History: Do you hold a job? Yes ___ No ___
    If yes, what is the job? _____

13. How do you feel about your job?
    Good ___ Satisfactory ___ Bad ___ Very bad ___

14. Do you always fulfil your work responsibilities? _____

15. Describe your relationships with co-workers. _____

16. Describe your relationship with your supervisor. _____

17. What is the probability that you will be able to keep your current job?
    Very Good ___ Good ___ Don't know ___ At risk ___ Unlikel ___

18. Employability if unemployed:
    Very Good __ Good __ Satisfactory __ Bad __ Very bad __

19. Employment goals *(note any new skills needed to achieve these goals):*
    a. _____

    b. _____

    c. _____

20. What are the client's interests and hobbies now?
    _____

Date: _____

Staff signature: _____

5. Specific follow-up assessment tools for use as necessary:

Brief Mental Health Screen

Physical Health Screen

Family Assessment Screen

Brief Mental Health Screen – Follow up

1. In the **last 3 months** have you had any **significant** problems with (please ✔ either YES or NO for each question a-i).

		YES ✔	NO ✔
a	Feeling very trapped, lonely, sad, blue, depressed or hopeless about the future?		
b	Having no energy and losing interest in work, school, friends, sex or other things you cared about?		
c	Remembering, concentrating, making decisions, or having your mind go blank?		
d	Feeling very shy, self-conscious, or uneasy about what people thought or were saying about you?		
e	Thoughts that other people did not understand you or appreciate your situation?		
f	Feeling easily annoyed, irritated, or having trouble controlling your temper?		
g	Thoughts of ending your life?		
h	Have you attempted to end your life in the **last 3 months?**		
i	Have you <u>ever</u> attempted to end your life? →If yes answer questions below →If no go to Question 5		

2. If you have ever attempted to end your life, (please list)
   a. How many times? ..... Means used: *overdose on heroin*
   b. How old at first attempt? ..... Means used: *overdose on heroin*
   c. How old at last attempt? ..... Means used: .....

3. In making the attempt(s) to kill yourself did you: *(✔ one or more)*

Just want to stop the pain/anger/frustration	
Want to stop the pain but I did not care if I died	
Want to die	
Did not know what else to do	
Other	

4. Thinking back to your most serious attempt, how likely was it that you could have died?
   Not at all __ A little __ Somewhat likely __ Likely __ Very likely __

5. Have you ever seen a mental health professional *(e.g., psychologist/ psychiatrist/ social worker/school counsellor)*?
   Yes ___ No ___ If yes, what for? .....

6. Were you ever given a diagnosis; e.g., anxiety, depression, or psychosis *(e.g., schizophrenia or other)?*
   Yes (please specify) .....…….. No X

7. Are you currently taking any psychiatric medication? Yes____ No__X__
   If yes, please specify and list all medications:

Antipsychotic	Anticonvulsant/Mood Stabiliser
Antidepressant	Other

8. Are you currently using any other prescribed medication(s)?
   Yes ___ No ___
   If yes, what for?……

9. Do you have any chronic health problems *(e.g., asthma, diabetes, etc.)*?
   Yes ___ No ___
   If yes, what? ……

10. Have you had any major health problems *(e.g., major accidents, surgery, etc.)*? Yes ___ No ___
    If yes, what? ……

Physical Health Screen – Follow up

Observation:

- Body hygiene and clothes: Is he/she clean? ____
- Face: How does the client look? In reasonably good shape? ____
  Poor shape? ____
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck? ____
- Dehydration: Does the client have dry skin, dry lips and tongue, and/or sunken eyes? ____
- Pallor: Is he/she pale? ____
- Jaundice: Do the whites of his/her eyes look yellow? ____
- Mouth/lips: Are there whitish patches? Are there bad teeth? ____

*Have you had any of the following during the **last year**? (✔)*

General	**Yes**	**No**	Comment
Fatigue/energy loss			
Poor appetite			
Weight loss/underweight			
Weight gain/overweight			
Trouble sleeping			
Fever			
Night sweats			
Swollen glands			
Jaundice			
Bleeding easily			
Bruising easily			
Teeth problems			

Eye/vision problems			
Ear/hearing problems			
Allergies			
Injecting related problems			
Overdose			
Abscesses/infections			
STIs			
Hepatitis B/C			
Cardio/respiratory			
Persistent cough			
Coughing up phlegm			
Coughing up blood			
Wheezing			
Sore throat			
Shortness of breath			
Chest pains			
Heart flutters/racing			
Genito-urinary			
Painful urination			
Loss of sex urge			
Unusual discharge from penis/vagina			
Rash on or around penis/vagina			

Gynaecological (females)			
Irregular period			
Miscarriage			
Abortion			
Musculo-skeletal			
Joint pains/stiffness			
Broken bones			
Muscle pain			
Neurological			
Headaches			
Blackouts			
Tremors (shakes)			
Numbness/tingling			
Dizziness			
Fits/seizures			
Difficulty walking			
Head injury			
Forgetting things			
Gastro-intestinal			
Nausea			
Vomiting			
Stomach pains			
Constipation			
Diarrhoea			

Family Assessment Screen – Follow up

The following are a number of statements about families
(Family Assessment Device – General Functioning Scale – short).
Please read carefully and decide how well it describes your family.
SA = strongly agree, **A** = agree, **D** = disagree, **SD** = strongly disagree.

	SA ✔	A ✔	D ✔	SD ✔
Planning family activities is difficult because we misunderstand each other				
In times of crisis we can turn to each other for support				
We cannot talk to each other about the sadness we feel				
Individuals are accepted for what they are				
We avoid discussing our fears and concerns				
We can express feelings to each other				
There are lots of bad feelings in the family				
We feel accepted for what we are				
Making decisions is a problem for our family				
We are able to make decisions about how to solve problems				
We don't get along well together				
We confide in each other				

6. General treatment principles

The following principles were developed by NIDA (1999) and are applicable to the treatment of young substance users:

1. No single treatment is appropriate for all individuals;
2. Treatment needs to be readily available;
3. Effective treatment meets the different needs of a young substance user and does not only address her/his substance use;
4. A substance user's treatment should be assessed continuously as substance users' needs change with the different stages they experience;
5. It is important for a substance user to remain in treatment for an adequate period of time to make sure that the treatment is effective;
6. Counselling and other behaviour therapies are important parts of treatment;
7. Medications are also an important part of treatment;
8. Substance users who also have psychological or mental problems should be treated for both problems;
9. Medical detoxification alone is not sufficient for treating long term substance dependence;
10. Effective treatment does not have to be voluntary. Motivation and/or sanctions in the setting can help substance users remain in treatment;
11. Monitoring substance users during treatment is important, as lapses may occur and substance users could revert to old habits;
12. Treatment programmes should provide assessments for HIV, hepatitis B and C, tuberculosis, and other infectious diseases;
13. Treatment for substance dependence is a long process and may require treatment for different episodes/events.

6.1. Broad categories of treatment

1. Outreach programmes that include peer workers who interact with young substance users and provide information on health, harm reduction, and HIV. Improving young substance users' access to health services are often part of outreach programmes.

2. Out client/patient services in community settings or as part of a hospital service include counselling, family support, medical intervention, and life skills development.

3. Residential programmes either in the community (e.g., a small house run by an NGO) or in a public institution, such as a hospital or temple or monastery, or a specific residential drug treatment and rehabilitation programme, such as a therapeutic community run by an NGO or public institutions (e.g., juvenile corrections, health, public security).

4. Continuing care in the family and community.

   All the above interventions could be early or late, brief or intensive and over a long period. The main helping approaches or strategies are about changing behaviour, providing skills training, supporting the user's family, and helping the user's community develop its own helping programme for members. A comprehensive treatment programme includes early intervention counselling for the user and his/her setting, provision of alternative activities (recreation, job training and skills development) and access to information on the substance and its effects.

   Most treatment programmes for young substance users emphasize family involvement. Family participation, their inclusion in therapy and parental training are important. The involvement of schools and teachers is another important aspect of treatment programmes. Peer support and drawing on the experiences and knowledge of young substance users who have succeeded in giving up dependence could strengthen treatment programmes. However, such programmes need to be monitored carefully, as those who have just come out of recovery may tend to impose their views on others, especially if young people are trying to give up dependence.

6.2. Targeted at the setting

Particular problem	Suggested intervention
Major life events: separation, death in family, loss of employment, expulsion from school	Crisis and on-going counselling, bereavement counselling, medical care
Enduring life strains: tension within family, problems at school and work, worries about effects of substance use	"Time-out programmes" through holiday camps, training in problem solving and conflict resolution, counselling in community, use peer educators
Life transitions: displacement, relocation, becoming a parent, pregnancy in young women substance users	Training in living and coping skills, counselling, financial assistance, help with housing and health care, peer and family support programmes
Adolescent development changes	Information on bodily changes, access to health services, supportive counselling, survival skills training
Method of substance use	Promoting safer methods of use, instruction on safer techniques including injection practices and equipment cleansing, providing information on services, access to disposable syringes, bleach and condoms, relapse prevention, use peer educators
Consequences of substance use	Provision of shelter, food, emergency services and referrals, peer educator support
Experience of substance use	Encourage users to plan their usage, create safe environments for substance use, discourage dangerous activities during substance use, for example, swimming and driving, provide first aid training to users, relapse prevention

Particular problem	Suggested intervention
Major life events: natural disasters, relocation of communities, reconstruction of public areas	Strategic plans to address the specific needs of young substance users during disasters, emergency medical plans, organizing support for young users who are victims of disruptions, services for young refugees who could be substance users
Problems with having young substance users using public areas	Outreach programmes for young substance users, peer education programmes on risky practices for the community and young substance users, providing safe places for substance use, training police on how to manage intoxicated individuals, crisis care for young people who are intoxicated and therefore vulnerable
Tackling unsafe practices of substance users	Training programme for health and youth workers, distribution of sterile injection equipment having an exchange programme for injection equipment, using outreach peer educators, hepatitis vaccination programmes, drug substitution programmes, for example, methadone
Lack of information on substance use for young people	Training programmes for young people at schools, religious centres and community centres, creating appropriate information on substance use and its effects for adolescents, and on harm reduction, peer education activities in communities

Particular problem	Suggested intervention
Treatment programmes for young substance users	Establish community based treatment centres that are accessible to young substance users and "youth friendly" and appropriate, institute a culture of fairness and non-judgemental approaches to young people who are substance users
Lack of implementation of regulations and measures on sale of substances	More stringent rules, stricter enforcement mechanisms, neighbourhood watch and youth support committees, increased parental supervision, criminalization of traffickers and sellers of substances


A TOOL KIT

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

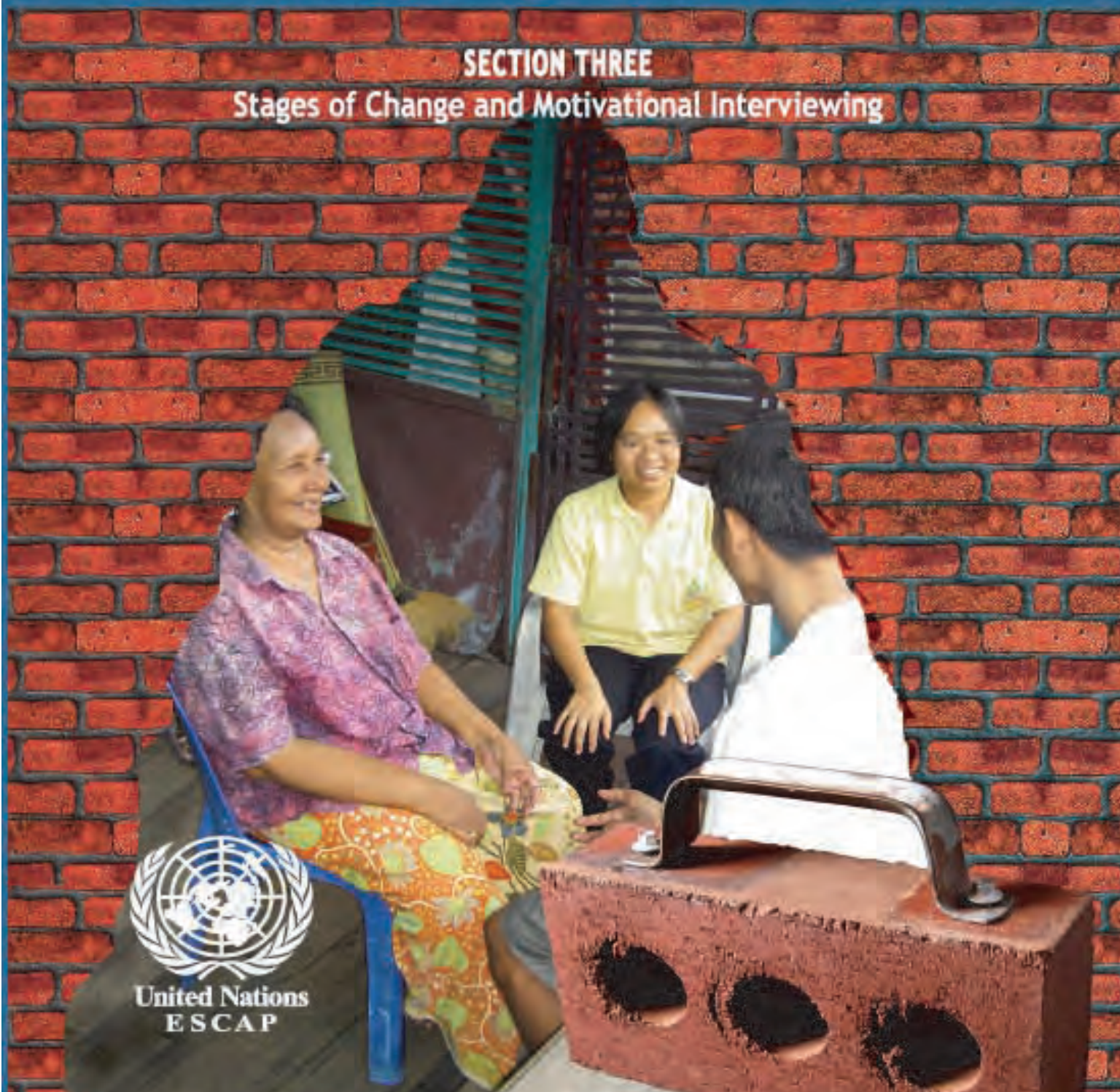
Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION THREE

Stages of Change and Motivational Interviewing



United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Three

Motivational Interviewing 5

1. Assessing and responding to stage of change 6

2. Stages of change 7

3. Tools and motivational interviewing 14

4. Components of brief interventions that work 16

5. Specific skills 21

6. Brief intervention with moderate risk users 26

7. Choosing the substance of most concern 27


A TOOL KIT

Section Three

Motivational Interviewing

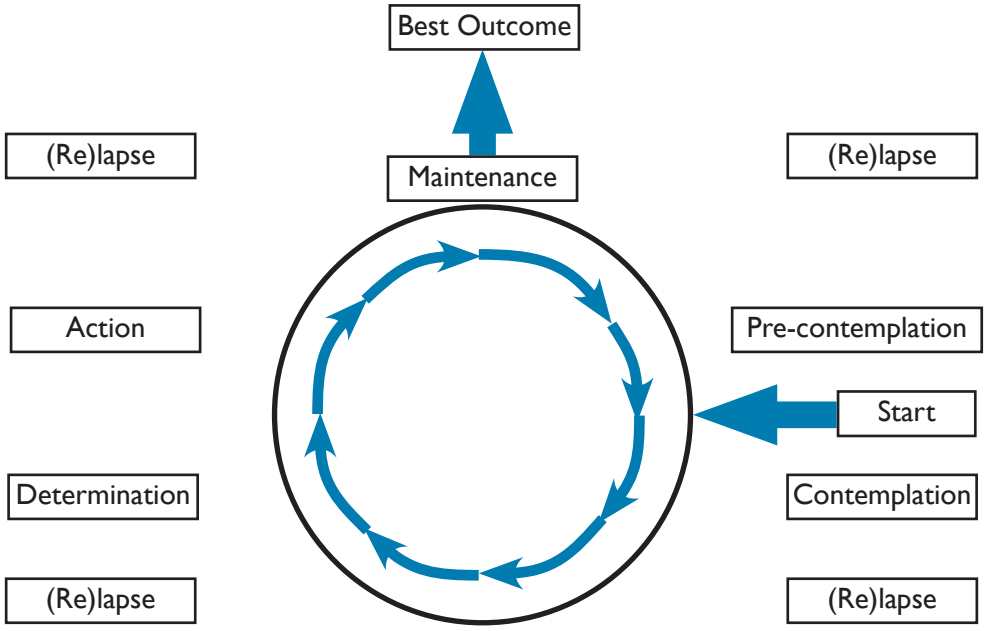
This section introduces the Tool Kit and presents five case studies that are used throughout the kit to illustrate various aspects of working with young people and their families experiencing substance use-related difficulties.

1. Assessing and responding to stage of change

In planning treatment interventions for young substance users, it is important to identify their 'stage of change'. By this we mean, whether they have been forced to come to seek assessment and/or treatment, but do not want to give up their substance use, or whether they want to, or have been trying to change. The following discussion on **Stages of Change**, is based on a useful framework to help us understand how people change from behaviour that can be both rewarding and at the same time problematic, to more healthy behaviour. Most of the material in this section is drawn from Ted Noffs Foundation (2006) and WHO (2003) materials on brief interventions.

Young substance users go through different stages of change as they try to give up substance use. In the diagram below, we outline the different stages and the matching helping strategies.

Stages of change model



2. Stages of change

2.1. The pre-contemplation stage

In this stage, the user is not considering giving up drugs. In response, you work at forming a relationship with the young person and try to raise his or her awareness of the consequences of drug use for himself/herself, his or her family, and the community. But don't push them too hard! At this point, your main job is to make a connection with the young person and get them involved in thinking about changing their lives. How do you help? Form a relationship!

Some useful questions:

- *How will you know when it is time to think about changing?*
- *What signals will tell you to start thinking about changing?*
- *What do you like most about yourself?*
- *What do you think you are best at?*
- *What connection is there between those qualities and your drug use?*
- *Imagine what your life was like before you began using drugs? How does that image feel to you?*
- *Imagine what your life would be like if you continued the way you are going now? How does that image feel to you?*
- *Imagine what your life would be like if you changed? How does that image feel to you?*
- *So, what are the good things about your drug use? Let's make a list.*
- *What are the not so good things about your drug use? Let's add these to the other side of your list.*
- *What would be the worst things that could happen if you changed (e.g., gave up drugs)?*
- *What would be the best thing if you kept going the same way as you are now (i.e., using drugs)?*
- *So, let's list down this side the 'good things' about giving up drugs.*
- *So, let's list down this side the 'no so good things' about giving up drugs.*
- *Now… what comes to mind when you look at these lists?*

2.2. The contemplation stage

The user begins to think about doing something about his or her drug use, but has not yet reduced his or her level of use. The young person is usually ambivalent about change. 'Contemplation' is often induced by someone or something external. You help the child or young person at this stage by discussing the advantages and disadvantages of substance use, and the advantages and disadvantages of quitting (Motivational Interviewing). Make observations and provide information, but avoid arguing. How do you help? Discuss with her/him! Do not argue!

Some of the **tasks for a worker** encountering a young person at this stage may be to:

- *Continue to raise awareness of perceived risks of continuation of behaviour;*
- *Assist the young person to make informed choices (using motivational interviewing techniques);*
- *Offer continued support, assistance and encouragement;*
- *Acknowledge the 'pleasant effects' of substance use and discuss what could be missed by change;*
- *Avoid too much focus on 'action';*
- *Try to tip balance in favour of change.*

Some useful questions:

- *What has happened to make you think that you need to make some changes in your life?*
- *What are the good things about the way you are currently trying to change? Let's make a list.*
- *What are the not so good or harder things? Let's add them to the other side of your list.*
- *What will your life be like if you make the changes you want?*
- *It is great that you are thinking about changing… what do you need to help you make the changes you want to make?*

2.3. Preparing for change

A young person's attitude tips towards change and he/she may decide to attempt change. This is the stage at which behavioural change begins with a change in pattern or level of use. A plan is made and instituted. When the young person accepts that he/she needs to make changes in relation to his/her substance use, there is a need to undertake a full assessment to prepare for the change. It is important to know:

- *What drugs are they using?*
- *How much are they using?*
- *How frequently is their drug use (e.g., daily, 3 times per day, weekly)?*
- *What method of administration do they use (e.g., inject, inhale, swallow) and if they have changed method of administration, how and why?*
- *Whether they are experimental, functional, dysfunctional, harmful or dependent users.*
- *How they have tried to give up or reduce use in the past?*
- *Are they open to considering supervised withdrawal management including, perhaps, detoxification in cases of prolonged or heavy use of substance such as heroin?*
- *What functions their drug use is serving, that is, what needs are being met by drug use?*
- *What supports do they have?*
- *How they are paying for their drugs?*
- *Whether they use drugs alone, with company or both.*

Some useful questions:

- *What are some of the barriers to making the changes you want to make?*
- *Choose one of the barriers to changing and list some of the things that could help you overcome this barrier.*
- *Choose one of these things and decide to do it.*
- *What made you decide on that one?*

Part of a **worker's task** might be to:

- *Provide feedback;*
- *Support self-efficacy;*
- *Undertake a full assessment;*
- *Advise on options;*
- *Assist the young person in making a plan;*

- *Assist in maintaining motivation;*
- *Assist in skill development and use of appropriate strategies;*
- *Provide practical assistance;*
- *Teach relapse prevention skills.*

2.4. The action stage

At this point, the young substance user attempts to quit, or at least reduce his/her intake of substances. You can be more active at this stage by helping the young person to learn skills and develop strategies that are needed to live a substance-free life. The user will need to find out, by looking at his or her own life, what factors are influencing his or her drug use, such as people, places, feelings or things. Skills training, therapy, and, above all, support are necessary during this stage. How do you help? Help by teaching life skills and coping strategies. Be supportive.

Once the users have identified some of their personal prompts for using substances, they can begin trying to eliminate these from their lives. For some young substance users, this may mean throwing away inhalant equipment, such as plastic bags and smoking instruments. For others, it may mean finding a job to avoid boredom. Other people may have to avoid friends who are drug users. There may be a need to talk about the past or work with the family, if they are available, or other people who play a significant role in the life of the child or youth. It may also mean changing employment.

Many, if not most, of these interventions are those commonly used in counselling for problem behaviours.

During this stage the young person maintains her/his changed behaviour, working to keep from (re)lapsing. Part of a **worker's task** might be to:
- *Provide reinforcement in difficult times;*
- *Assist the young person in maintaining status;*
- *Teach self reinforcement skills;*
- *Monitor relapse prevention skills;*
- *Teach self monitoring skills;*
- *Let it be known that self-help groups may be useful.*

Some useful questions:

- *Congratulations!! What has worked in taking these steps?*
- *What could help to make it better?*
- *What else would help?*
- *Can you break these things you have identified into smaller, achievable steps?*
- *Is there anything that I can do to assist you?*

2.5. The (re)lapse stage

After trying to abstain, most young substance users go through a stage where they resume taking substances at the same or a slightly reduced dosage as before. This is not failure. Due to the relapsing nature of substance use this is the most likely initial outcome. It is simply a part of the process of changing. You need to prepare the user in advance for this stage and then help him or her get through it. It is best to help the young person to find out what caused him or her to resume drug use. Not all change strategies work for all users. When the user is ready to try to quit again, you can help the individual make a more effective plan of action. How do you help? Assure him/her that is part of the change process. Help him/her find out why the lapse occurred. When he/she is ready again, be there!

When an individual returns to use (lapse) or previous patterns of use (relapse) it may be one-off or continued use. A **worker's task** might include:

- Prepare the young person for this in advance; explain that this is often the most likely outcome;
- Assist the young person to reframe experience;
- Assist the young person to identify 'lessons learned' from the (re-)lapse;
- Assist the young person to distinguish between a *'lapse'* and *'relapse'*;
- Help minimize harm from (re-)lapse;
- Support the young person to renew resolution for change;
- Support the young person to identify and try different strategies.

Some useful questions:

- *Was there anything that worked for a while?*
- *Why do you think it worked for a while?*
- *What happened that made it difficult to keep change happening?*
- *What did you learn from this?*
- *Did you think of some other ways of maintaining the change?*
- *What happened to make these not work for you?*
- *What did you learn from this?*
- *Let's try to think of some things that you might try to see if you can get things moving again so that you are more in control of your life. Let's make a list.*
- *Can you break these things you have identified into smaller, achievable steps?*
- *Is there anything that I can do to assist you?*

2.6. The maintenance stage

The person at this stage is usually abstaining from substance use and wants to remain that way. You need to help the individual develop a healthy lifestyle, which might include moving to a community where drugs are less prevalent, finding activities that keep him or her off the streets and away from users and dealers, and spending free time with only non-users. Most importantly, individuals at this stage must learn to monitor themselves and recognize when they are entering into risky situations. It is very difficult for young people and older ones too, to maintain the change. The drugs were helpful to them in many ways, but they also brought them numerous problems. They may grieve the loss of the drugs, like the death of a good friend. It is important for the worker to keep in mind why the young person used drugs in the past and what they are missing (such as, pleasant hallucinations or feeling good) or what they need to cope with the absence of drugs (such as, painful memories of abuse, anxiety or depression). How do you help? Understand his/her feelings, what they could be missing and be as supportive as possible.

Some **appropriate responses** would be to:

- *Continue to be supportive;*
- *Reinforce gains, don't assume all is lost if there is a lapse;*
- *Keep the person connected to services;*
- *Bring him/her back in for a "top up" or full intervention;*
- *Encourage him/her to access other appropriate services.*

Some useful questions:

- *Congratulations!! What do you think is working to keep you in control of your life?*
- *Is there anything you can think of that could help to make it better for you?*
- *What else would help?*
- *Can you break these things you have identified into smaller, achievable steps?*

2.7. Summary:

- The **process of change is a continuum** as substance users move from one stage to another.
- At the **pre-contemplation** stage the user is not considering giving up substance use and dependence.
- During the **contemplation stage** the user begins to think about doing something about substance use.
- When the **action stage** occurs, the user attempts to quit, or reduce the intake of substances.
- At the **lapse stage**, after trying hard to give up substance use, most users tend to resume use and this should be seen as part of the change process.
- At the **maintenance stage**, the substance user has usually succeeded in giving up the reliance on substance and wants to remain that way.

3. Tools and motivational interviewing

3.1. Good things and less good things about substance use

Using a table, such as the one below, can be helpful in assisting young people explore their substance use and to identify issues that could become a focus of their treatment.

Good things about USING Drugs	Less good things about USING Drugs
Good things about NOT USING Drugs	**Less good things about NOT USING Drugs**

3.2. The following scales can assist young people "visualize" where they are up to in thinking about change, they come from WHO (2003) materials:

3.2.1. Importance

A simple way to find out how important the client thinks it is to reduce their substance use is to use the "readiness ruler". This is just a scale with gradations from 0 to 10, where 0 is not at all important and 10 is extremely important. Clients can be asked to rate how important it is for them to change their substance use.

"The Readiness Ruler"

"How important is to you to cut down or stop your substance use?
On a scale of 0 to 10, where 0 is not at all important and 10 is extremely important, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10
	Not at all important								Extremely important	

The readiness ruler can be used at the beginning of a brief intervention to help target the intervention at the appropriate stage of change or it can be used during the intervention as a way of encouraging the client to talk about reasons for change.

3.2.2. Confidence

The same sort of scale can also be used to assess how confident clients are that they are able to cut down or stop their substance use. The confidence ruler can be used with clients who have indicated that it is important for them to make a change or it can be used as a hypothetical question to encourage clients to talk about how they would go about making a change.

"The Confidence Ruler"

"How confident are you that you could cut down or stop your substance use if you decided to do it? On a scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10
	Not at all important								Extremely important	

It is not necessary to actually show the client a ruler, but it may be helpful, especially for clients with low literacy and numeracy. For some clients it may be enough to just describe the scale using words like those in the examples given above.

4. Components of brief interventions that work

Often, there is limited time available to assist a young substance user. However, there are brief interventions that have been developed to use when time is limited. This section is from WHO and has been adapted [WHO (2003) *Brief Intervention for Substance Use: a Manual for use in Primary Care* (Draft Version 1.1). Downloadable from website: http://www.who.int/substance_abuse/activities/assist/en/index.html]. The research into effective brief interventions for substance use has found that they include a number of consistent features which appear to contribute to their effectiveness. These have been summarized using the acronym **FRAMES: Feedback, Responsibility, Advice, Menu of options, Empathy and Self efficacy** (confidence for change). A number of these features (empathy, self efficacy, responsibility and menu of options) are also associated with **motivational interviewing** (see below) which is a style of intervention aimed at helping people move through the stages of change.

4.1. 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;
- 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.

4.2. Motivational interviewing

Motivational interviewing 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 stages of change. It is especially useful when working with clients in the pre-contemplation and contemplation stages, but the principles and skills are important at all stages.

Motivational interviewing is based on the understanding that:

- Effective treatment assists a natural process of change;
- Motivation for change occurs in the context of a relationship between the client and the therapist; and
- The style and spirit of an intervention is important in how well it works, in particular, an empathic style is associated with improved treatment outcomes.

4.2.1. Principles of motivational interviewing

Express empathy

In the clinical situation empathy involves an accepting, non judgemental 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. Skilful reflective listening which clarifies and amplifies the person's own experience and meaning is a fundamental part of expressing empathy. The empathy of the health 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 substance use behaviour when they see a difference or discrepancy between their current substance 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)

As discussed above, clients need to believe that reducing or stopping their substance use is important and be confident that they are able to do so. Using negotiation and confidence building to persuade clients that there is something that they can do is an important part of motivational interviewing. The therapist's belief in the client's ability to change their behaviour is also important and can become a self fulfilling prophecy.

5. Specific skills

Motivational interviewing makes use of five specific skills. These skills are used together to encourage clients 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 substance use behaviour.

5.1. *OARS*

Open ended questions

Open ended questions are questions which 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 substance use?"*
- *"Tell me about the not so good things about using…(drug)?"*
- *"You seem to have some concerns about your substance 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 substance 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 about …..I 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 substance use."*
- *"You would like to cut down your substance use at parties."*
- *"You really enjoy your substance 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."

5.2. 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 substance use?"*
  - *"What do you think will happen if you don't make any changes?"*
  - *"What would be the good things about cutting down your substance 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 substance use?"*
  - *"What are you thinking about your substance 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 cocaine 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 substance use. For example, ask:
  - *"What are the most important things in your life?"*

5.3. Feedback of assessment results

A simple and effective way of giving feedback which takes account of the client's existing knowledge and interest, and is respectful of their right to choose what to do with the information involves three steps:
Elicit – Provide – Elicit.

- **Elicit** readiness/interest for information. i.e.: ask the client what they already know and what they are interested in knowing. It may also be helpful to remind the client that what they do with the information is their responsibility.
  - *"Would you like to see the results of the questionnaire you completed? What you do with this information is up to you."*
  - *"What do you know about the effects of amphetamines on your mood?"*

- **Provide** feedback in a neutral and non-judgemental manner.
  - *"Your use of cannabis is higher than average, which means that you are at risk of experiencing health and other problems related to your cannabis use at your current levels."*
  - *"Amphetamines affect the chemicals in your brain that regulate mood and regular use can make you feel depressed, anxious and in some people angry and violent."*

- **Elicit** personal interpretation. i.e.: ask the client what they think about the information and what they would like to do. You can do this by asking one of the following key questions:
  - *"How do you feel about that?"*
  - *"Where do we go from here?"*
  - *"What would you like to do about that?"*
  - *"How concerned are you by this?"*
  - *"What concerns you most?"*

6. Brief intervention with moderate risk users

People whose score for any substance indicates moderate risk of substance related problems should be offered a brief intervention. Brief interventions should be flexible and take account of the client's level of risk, specific problems, and readiness to change, as well as the time available. If it seems appropriate you can ask the client to come back for a further appointment to discuss their substance use in more detail. This may occur if time is short, or if you are particularly concerned about the client's substance use and related problems, or if the client really wants to do something about their substance use. If necessary, the intervention could be implemented over a number of consultations.

The main components of a brief intervention are:

- Provide feedback (FRAMES) of results and risk levels. Discuss the meaning of the results and link to the specific problems listed.

- Provide clear advice (FRAMES) that the best way to reduce the risk of substance related problems is to cut down or stop substance use. At the same time it is important to emphasize that the client is responsible (FRAMES) for their own substance use behaviour.
  - *"The best way to reduce your risk of experiencing these problems is to cut down or stop your substance use but nobody else can make that decision for you. It is up to you to decide. If it is alright with you I'd like to talk with you about that"*

- Take a brief history of substance use over the past week.

- Discuss perceived benefits of substance use:
  - *"What are the good things about using…(substance)?"*

- Discuss negative consequences of substance use.
  - *"Can you tell me about some of the less good aspects of using… (substance)?"*

- Encourage the client to consider both long term and short term consequences. Refer back to the problems listed. If the presenting

complaint, or a problem in the medical history may be related to substance use, it is important to discuss this with the client, and refer them for a full medical examination.

- Encourage the client to weigh up the positives and negatives. You can use the decision balance or the table of benefits and costs to help the client think about this.

- Discuss the client's level of concern about their substance use. You can use the importance ruler to help the client show you how important they believe it is to change their substance use.

If the client is not concerned about their substance use, or is not ready to consider change (pre-contemplator):

- Provide relevant written information about the specific substances they use, and available services in their area.
- Invite them to return to discuss their substance use if they become concerned at any time in the future.
- End the current session. Review substance use whenever they return to see you about other health problems.

7. Choosing the substance of most concern

Some clients will have substance use scores indicating hazardous or harmful use of more than one substance. A sub-group of these clients may also be injecting one or more types of drug. For these clients it may be necessary to choose one substance only to be the focus of the intervention. Trying to change a number of behaviours at the same time can be difficult and may lead to the client feeling overwhelmed and discouraged. It is better to focus on one behaviour at a time. Clients will be more likely to respond to an intervention if they are involved in choosing which substance is of greatest concern to them. It is likely that the substance of most concern will be the substance that is being injected (where relevant) and the substance for which they have received the highest score, however, some clients may be more concerned about a lower scoring substance. The intervention should therefore focus on either:

- The substance with the highest Score*, or*
- The substance of most concern to the client*, or*
- The substance that is being used intravenously.

What to do with high risk users or frequent injectors

Clients who have been injecting drugs regularly over the last three months and/or whose scores are in the high risk range for any substance may require more intensive treatment. This may take the form of treatment within the primary care agency, such as pharmacotherapy or on-going counselling, or may be referral to a specialist drug and alcohol treatment agency if available.

Some clients who are at high risk may not be concerned about their substance use or may not be willing to accept intensive, higher-level treatment. Elements of the brief intervention may be used to motivate such clients to accept further treatment.

- Provide feedback of results and risk levels. Discuss the meaning of the results and link to the specific problems, and the "*Risks of Injecting*" if relevant.
- Provide clear advice that the best way to reduce the risk of substance related problems and to manage existing problems is to cut down or stop substance use. If the client has tried unsuccessfully to cut down or stop their substance use in the past, discuss these past attempts. This may help the client understand that they may need treatment to change their substance use.
- Link the results to specific problems the client is already experiencing.
- Take a brief history of drug use over the past week.
- Encourage the client to weigh up the positives and negatives. You can use the decision balance or the table of benefits and costs to help the client think about this. Asking open ended questions is also an effective technique:

    - *"Tell me about the good things about using…(substance)".*
    - *"Can you tell me about some of the less good things about using …(substance)?"*

- Encourage the client to consider both long term and short term consequences.
- Discuss the client's level of concern about their drug use. You can use the importance ruler to help the client show you how important they believe it is to change their substance use.
- Provide information about what is involved in treatment and how to access treatment.
- Provide encouragement and reassurance about the effectiveness of treatment.
- Provide written materials on problem substances and strategies for reducing use. For example, the harm reduction materials from PSI, Kunming, which are included at the end of Section Seven.

Review and monitor all clients, whether they agree to more intensive treatment or not, whenever they return to see you about other health problems. Invite them to make an appointment to come back and talk to you about substance use at any time.

The following two examples demonstrate brief interventions for problematic cannabis use. The first is for Zhong who has started to develop problems with cannabis, and is a very short intervention (only about 3 minutes). The second is for Minh who has been using cannabis regularly, which is a brief but slightly longer intervention (just over 5 minutes).

A BRIEF INTERVENTION FOR PROBLEMATIC CANNABIS USE – <u>Feedback and advice only ~ 3 minutes</u>

Zhong has been doing well, but now has developed problematic cannabis use.

After completion of the assessment questionnaire with Y, Zhong, an 18-year-old man who lives with his family, has scores in the low risk range for all substances except cannabis. His score for cannabis places him in the moderate risk category. FRAMES Techniques and Motivational Interviewing strategies used are in red in brackets at the end of sentences.

Y: OK, thanks for going through this questionnaire with me (affirmation). Would it be fair to say that cannabis is the drug that you use the most at the moment?

Zhong: Yeah, pretty much.

Y: How much would you smoke, say, on an average day after work? (Taking brief history)

Zhong: Um, usually about 3 or 4 'cones' (amount of cannabis used to use in bong or water pipe) throughout the evening, maybe a bit more on the weekends.

Y: Would you like to see the results of the questionnaire that you did? (Elicit)

Zhong: Yes.

Y: If you remember, the questions asked about your drug and alcohol use and whether you have experienced any problems related to your substance use. It really is up to you what you would like to do with this information. (Responsibility)

From your answers it appears that your scores for most of the substances we asked about are in the low risk range so you may not have any problems from those substances if you keep on with your current pattern of use. However, your score for cannabis was high, which means that you are at risk of experiencing health and other problems related to your cannabis use by smoking cannabis at your current levels. (Provide feedback)

(*tells the client:* Some of the problems that are caused by risky use of cannabis are – problems with attention and motivation, anxiety, feeling depressed, panic, paranoia, decreased memory and problem solving ability, high blood pressure, asthma and bronchitis, heart disease and lung disease. (Provide advice)

Y: How concerned are you about cannabis affecting you? (Open ended question, elicit self motivating statement)

Zhong: Yeah…I don't know, I never thought about it…..I mean…. I suppose it is a bit worrying that it could cause all these problems. I don't know. (Dissonance)

Y: Can I give you some pamphlets about using cannabis that you can take home with you? They just explain more about the effects that cannabis can have and provide information about how to cut down, if that's what you want to do (hands Zhong written materials). Have a read, and if you want to talk about it more I'm happy to talk to you about it at our next appointment (Menu, written advice). And you could talk with one of our peer educators.

Zhong: Ah….OK….thanks…I'll have a think about it.

If the client is concerned or is ready to consider change (**contemplator**) then further intervention should be offered. Key components of this intervention could include:

- Further feedback linking substance use with current and potential health problems.
- Further discussion aimed at eliciting change talk.
- Discuss the client's level of confidence that they can change their substance use if they want to. Use the confidence ruler to help the client tell you how confident they feel. If confidence is low, encourage the client to tell you about other changes they have made or the personal qualities which would help them to make changes in their substance use.
- Discuss specific options to assist change (Menu of options).

  Examples include:

  o Keep a diary of substance use including:
    - Time and place of using;
    - Other people present when using;
    - What substances were used, and how much;
    - How much money was spent;
    - Identify high risk situations and strategies to avoid them or to reduce use in those situations;
    - Identify other activities instead of drug use.

- Help the client decide on their goals.
- Encourage the client to identify people who could provide support and help for the changes they want to make.
- Provide self help resources and written information to reinforce what has been discussed in the consultation.
- Invite the client to return to discuss their substance use if they need further help or information. Review how they are going with changing their substance use whenever they return to see you about other health problems.

A BRIEF INTERVENTION FOR PROBLEMATIC CANNABIS USE – <u>Feedback and exploring pros and cons of use ~ 5 minutes</u>

After completion of assessment questionnaire with Y, Minh, who is now an 18-year-old man who lives with his girlfriend and their young child, has scored low risk for all substances, with the exception of cannabis, placing him in the moderate risk category.

FRAMES Techniques and Motivational Interviewing strategies used are in red in brackets at end of sentences.

Y: OK, thanks for going through this questionnaire with me. Would it be fair to say that cannabis is the drug that you use the most at the moment? (Affirmation)

Minh: Yeah, pretty much.

Y: What do you enjoy about using cannabis – I mean what are the good things about it? (Open ended question – exploring pros and cons)

Minh: Well, it makes me relax, especially after coming home from work. It really helps me to unwind and forget the day. It's also good when you're out with mates or at a party or something on the weekend because you enjoy yourself more.

Y: How much would you smoke, say, on an average day after work? (Taking brief history)

Minh: Um, usually about 3 or 4 cones (amount of cannabis used to use in bong or water pipe) throughout the evening.

Y: Would that be the amount you'd usually use on the weekends? (Taking brief history)

Minh: Yeah…probably a bit more actually…maybe 5 or 6, I don't know, sometimes I lose track (laughs).

Y: What are the less good things about using cannabis? (Open ended question – exploring pros and cons)

Minh: Ask my girlfriend – she always nagging me about it (laughs). I guess probably the worst thing about it for me is that it seems to affect my memory and concentration at work. Sometimes after a big binge session the night before, the next day at work I'm a bit hazy and I feel really tired. If I feel really bad sometimes I won't go into work that day.

Y: So smoking dope (cannabis) helps you to relax and unwind after work, but it also makes you forgetful and tired, and sometimes you miss work because of it. You also said your girlfriend doesn't like you using it – why do you think that is? (Reflective listening, refocus, open ended question)

Minh: She doesn't like me getting 'stoned' all the time because she says I don't do anything except sit around and watch TV and that I'm always forgetting to do stuff. She says I don't do enough around the house and that she's always left to do all the work and look after the baby. But, I mean, I work and bring home a wage every week….

Y: And it's hard for you because using cannabis helps you relax, but at the same time you're not lending a hand around the house because you're 'stoned 'and sometimes you forget to do things that she is relying on you to do. (Summary, empathy)

Minh: Yeah.

Y: Would you like to see the results of the questionnaire that you did? (Elicit)

Minh: Yes.

Y: If you remember, the questions asked about your drug and alcohol use and whether you have experienced any problems related to your substance use. It really is up to you what you would like to do with this information. (Responsibility)

From your answers it appears that your scores for most of the substances we asked about are in the low risk range, so you are unlikely to have any problems from those substances if you keep on with your current pattern of use. However, your score for cannabis was high, which means that you are at risk of experiencing health and other problems related to your cannabis use by smoking it at your current levels. (Provide feedback)

[Tells the client some of the problems that are caused by risky use of cannabis – problems with attention and motivation, anxiety, dysphoria, panic, paranoia, decreased memory and problem solving ability, high blood pressure, asthma and bronchitis, heart disease and lung disease.] (Provide advice)

You said you've experienced some of these problems with your memory and concentration and motivation……..

Minh: (interrupts) yeah, but that could be because I'm always tired because I don't always sleep well if the baby cries at night. (Resistance)

Y: So it seems to you that the only reason you're forgetting things and finding it hard to concentrate and help your girlfriend after work is because you don't get enough sleep? (Roll with resistance – amplified reflection)

Minh: Well, that's part of it anyway. I guess part of it could be from using cannabis too much. (Ambivalence)

Y: How concerned are you about the way using cannabis affects you? (Open ended question, elicit self-motivating statement of concern)

Minh: Yeah…I don't know…..I mean….I suppose it is a bit worrying that it's doing this to my brain…I don't know. (Dissonance)

Y: Listen Minh, you do have many options available, and it's up to you to decide what is best for you. Can I give you some pamphlets about smoking dope that you can take home with you? They just explain more about the effects that cannabis can have and provide information about how to cut down, if that's what you decide to do (hands Minh written materials). If you want we could talk about your options more at another time. (written advice, menu, emphasis on personal choice and control). And maybe you could talk with one of the peer educators.

Minh: Ah….OK….thanks…I'll have a think about it.
(A longer session could focus on the importance of the relationship between Minh. and his girlfriend and child)

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION FOUR

Individual Counselling

United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Four

Individual Counselling 5

1. **Individual counselling** 6
2. **Overview of a counselling protocol** 19
3. **Probable challenges when counselling adolescents in decision making** 26
4. **Solution-oriented brief therapy** 27
5. **Referral** 31
6. **Life skills** 33


A TOOL KIT

Section Four

Individual Counselling

This section overviews important elements on individual counselling and provides some examples of how to deliver counselling interventions. It concludes with a brief overview of solution focussed interventions.

1. Individual counselling

The material for this section comes from three main sources: Ministry of Health, Jamaica (2004), UNDCP (2000) and training materials provided by Mr. Mika Niskanen (2005), with some adaptations.

As mentioned in Sections One and Two, in compulsory residential treatment facilities 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 counselling relationship.

1.1. The drug counsellor's art

[Adapted from UNDCP (2000), with amendments]

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

- Relationship building;
- Assessing the problem;
- Addressing the problem.

The helping process can be characterized as comprising three major phases. Each of these phases has distinct objectives. While you may use some of the same skills and processes in all phases, each phase has distinct objectives.

1.2. Three major phases of counselling:

Phase I: Exploration, Assessment and Planning
Your main objectives in the first phase are to understand the client as a whole person, not merely as a complex of problems, to plan your intervention, and to work out an agreement with the client.

Phase II: Rehabilitation Counselling and Goal Attainment
Your objectives in this phase are to initiate and implement your treatment plan in cooperation with the client.

Phase III: Termination and Evaluation
The objectives in the final phase are to conclude treatment and discuss its outcome with the client, and to work out agreement on future action with the client. As a counsellor, you need to be committed to a set of principles that can guide the way that you treat your clients.

1.3. Principles of counselling

1. ***Individualization:*** it is your recognition and understanding of each client's unique qualities. Individualization is based upon the right of human beings to be individuals.

2. ***Purposeful expression of feelings:*** your recognition of the client's need to express his/her feelings freely without being discouraged or condemned.

3. ***Controlled emotional involvement*:** the counsellor's sensitivity to the client's feelings, an understanding of their meaning and a response to the client's feelings.

4. ***Acceptance:*** the counsellor perceives and deals with the client as he 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:*** your practical recognition of the client's right and need to freedom in making his 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.

1.4. Counsellor Attitude

Personal qualities for successful counsellors include:

- **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.

1.5. Counselling micro skills

[Adapted from Ministry of Health, Jamaica (2004)]

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

(a) **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.

(b) **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:

i. **Non-verbal responses** – Eye contact, appropriate facial expression, nodding;
ii. **Encouragers** – "Mm-hm", "OK", "Really", used in a non-judgemental manner;
iii. **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";
iv. **Summarizing** – Briefly feeding back in your own words the salient features in the client's story;
v. **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;
vi. **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.

(c) **Giving feedback:** Feedback involves providing the adolescents with information about what they have previously stated and serves several purposes. Forms of feedback include:

i. **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;

ii. **Making affirmation** – This is when the counsellor 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;

iv. **Reframing** – Adolescents tend to view their situations from a very short-sighted 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?"

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 issues or problem and the counsellor perceives that the adolescent needs to be encouraged to move on to other issues of 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.

1.6. Inventory of counsellor's non-verbal communication

[Adapted from UNDCP (2000), with amendments]

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

Desirable	Undesirable
Facial expression. 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.	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 Arms and hands moderately appropriate gestures. Body leaning slightly forward, attentive but relaxed.	Rigid body positions, arms tightly expressive, 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 One to two metres between your chairs.	Excessive closeness or distance.
Voice Clearly audible but not loud. Warmth in tone of voice; voice modulated to reflect feelings of concern, approval, etc. Moderate speech tempo.	Mumbling; speaking inaudibly. Monotone voice; frequent grammatical errors Prolonged silences, nervous laughter, speaking loudly.

1.7. Setting Goals

[Adapted from UNDCP (2000), with amendments]

Goals specify what the client wishes to accomplish or change, based on the wants and needs which you have helped to identify.

Goals such as the following assist in the helping process:

- To make sure that you and the client are in agreement about objectives to be achieved;
- To provide direction and continuity in the helping process;
- To facilitate the development and selection of appropriate strategies and interventions;
- To assist you and your client to monitor their progress;
- To help you and the client to evaluate the effectiveness of specific interventions and of the helping process.

Goals may be categorized in a broad sense as 'discrete' or 'ongoing'. Discrete goals are one time actions or changes that address problems. An example may be obtaining a needed resource (e.g., medical treatment). Ongoing goals, by contrast, involve actions that are continuous and repetitive. Progress towards such goals is step-by-step. Examples of ongoing goals include managing conflict effectively, for example avoiding the use of force or violence (mood management, with a focus on anger).

1.8. Guidelines for selecting and defining goals

Goals should be selected and defined with care. Below are some guidelines for goal selection that you can use with your clients:

- 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;
- Goals should be consistent with the functions and mission of your group or agency.

The easier goals should be addressed first. This allows the client to feel success, which builds confidence and motivation.

1.9. Process of mutually selecting and defining goals with the client

- Determine your client's readiness to negotiate goals;
- Explain to your client the purpose of selecting and defining goals;
- Select appropriate goals mutually;
- Define the goals explicitly;
- Determine the feasibility of goals and discuss their potential benefits and risks;
- Assist your client to make a choice about committing himself/herself to specific goals;
- Rank goals according to your client's priorities and according to the nature of the goals.

1.10. Breaking down large goals into smaller steps

The first task in developing strategies to attain goals is to reduce them to manageable parts. These parts consist of discrete actions to be undertaken by the client. 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.

1.11. 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;
- To work together in identifying problems and employing problem solving strategies.

1.12. Formulating tasks

After having begun work on sub-goals, the next step is to help your client develop the means for reaching them. This involves mutually planning the tasks or actions that the client needs to accomplish to attain each sub-goal. Tasks may consist of changes in thought or actions that require effort on the client's part. An example of an active task: "To talk about feelings of hurt to a significant person in your life". An example of a thinking task: "To meditate for thirty minutes daily or to recognize your angry feelings before they get out of control".

After agreeing on one or more tasks, your next step is to assist your client in preparing to do each task. To do this, it is useful to:

- Enhance the clients' commitment to carry out a specific task by asking him/her to repeat the task out loud and promise to do it;
- Plan the details of carrying out the task;
- Analyze and resolve obstacles that the client expects to face;
- Ask the client to rehearse or practice the behaviours involved in carrying out the task;
- Summarize the plan of task implementation. Offer encouragement and express your expectation that the client will carry out the task;
- Determine a time-frame to perform the task.

1.13. How to develop the client's confidence and ability to change

One of the counsellor's major tasks is the attempt to create an incentive for change. Although many clients know what their problems are and have a real desire to change, they may lack the confidence to try. The capacity to hope is essential for the young client in treatment; it is part of your job to revive, instil and foster this precious feeling in your client.

Small victories are very important. Identify small changes that the client can make in his/her life that will have a positive impact, increase their comfort, security and sense of self-worth. Look for the smallest signs of hidden strength, latent goodness or buried desire for approval and acceptance in your clients. These are the young person's hidden inner resources, out of which new self-esteem can grow.

To inspire the client to seek change, you need to communicate your own hope, respect and confidence in the client's basic potential and dignity. You need to have faith that you can help them deal effectively with their problems.

You can also help the client to see and understand how their habits of thinking may be preventing them from changing. Young substance users typically convince themselves that they are victims of forces beyond their control. The drugs are 'too powerful,' everything happens to them, they have no control to change their situation. By helping the client to tell their stories, you can help them recall how they may have shown personal strength in the past. You can help regain confidence in their ability to change.

Acknowledge that his/her drug-taking may have been an attempt to take care of himself/herself in very difficult circumstances, while pointing out that this has had negative consequences for him/her. Self-knowledge is liberating.

1.14. Counselling strategies

[Adapted from Ministry of Health, Jamaica (2004), with amendments]

Counselling strategies are used to enhance the counselling process. Some strategies used in this counselling protocol are discussed below.

1. **Identification of the problem**
   Using the various counselling techniques described above (counsellor attitude and skills), the counsellor is able to, with the young person, identify the problems that may be influencing the young person's substance use decision-making and subsequent behaviour.

2. **Observation of behaviour**
   The counsellor should be very observant of the young person's behaviours throughout the counselling session in order to reflect feelings to the young person. The young person can also be encouraged to observe his/her own behaviour via the use of a diary or journal.

3. **Psycho education**
   The counsellor should share relevant knowledge and experiences with the young person in order for them to integrate useful information into his/her own body of knowledge.

4. **Identifying personal triggers**
   A trigger is an activating event that leads to something else. The counsellor is encouraged to explore with the young person what the triggers are as it relates to him/her being in a potentially risky situation. Recognition of these triggers becomes important to the young person as he/she seeks to avoid or manage possible risk situations.

5. **Finding more appropriate ways to get needs met**
   The counsellor needs to guide the young person through exploring how he/she can meet his/her personal needs without becoming the object of another's sexual gratification.

6. **Setting lifestyle goals**
   Lifestyle goals provide a sense of direction for young people as they go through the unforeseen territories of their lives. Goal setting also provide motivation for a young person to maintain goals previously attained. Goals can take several forms including:

   i. **Task oriented goals:** These goals are geared toward meeting material needs or making behavioural changes.
   ii. **Relationship-oriented goals:** These goals are set for the purpose of the young person defining relationships between themselves and others with whom they come in contact.

7. **Role play**
   Role-playing allows for the exploration of several aspects of the self. It can also be a useful skill when making choices and getting at one's feelings and belief's that are not easily verbalized. Role-playing is used to show how a young person could discuss or negotiate sexual decision with a prospective sexual partner.

8. **Making decisions**
   Young people need help to make good sexual decisions and counsellors need to enable them to use available resources to make good decisions. The counsellors also need to teach the young person the skills of healthy sexual decision making and provide them with the information they need to assist them in decision-making. Here are the stages of decision making:

   - Identifying unhelpful decision making response patterns;
   - Exploring risks associated with change or with not changing;
   - Exploring lifestyles goals;
   - Identifying losses involved in choosing;
   - Examining alternatives;
   - Informing others of a decision;
   - Maintaining a commitment to a decision.

9. **Negotiation skills**
   Negotiation is a useful skill in trying to achieve one's desired outcome. It is exceptionally useful for young people to optimize this skill. Important issues are as follows:

   - Be clear and state the reasons why you want to do the desired behaviour;
   - Identify rebuttals/responses to your friend's or prospective partner's anticipated response;
   - Shift the focus of the discussion towards yourself and your feelings, beliefs, intentions, etc.;
   - Establish what behaviours you just definitely will not accept (refusals).

2. Overview of a counselling protocol

[Adapted from Ministry of Health, Jamaica (2004), with amendments]

A Typical Counselling Session:

Introduction to Counselling – Time: 1-2 minutes	
Tasks	Questions and Comments/pointers
Greet the client with respect and introduce yourself to the client.	Hello, my name is _____. Are you comfortable enough here (e.g., in this room)? Do you need some water or anything else to help you be comfortable? Did you decide to come here today or has someone suggested or pushed you into coming? Today we are going to be talking about things that might have led you to use drugs and ideas that might assist you to make wise decisions. *[If the young person has been referred by someone else who provided you with some information, you might say:* I have here the summary of your assessment by "X" and would like to review it later with you and we might just go through it to make sure you know what I have been given by X (person who did the assessment if not you).*]*

Outline role as counsellor	I am a counsellor/peer educator and my role is to try to assist you make wise or sensible choices in your life. You have probably made many sensible decisions, and some that may have not been so sensible. Have you got any questions for me before we start? This session will take about 60 minutes.
Explain confidentiality	What we will talk about today will be kept confidential. That means that your personal information will not be discussed with anyone else except those involved directly in your care. However, there may be some circumstances that may require that I break this confidence and some could include situations that cause me to feel that you have been harmed or were likely to harm yourself or someone else.
Address questions and concerns	Before we go any further, do you have any concerns or questions that you need to talk about right now?

Assessing Client Understanding of Drug Use and Risk – Time: 10 minutes	
Tasks	Questions and Comments/pointers
Introduction	In order for us to explore the things that affect your decision-making later in the session, we might start by talking about drug use and any risks young people might take when using them. What do you consider risky behaviour to be?
Explore drug use decisions	Substance use decisions are choices that you make that affect your life. Can you think of some ways drug use can be a risky activity?
Explore leading risk behaviours	Leading risk behaviours are those behaviours that may lead to greater risk.
Ascertain client's understanding of substance use and risk	When you think about drugs, could you describe the different ways that people use them (e.g., smoking, inhaling, injecting)? Do you think that any of these types of substance use activity are risky? Are some more risky than others? Why do you view these as risky?

Clarify client's perception of risky drug use behaviour and consequences	What do you think could result from risky drug use?
Examine client's understanding of prevention (overdose, arrest, school/ employment difficulties, pregnancy, HIV and other STIs)	What could you do to reduce your risk of negative consequences of drug use? OK, we will come back to this later.

Exploring Possible Influences on Decision Making – Time: 10 minutes	
Tasks	Questions and Comments/pointers
Introduction	Could you think of any things that may influence you to make decisions?
Discuss how peer influence affects decision-making	How does what your friends think and say about you affect your decision to engage in drug use activity? How does this make you feel? In what ways do you think you try to resist these pressures?
Discuss how the desire for fun influences drug use decision-making	How would wanting to have fun affect your decision to use drugs?
Explore inability to say no to drug use	How would you refuse an offer to use drugs? How would you feel about saying no? Later we can talk about ways to help you say no and not make your friends too angry at you.

Summarize issues/factors that affect client's drug use decision-making	We have talked a lot, now let me just summarize what I hear you say about what would affect your decision to use drugs and maybe have unsafe sex.

Identifying and Exploring Risky Situations – Time: 15 minutes	
Tasks	Questions and Comments/pointers
Assess the client's reason(s) for accessing service	Now we have been talking a lot about other young people. Let's now talk more about you. You mentioned before that you came here today because of….. could you tell me any other reasons that brought you here today? Let me review what X has told me about you, and we can check whether you think that it is correct. *Review assessment, if one is done, or referral information made available to you.*
Identify previous drug use decisions	Let's discuss some of the drug use decisions that you have made. Can you tell me about a recent time when you used a drug or more than one drug? What were you doing before you used the drug? How did you make the decision to use? How did you use the drug? Were there others there when you used? Was that typical of your drug use/how you use drugs? If not, what would be a more typical/usual example?
Identify positive/ healthy decisions	Can you tell me about any times in the past when you did not use a drug when you could have, or resisted the temptation to try to get drugs? Can you tell me about any times when you did use a drug, but you tried to make sure that there were not many risks, such as infection, STIs, crime, etc.?
Explore concerns about previous decisions	Now that we have had a chance to talk for a while, how do you feel about these decisions that you made in the past about drug use?

Explore client's view of risky outcomes	What would you consider a risky outcome for you? Can you identify any risks for you during the time of using the drug(s) you just told me about? I am curious to know what you think about these risks. Can you think of other behaviours that you have engaged in that could put you at risk?
Explore the frequency of risky situations and the potential for negative consequences	Tell me about the last time that you may have put yourself at risk. How often would you say that you are at risk?
Assess the client's perceptions of potential risk	How concerned are you that you could have been at risk? Would you have engaged in the behaviour if you knew that you could be at risk? If yes, why?
Identify risky situations or outcomes	Let's talk about how you can begin to identify possible risk situations before they occur?
Summarize and link current issues to previous ones	Let's sum up what may have influenced your drug use decisions and therefore put you at risk.

Risk Reduction – Time: 25 minutes	
Tasks	Questions and Comments/pointers
Explore risk reduction options	What would be your best options to reduce risk of negative outcomes?
Identify successful experiences with risk reduction	Can you think of a time when you were able to reduce your risk? Can you tell me about that time? How was that for you?
Identify obstacles to risk reduction	What have you found most difficult when trying to reduce your risk of …?

Explore situations that increase the likelihood of high-risk substance use behaviour (Triggers)	Are there times when you think you are more likely to find yourself in a risky situation? Could you tell me about that? In what particular situations or in whose company do you find it difficult to avoid risk?
Introduce and/or develop negotiation skills	Effective negotiation can help to reduce your risk. Do you know what "negotiation" means? If not explain in simple language. You can use negotiation skills in several ways. What do you think may be involved in good negotiation? Could you tell me why you think not using or reducing your drug use could be good for your health? How might your friends respond to *(summarize what client stated as reasons to abstain/reduce use?)* How will you deal with that *(feedback client's friend's response)?*
Introduce and/or demonstrate safer IDU – <u>if necessary and appropriate/ permitted</u>	Since we have spoken about safer injecting drug use, would you like me now to demonstrate this? *(Demonstrate to client safer us – without actually injecting, or show a picture guide)* Where would you be able to get clean/sterile injection equipment when you need some? *(give the client information about other resources in the community).* Now what about safe sex? Do you use condoms? How often? Are there any problems in making sure they are effective at preventing an unwanted pregnancy and getting a STI? *Give client information on appropriate condom use. For young women, give any necessary advice about other methods of contraception and referrals as appropriate.* Where are you able to get condoms for free or for not much money? *(give the client information about other resources in the community).*

Use role-play to develop refusal and problem solving skills	What do you understand by refusal skills – saying "no"? Tell me your feelings about refusing someone's (boyfriend/girlfriend, family member, friend, older person) suggestion for you to use drugs, and how they may react to your refusal. How would you handle this? Let's role-play your refusal skills. Let's imagine that you are the person pressuring you to use drugs. Now try to get me to use drugs and I will respond to you. *(Role play)* Now let's switch roles. You will be you, and I will be the person who wants you to use drugs. How did you think the role-plays went? What was positive about it? What could have been done better?
Explore ways of coping with emotional influencing factors	We discussed how emotional factors such as *(feedback relevant information about emotional issues that client stated in previous section)* affects your drug use decision making. How do you feel you could effectively manage these factors?
Other triggers to drug use	Can you think of other "triggers" for you to use drugs? Let's discuss them one by one and build up a list of them, and quickly explore some things you could do to resist them. *Draw up list.*
Summarize risk reduction options/ discussions	You have a lot of choices to help you make safer drug use decisions and therefore lower or eliminate your risks. During our conversation, I have been writing down on this paper some of the choices that you seem comfortable with. Let's write down your risk reduction plan on this form so you will have a copy of the specific details of your risk reduction plan. Set some simple homework tasks – *e.g., review list and add to it, and practice ONE of the strategies you have discussed or role-played.*

Concluding	It has been great talking with you today. You certainly seem to know a lot about risky behaviour. I know it seems to have been hard for you to deal with the difficulties you have been experiencing lately. I hope our talking has been of some help and that you will try the "homework", and that we will review it next time we meet so we can work out what worked for you, and what did not. We are all different and what works for one person might not for someone else. When would be good for you to come back to see me? How about… Remember to use your supports, like X, Y and Z (e.g., peer educators, friends) – you don't have to be alone with this. Are you feeling OK about leaving now, or do you want to just spend some time by yourself or with some other young people before you go?

3. Probable challenges when counselling adolescents in decision making

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 and sex** – 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.

4. Solution-oriented brief therapy

[Adapted from Mika Nishkanen (2005)]

PRINCIPLES

The client has a lot of **potential**, and humans have a natural tendency for **good and growth**.
The focus of talk is on **solutions**, not on problems.
The **client's objectives** are the basis of counselling.
Much interest in "positive exceptions."
Much interest in human relations.
The goal is to get the client to **do something differently** or to **give new meanings** to the problems.
A **small change can be enough** to start a big change process.
This approach aims to give more self-confidence to the client.
This approach aims to prevent anyone to be seen as "the guilty one."

WHAT IS "A SOLUTION"?

A solution is different action, or
A solution is a way to perceive the problem in a different (more positive) way.

SETTING GOALS

"It is easier to progress, when it is clear where you are going."
"Setting goals promotes an idea that the problem does not need to last forever."
"Setting goals promotes **hope** about a positive change and the future."
"Setting clear goals helps to identify what the client can start to do differently."

HOW TO SET GOALS?

"How would you know that the problem has been solved?"
"What is different when the problem has been solved?"
"What will you do differently when the problem has been solved? What else?"
"How would your friend/partner see that the problem has been solved?"
"Which would be signs for you that there has been progress towards the goal?"

WHAT IS A GOOD GOAL LIKE?

Small, **concrete** and practical.
Formulated in a **positive** way.
Reflects what **action** the client will take.
Formulated in the **client's own words**.
Stresses what the **client himself/herself** can do.

"POSITIVE EXCEPTIONS"

"In which situations does the problem **not** exist or it is smaller than usual?" "What do you do differently then?"
- In the past life history?
- Recently (recent 2 weeks)?
- Frequently?
- In the future?

WHY EXAMINE POSITIVE EXCEPTIONS?

To help the client to see that the problem does not always exist.
To help the client to see that he/she already has capacity to affect the situation.
To help the client to see what he/she can do more, and which circumstances help to cope with the problem.
To help to define goals and to set tasks.

ABOUT POSITIVE EXCEPTIONS

Often the client does not see that the problem does not always exist.
Often the client does not see that he/she already has capacity to affect the situation.
"In the future, do more things that already work well!"

WORKING WITH EXCEPTIONS

"How did **you** manage to make this exception?" ("Wooww!")
"What should happen to you so that you would do that again?"
"What happens **between you and your father** when the problem does not exist?"
"How long should the problem stay away so that you would know that it has been solved?"

YES EXCEPTION / NO EXCEPTION

If the client **can give examples**: "Do more of this!"
If the client **can not** give examples: "Examine the positive exceptions during next week(s)!"
"Do something totally different."
"If something does not work/help, do not do that anymore, do something different!"

THE SCALE QUESTION

"Describe the worst situation in the past. Let's name that as 'zero' (0)!"
"Let's name your goal as 'ten' (10)"
"Between 0-10, where are you now?"
"What have you already done to get to 'three'"? "What else?"
"Woowww!"
"What would be different in 'four' (4)?" "What would you do differently?"
"Who/what would help you to get to 'four' (4)?"
"Which number would be **enough** for you?"
"How much **motivation** do you have to get from 'three' (3) to 'five' (5)"?
"How much do you **believe** that you will get from 'three' (3) to 'five' (5)?"

IF THE ANSWER IS "ZERO" (0)

"What gives you **strength** to tolerate this situation?"
"How do you manage to live in this situation? What does it tell about you?"

THE "MIRACLE QUESTION"

"Let's imagine that tonight the problem will disappear. In the morning, **how will you notice** that the problem does not exist anymore?" "What will you **do differently**?" "How will **other people** notice that the problem has gone?"

POSITIVE REFRAMING

Examples:
Client: "I felt so bad about myself that I had to come to see you."
Counsellor: "You have taken a courageous step to start to solve your situation!"

Client: "I am ashamed because I have done wrong and my family feels bad with me".
Counsellor: "You show a lot of responsibility because you want to make the situation better now!"

SETTING TASKS

Tasks reflected in the positive exceptions – "Do more!"
Tasks reflected in the Miracle Question – "Try to act as if the miracle had happened!"
"Observe the positive exceptions during next 1-2 weeks!"
"Change something in your behaviour, milieu or people involved the problem!

CLIENT TYPE 1: "**Visitor**"

Often comes referred by someone
No clear goals or objectives
Often needs more time to get motivated for counselling
- Give positive feedback on what he/she does well
- Normalize
- Show empathy

CLIENT TYPE 2: "**Complainer**"

Admits that there is a problem, but does not want to do anything about it
Does not want to talk about exceptions, talks about problems only
Expects that other people will change things instead of himself/herself ("Victim")
- Show appreciation
- "What in your life do you wish **not** to change?"
- Give more time to become motivated

CLIENT TYPE 3: "**Real Client**"

A clear goal set
Some solutions identified
Understand his/her role in changing things
- Setting tasks
- Giving positive feedback
- Normalizing

5. Referral

[Adapted from UNDCP (2000)]

The recovery of the whole person is complex and can benefit from a large variety of services. No single centre will be able to offer all the most appropriate facilities and cater for all the rehabilitation needs of the young substance user. You have to work with the resources that are available to you. If you have access to other helping services, you will often refer clients to these other services and opportunities.

Over time, you will need to establish links with other organizations, detoxification centres, self-help groups, hospital wards, social welfare centres, religious and spiritual organizations, the probation service, trade schools or vocational training institutions, Alcoholics Anonymous (AA) etc. It is important for you to know where these services are located, who to contact within each and their telephone numbers.

When making a referral, it is a good idea to meet with the service provider if you can in the other centre to discuss the contents of your client's file (with the client's consent). The client must not feel rejected. You need to be sure he/she understands that it is in his/her best interests to be transferred to a specialized service and that appropriate follow-up will be ensured by the Case Manager.

Referring clients to other resources requires careful handling, otherwise clients often do not follow through to reach resources that could be very beneficial to them. The following are guidelines that can help you in making referrals:

- Be clear about the reason why you are considering referral. A referral is an action intended to assist a client solve a specific problem. Therefore, it is important to help the client identify and clarify the problem as he/she sees it. Only then can the counsellor hope to make an appropriate and effective referral;
- Determine which resource best matches the client's needs. To accomplish this, you must be knowledgeable about various helping people and organizations in your community, the quality of their services and any rules or conditions that your client should know

about. It is useful for you to develop your own list of resources and to have personal contact with the responsible officers or helpful individuals in each place;
- You can recommend positive referral options, but you need to respect the client's right to self-determination. He/she may not be ready or willing to seek additional help;
- Avoid making unrealistic promises about what another agency can do in assisting the client;
- Although you should clarify the function and methods of the agency selected, avoid specifying which services will be provided to your client. You probably have very little influence on the approaches and services provided by your colleagues.

Consider these seven "connection techniques" which can enhance your rate of achieving successful connections between clients and resources in the community:

1. Write out the necessary facts about contacting the resource, including such information as name and address of the resource, how to obtain an appointment, how to reach the resource and what the client may expect upon arrival;

2. Provide the client with the name of a specific contact person. To avoid disappointment and discouragement if the contact person is not available, provide alternate names. Ideally, help make the contact by phoning to introduce the client;

3. If the client's problem is complex, provide the client with a brief written statement, addressed to the resource, detailing the problem, actions initiated and the services desired or needed by the client;

4. If your client is reluctant to go to the resource alone, it may be advisable to arrange for the accompaniment of a family member or friend;

5. Have the client call the resource from your organization/office to make an appointment. You may choose to place the call to assure that the

client reaches the contact person and then turn the conversation over to the client.

6. Make a follow-up call to ensure contact has effectively been made;

7. If a client has been referred to your service, it is a good practice to send an acknowledgement note to the person who sent the client.

6. Life skills

Building life skills is an important part of most treatment for young people.

Ten core life skill strategies

According to UNICEF, UNESCO and WHO, there are ten core life skill strategies. These are:

1. Problem solving;
2. Critical thinking;
3. Effective communication skills;
4. Decision-making;
5. Creative thinking;
6. Interpersonal relationship skills;
7. Self-awareness building skills;
8. Empathy;
9. Coping with stress;
10. Coping with emotions.

Of the above core life skills, some are about developing one's psycho-social conditions/strengths, others are about practical skills for survival and still others serve to enhance mental prowess and creative abilities. The utilization of core life skills work best when complemented with access to information/knowledge and encouragement from the external environment including the provision of a nurturing learning environment where personal perspectives and experiences are valued and shared. Such an approach towards bringing about changes in knowledge, attitudes and behaviour therefore becomes more within the reach of young people who may have decided to change.

It is important to identify areas for skills training in the young person not only during assessment, but as an integral part of an unfolding counselling process.

Area	Type of training/skills building
Confidence building	Peer support group, assertiveness training, negotiating skills
Survival support	Survival skills - how to look for safe housing, getting heath care, finding work, getting an education/training
Social skills	Communication training, value clarification, inculcating respect for others
Leadership	How to help others, organizing skills, training in mentoring
Family relations	How to have open communication, how to understand a parental situation, getting along with siblings and larger family
Community relations	Respect for authority, listening skills, respect for others' beliefs

Prevention strategies for addressing substance use among young people benefit from the incorporation of core life skills together with resources and attachments that are protective factors.

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION FIVE

Group Counselling

United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Five

Group Counselling 5

1. Basics of group counselling 6

2. How to facilitate group counselling session 12

3. Group facilitation techniques 13

4. Typical problems during group counselling sessions 16

5. Some groups for young drug users 17


A TOOL KIT

Section Five

Group Counselling

This section provides some guidance for group counselling interventions, and then a selection of useful groups that can be adapted to local conditions for use with young people experiencing substance use-related difficulties.

1. Basics of group counselling

Group counselling is a popular and commonly used method to provide treatment for substance use and related difficulties. The following sections come from four main resources: Mika Niskanen (2005); Department of Juvenile Observation and Protection (2004a and 2004b) *[Manual for Rehabilitation and Treatment Activities for Children and Young People in Juvenile Training Centres and Manual for Rehabilitation Activities for Young People at Risk of Drug Use, Drug Users and Drug Addicts];* UNDCP (2000), and UNESCAP (2006) *HIV Prevention among Young People: Life Skills Training Kit.*

1.1. Introduction

The groups presented in the section can be used in community OR residential treatment – voluntary or compulsory. As mentioned in Section One, confidentiality and safety may require greater consideration in compulsory residential centres. Also, some activities may need to be modified to fit in with any rules that apply to the behaviour of young people in compulsory residential centres.

The group counselling approach works as well in residential facilities as it does in the community. In fact, most of the groups included in Section Five were developed for use in residential treatment facilities. While the approach taken in this Tool Kit 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. In compulsory residential treatment facilities, it is very important that **confidentiality** be taken very seriously. 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. It is very important to consider these issues and adjust your approach.

The groups in the section cover: ice breakers, developing trust, improving communication, expressing emotions, relationships with parents, interpersonal conflict, decision-making, refusal skills, managing stress, meditation.

There are many manuals or collections of group techniques that could be helpful as **"ice breakers"** or to develop actual group sessions; however, aspects of only four are included in this Tool Kit. In addition to these, two examples of useful manuals for warm-up and ice breakers are:

International HIV/AIDS Alliance (2004) *A parrot on your shoulder: a guide for people starting to work with orphans and vulnerable children.* Downloadable from: http://www.aidsalliance.org/sw7467.asp

PATH (2002) *Games for adolescent reproductive health: an international handbook.* Downloadable from: http://www.path.org/files/gamesbook.pdf

Another very useful resource is a **Life Skills training kit** produced by **UNESCAP – HIV Prevention among young people: Life Skills Training Kit –** which contains many useful group activities that cover such areas as:

- An introduction to learning and training – with many "ice breakers";
- Organizing and running groups;
- Tips for peer educators;
- Essential life skills;
- Peer influence;
- Communication;
- Values;
- Setting goals;
- Learning to listen;
- Challenges of growing up – sexual and reproductive health, nutrition;
- Sexual health and HIV/AIDS;
- Substance use and HIV/AIDS;
- People living with HIV/AIDS;
- Skills building for peer educators.

UNESCAP (2005) HIV Prevention among young people: Life Skills Training Kit. Download available from: http://www.unescap.org/esid/hds/resources/publications.asp

1.2. Group methods to be used

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);
- Cultural background;
- Any members with a mental illness;
- Experience of group members of being in groups;
- Attention span.

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

- A greater activity level;
- Painting;
- Drama;
- Story telling;
- Role playing;
- A mixture of these.

The examples of groups provided in this section include most of the above.

1.3. Objectives of group counselling

[Adapted from Mika Niskanen (2005)]

- 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.

1.4. Role of the group counsellor

- 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 counselling
[Adapted from UNDCP (2000)]

- ➢ 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.

1.5. Techniques of group counselling

[Adapted from UNDCP (2000)]

- **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 payoffs, for example, praise, for effort and achievement in a group.
- **Responding to feeling:** letting others in a group know that you 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.

1.6. Group discussions

In addition to the examples of groups provided below in this section, general "group discussions" can be useful. Topics for group discussions could include:

- Forms and sources of alternative recreational activities;
- improving communication;
- Developing life skills;
- Improving problem solving;
- The value of productive work and other activities that can diminish the urge to use drugs or alcohol;
- Resisting drug offers;
- Coping with social/family pressures;
- Coping with negative feelings;
- 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;
- Understanding psychological dependence;
- Identifying personal triggers;
- How to prevent a slip or lapse;
- What to do immediately after a slip or lapse;
- 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.

2. How to facilitate group counselling session

[Adapted from Mika Niskanen (2005)]

2.1. How to facilitate a first group counselling session

1. Welcome everyone and give them positive feedback of attending.
2. Introduce the counsellor briefly.
3. Introducing the reason for group counselling, for example: "Often people who have similar life experiences can benefit a lot of sharing experiences and ideas together. That is what we shall encourage with this group, too!"
4. Introduce rules and structures: Group sessions often last for 90 minutes each, everyone is encouraged to talk, but everyone has the right to decide how much he/she talks, a confidentiality agreement with all group members is important, while the role of the counsellor is not to give answers, but to help the group to discuss and work together.
5. Encourage everyone to introduce themselves, preferably telling their "life story" in relation to the problem issue. Actually, the whole first session can be used for telling and listening to participants' stories (for example 10 minutes each). The counsellor actively encourages participants to say what they think about others' stories.
6. The counsellor encourages the group members to set up objectives and goals for the group sessions. It is good if they can be written down for example on a flipchart, and be kept visible during all sessions. During the group process, the counsellor can now and then look at the objectives with the group, and evaluate if the group is going in the right direction to achieve them.
7. The counsellor stops the group from talking about new issues around 10 minutes before the session ends, and asks everyone to express in some way what they feel and think.
8. Agreements can be made on what the group members will try to do before the next session.

2.2. How to facilitate next group sessions

1. Welcome everyone and ask everyone to tell briefly how they are and/or what has happened to them.
2. Encourage the group to select a topic/topics for today's discussion, if not already decided.
3. Encourage and support the group to talk openly and to elaborate the topic and to develop ideas and solutions.
4. End the discussion about 10 minutes before the session ends, and ask participants to evaluate the session and/or tell what they think and feel.
5. Agreement can be made on what the group members will try to do before the next session.

3. Group facilitation techniques

3.1. Pair interview

Benefits:
- Develops listening skills;
- With a new group, it is "safer" to start with pairs;
- Helps people to get to know each other;
- Hearing my pair speak about myself can make me see myself in a new way.

Dangers:
- Not many.

When to use:
- In the beginning of group or training sessions.

3.2. Collecting information and opinions with sticker papers

Benefits:
- Anonymity encourages people to express thoughts openly;
- Helps to see which are the main issues and concerns of the group;
- Helps people to see that many people have similar concerns.

Dangers:
- This is a safe technique.

When to use:
- When people know each other a bit already;
- To clarify which topics the group should focus to work on.

3.3. Pictures

Benefits:

- Can give "distance" for a personal issue, and help in talking about it;
- Gives another way of communicating, besides language;
- Can be used in numerous ways.

Dangers:

- Can lead to deep and emotional expressions;
- Enough time should be used for sharing.

When to use:

- When people know each other a bit already;
- To reflect feelings, different time periods, future hopes.

3.4. Lines, coordinates and positioning

Benefits:

- Helps participants to position themselves, makes things visual;
- Shows differences between group members;
- Provides information for the facilitator.

Dangers:

- People may feel that this is a competition;
- Too personal questions to be avoided, especially in the beginning.

When to use:

- When starting new groups or training sessions;
- When evaluating energy level, progress, involvement.

3.5. Letters

Benefits:

- Gives a possibility for group's joint (anonymous) feedback for another group;
- The product can be saved and reread many times.

Dangers:

- Too negative feedback.

When to use:

- When there is a need for two distinct groups to give feedback for each other (women-men, teachers-students, supervisors-employees, parents-children).

3.6. Drama

Benefits:
- Makes problems and issues very visual;
- Makes people feel the issue, not only talk about it.

Dangers:
- Can make participants very emotional, much time is needed to reflect after;
- The roles become too personal.

When to use:
- When the group knows each other already;
- When there has been enough talk;
- To illustrate and to make problems visible.

3.7. Objects from nature

Benefits:
- Helps people to crystallize an issue and to give it an object form;
- Some "exercise" for the participant;
- A funny exercise.

Dangers:
- This is a safe technique.

When to use:
- For expressing feelings;
- For feedback.

3.8. Sculpting

Benefits:
- An effective method to elaborate people's relationships with each other.

Dangers:
- Can make participants very emotional, needs a lot of skills from the facilitator and a lot of time.

When to use:
- When participants know each other well already.

3.9. Sociometric exercises

Benefits:
- People get feedback from others;
- Makes people's relationships explicit.

Dangers:
- Can be very sensitive to get direct feedback from others.

When to use:
- When people know each other well already.

4. Typical problems during group counselling sessions

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 strop 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.

5. Some groups for young drug users

The following selection of groups can be used with young substance users in both residential and community settings. They are merely examples and should be adapted to suit local conditions, cultures, settings, age and mix of participants.

Groups 1-4 have been adapted from: UNESCAP (2005) *HIV Prevention among Young People: Life Skills Training Kit.*

Groups 5-29 are drawn from two manuals developed in Thailand: Department of Juvenile Observation and Protection, Office of Juvenile Justice System Development. Bangkok, Thailand; and Department of Juvenile Observation and Protection (2004a) *Manual for Rehabilitation and Treatment Activities for Children and Young People in Juvenile Training Centres.*

Department of Juvenile Observation and Protection, Office of Juvenile Justice System Development. Bangkok, Thailand; and Department of Juvenile Observation and Protection (2004b) *Manual for Rehabilitation Activities for Young People at Risk of Drug Use, Drug Users and Drug Addicts.*

The groups cover such topics as:

- Ice breakers/developing trust;
- Emotions;
- Communication;
- Relationships with parents;
- Interpersonal conflict;
- Decision making;
- Refusal skills;
- Managing stress.

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

1. Getting to know you

Ice breaker and trust development

Objectives:

1. To create a relaxed atmosphere and encourage each participant to introduce aspects of himself/herself.
2. To involve the participants in a creative activity that allows them to express themselves.

Materials:

1. One sheet of paper per participant.
2. Markers/sketch pens/colour pencils/crayons/pens/pencils.

Time:

10 minutes of portrait drawing and 10 minutes to look at the display of the drawing.

Process:

1. Ask participants to draw a self-portrait on a piece of paper. They can use any of the materials provided and choose whatever style they like – artistic, cartoon or abstract. Assure them that this is not an examination of their artistic expertise. Ask them to write their names (or a "tag") on the portrait.
2. Ask them to display the portraits on a wall (or board) in the room.
3. Give participants time to move around and have a look at the portraits. They can seek clarification from each other.

The facilitators should also participate in the exercise and draw their self-portraits.

Evaluation Criteria:

1. Active participation of all members.
2. Active discussion.
3. Participants know each other's names and appear more relaxed.

2. Something like me

Ice breaker and trust development

Objectives:

1. To introduce the participants to each other.
2. To create a sense of belonging/familiarity/trust.
3. To show the participants that you want to get to know them.

Materials:

Objects/things lying in the vicinity that can be used as symbols (or bring such materials with you – shapes, small toys, leaves, etc.).

Time:

30 to 45 minutes.

Process:

1. Ask the participants to take five minutes to find an object that they think symbolizes them in some way.
2. You can play some soft music in the background while they are choosing.
3. Reassemble the participants in the room.
4. Ask the participants to introduce themselves one by one, and explain why they chose their symbols.

The facilitators should also participate in the exercise and find an object that they think symbolizes them in some way.

This exercise is very suitable if the group is taking place outside or in an informal setting.

Evaluation Criteria:

1. Active participation of all members.
2. Active discussion.
3. Participants know each other's names and appear more relaxed.

3. Keeping the faith

Trust development

Objectives:
To define ***"trust" and "confidentiality"*** within the group sessions.

Materials:
None.

Time:
One hour.

Process:
1. Explain that participants are going to explore issues of mutual trust and confidentiality within the group. Caution them that they are going to be talking about some personal and difficult things.
2. Ask the participants to divide into small groups of four people each. Tell them to imagine a situation where they are suffering from a disease and find it impossible to come to terms with it. They want to talk about it with someone to seek help and advice. What qualities would they seek in that person? They should concentrate on the qualities of the person without mentioning any names. Give the groups 15 minutes for this discussion.
3. Call the participants back to form a circle, and ask them to describe the qualities they discussed in their groups. Invite the participants to write down these qualities, and put them on the wall for future reference.

Evaluation Criteria:
1. Active participation of all members.
2. Active discussion.
3. Participants appear more relaxed.

4. Blind walk

Trust development

Objective:
To help participants experience the value of team support and cooperation.

Materials:
A piece of cloth/scarf/large handkerchief.

Time:
45 minutes to one hour.

Process:

1. Ask participants to form a line from one end of the room to the other. Ask for a volunteer to be blindfolded. Explain to the group that this exercise is not intended as a competition, but as an exploration of feelings and to highlight the importance of support.
2. Use the scarf/cloth to blindfold the volunteer. Turn her/him around several times. Ask the volunteer to walk in a straight line from one end of the room to the other. S/he should stop when s/he thinks that s/he has reached the end of the room.
3. Tell the rest of the group to remain completely silent and give no encouragement or guidance at all. They must not touch the volunteer.
4. When the volunteer reaches the other end (or says that s/he has reached the other end) of the room, ask her/him to take off the blindfold. You may ask her/him to share feelings experienced during the walk. You may ask questions, such as, "Did you think that you were going where you wanted to go?" or "Did you feel the need for guidance?"
5. Ask the volunteer to replace the blindfold. Ask her/him to walk from one end of the room to the other again. This time, the others in the room should give verbal guidance and encouragement. However, nobody should touch the volunteer.

6. Ask the volunteer to share her/his experience with the others.
7. Repeat the exercise once again with another volunteer, and this time ask the observers to help the volunteer in any way they can.
8. Ask the volunteer to share the experience.
9. Repeat with more volunteers if there is time.
10. Close the group by emphasizing the need for mutual support and trust in our lives.

Evaluation Criteria:

1. Active participation of all members.
2. Active discussion.

5. Why people do what they do

Teacher Somjai

Objectives:

1. To learn how inner feelings and thoughts affect one's work.
2. To understand that people act differently for similar or different reasons. People have different drives in terms of feelings, experiences, values and needs. There are 4 kinds of partiality (Buddhist term "a-ka-ti"), which are partiality from love, anger, ignorance and fear. They have influence on actions and behaviours of people.
3. To understand that people have different techniques to accomplish their goals. The techniques chosen are based on the various personalities of people.

Materials:

One "Teacher Somjai" activity sheet for each group.

Process:

1. Form groups of 5-6 persons. In addition, 6 persons, as players, sit in an inner circle and do role-plays (see activity sheet below). The rest, as observers, are in an outer circle.
2. The 6 players in the inner circle act as representatives from different academic departments joining in a meeting. Each player is given a role. The rules are:
   - 2.1. Your role is a secret and not to be shared.
   - 2.2. Study your role carefully.
   - 2.3. The meeting is 15-minutes long.
3. While the players in the inner circle study their roles, the groups of observers are briefed on what they have to do:
   - 3.1. Observe methods each player uses to persuade the others.
   - 3.2. Observe gestures, choices of words, and emotions of each player.
   - 3.3. What is the outcome of the meeting? Is it accepted by everyone?
   - 3.4. How long does the meeting take?
   - 3.5. Guess what role each player is given.

4. Start the role-play.
5. After the role-play is done, members of the groups of observers work together to guess what role each player is given. The players answer.
6. In groups:
    6.1. The groups of observers report their observations.
        6.1.1. The atmosphere of the meeting.
        6.1.2. The methods each player used to persuade others.
        6.1.3. The conclusions/assumptions made.
    6.2. The players report the feelings they experienced during their role-plays (satisfaction, anger, upset, etc.).
    6.3. Identify the factors that lead to success/failure of the meeting, and how to solve the problems.
    6.4. Understand that emotions and actions may positively or negatively affect the outcome of the meeting.

Evaluation Criteria:

1. Active participation of all members.
2. Active discussion.

"Teacher Somjai" activity sheet

Situation: Teacher Somjai has been teaching for many years and is about to retire. The school establishes a committee on her farewell present. The committee consists of 6 members.

Role 1: You are Teacher Somjai's colleague. You do not like her because both of you always have different opinions and attitudes. You do not support the school to give anything to Teacher Somjai.

Role 2: You are Teacher Somjai's best friend. You know that Teacher Somjai will go abroad after her retirement. You think the school should give Teacher Somjai a piece of luggage which will be useful for her trip.

Role 3: You are a new teacher. You are not happy with how the school always asks for your donation. You are upset because more people are about to retire.

Role 4: You think the committee should give a present in the name of Teacher Somjai to the school. This is in memory of Teacher Somjai and the school will also have the benefit of that present.

Role 5: You are reluctant to give any ideas. You still wait and see whom you should support.

Role 6: You think you do not have anything to do with this meeting. You want the meeting to be over as soon as possible because you have an appointment with your friend.

6. Dice/wheel of emotions

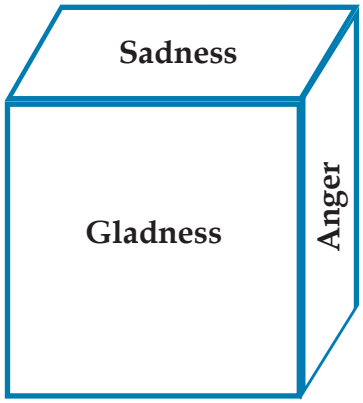
Objectives:

1. To learn to explore one's emotions.
2. To understand the nature of emotions and how to control them.

Materials:

1. Wheel of emotions.

2. Dice of emotions.



3. Activity sheet 1 and 2.
4. Information sheet.
5. Pencils/papers/erasers.

Process:

1. The activity leader asks for 5 volunteers, each to throw the dice of emotions or roll the wheel of emotions. Each volunteer expresses their opinions towards the emotion they get (what causes them to feel jealous, etc.).
2. In groups of 5-6 persons, discuss the topics in activity sheet 1.
3. Each group sends a representative to report the outcome of the discussion.
4. The leader gives additional explanations according to the information sheet.
5. Each member writes an essay on "what emotions I would like to have when I grow up" on activity sheet 2.

Evaluation Criteria:

1. Timely participation of all members.
2. Active discussion and idea sharing.

Suggested Activity:

Each member to practise to express and reflect on their true feelings in a constructive way.

Activity sheet 1

Instructions: In groups of 5-6 persons, discuss the following:

1. The cause of the emotion.
2. How to control the emotion.
3. What is the emotion you do not wish to have?
4. What is the emotion you wish to have?

Activity sheet 2

Write an essay on "what emotions I would like to have when I grow up" ……

Information sheet

People have different emotions. Some people express their emotions openly, while some choose to withhold certain negative emotions, e.g., envy, hatred. It is important to understand human emotions, to learn how to accept and manage them in order to live happily as an individual and also as a part of society.

7. Emotion card

Objective:
To understand one's emotions and also those of others.

Materials:
1. Information sheet.
2. Activity sheet.
3. Emotion cards.
4. Pencils/papers/erasers.

Process:
1. The activity leader and each member introduce themselves.
2. The leader chooses 3-4 members to answer "Have you ever felt angry before? and how did you express it?"
3. Each member picks an emotion card. This is not to be shared with anyone.
4. In pairs, try to guess what emotion card the other gets.
5. The leader asks which members get the right answers.
6. The leader asks how those members get the right answers.
7. The leader provides additional explanations according to the information sheet.
8. Each member writes down relevant information on the activity sheet under the topic "What are the benefits of understanding others' emotions?"
9. Closing.

Evaluation Criteria:
1. Number of participating members.
2. Members' reactions during the activity.

Information sheet
It is important to understand your emotions and those of others, and also to deal with your negative feelings. This will help you to adapt yourself to live with others happily.

Activity sheet
"What are the benefits of understanding others' emotions?"
.....

8. Skills in managing emotions

Objectives:
1. To identify the four steps of managing one's emotions.
2. To use skills in managing emotions effectively in different circumstances.

Materials:
1. Information sheet.
2. Activity sheet 1 and 2.
3. Case study "Dan's anger".
4. Pencils/pens.

Process:
1. The activity leader and each member introduce themselves.
2. The leader creates an example circumstance by scolding the members for no appropriate reasons.
3. The leader asks how the members feel when they get a scolding.
4. The leader reads the story "Dan's anger".
5. In groups of 4 persons, discuss the story according to activity sheet 1.
6. Each group sends a representative to report the result.
7. The leader gives additional explanations according to the information sheet.
8. In the same groups of 4 persons, practise managing emotions according to activity sheet 2.
9. A representative from each group reports the result.
10. The leader concludes the activity.
11. Closing.

Evaluation Criteria:
1. Active participation of all members.
2. Active discussion and opinion sharing.

Information sheet
Emotions are caused by different external factors. There are positive and negative emotions. You need to manage and control your emotions. There are four steps of emotion management:

1. Explore your emotions. Are your hands shaking? Is your heart beating fast? Is your body shaking? Do you clasp your hands tightly?
2. Predict the positive and negative impacts of expressing such emotions.
3. Control yourself using different methods:
   3.1. Breathe long and slowly.
   3.2. Count 1-10 slowly or keep on counting until you feel more relaxed.
   3.3. Give yourself a time out. Walk away from that place or that situation for a while.
   3.4. Use breathing practice. Focus on your inhalations and exhalations.
4. Explore your emotions once again. Admire yourself for being able to control your emotions.

Case Study "Dan's anger"

Dan came to school late. His is extremely upset that his teacher scolded him in front of his classmates. Dan was very embarrassed and very angry that his teacher did not give him any opportunity to explain himself. However, he chose not to express his anger, knowing it would only upset his teacher and worsen the situation. He counted 1-10 in his mind. After his teacher finished scolding him, Dan gave his teacher a *wai* (a gesture of respect) and walked to his seat.

After the class was over, Dan came to see his teacher and explained that he was late because his mother was sick and he had to take her to hospital.

The teacher forgave him and also apologized for not listening first. Dan was proud that he could manage his emotions well and make his teacher understand.

Activity sheet 1

In groups of 4 persons, discuss the process of Dan's anger management (in 5 minutes):

1. Explore emotions.
   Dan felt……when he was scolded in front of his friends.
2. Predict the positive and negative impacts of expressing his emotion.

If he expressed his feelings:	If he withheld his feelings:
Positive points…..	Positive points…..
Negative points…	Negative points…

3. What was the method Dan chose to control his emotion?
   ……
4. At the end, how did Dan feel? ……..

Activity sheet 2

Use the same 4 steps to analyze the stories below:

1. Don's mother bought a toy only for his little brother but not for him. He is very upset and jealous of his brother. He wants to destroy the toy.
2. Orm is poor. Her school uniform is very old. Her more well-to-do friends like to make fun of her. Orm is embarrassed and wants to do something as payback.
3. Fluke and Touch are enemies. Fluke has a birthday party and invites everyone in the classroom except Touch and Touch's close friends. Fluke makes an announcement that Touch's group is not invited. Touch is embarrassed and wants to disturb the party.
4. Bird is fatherless. He lives with his mother and two younger sisters. His friends always accuse him of being gay (homosexual). One day, Bird is walking with a female friend when somebody shouts "Bird's got a girlfriend finally!" He recognizes it is Pom's voice. He is very angry.

9. Self-control

This bicycle provokes thinking

Objectives:

1. To realize the importance of being able to control oneself.
2. To learn the methods of controlling oneself and how to react to one's negative emotions.

Materials:

1. Picture of a bicycle.
2. Record form.

Process:

Learning stage

1. The activity leader shows a picture of a bicycle and explains as follows:
   Imagine you have a new bicycle. At first you might not know how to ride it and need another person to help you control it, but after practising, you will be able to ride the bicycle on your own. You will learn how to slow your bicycle down when it goes too fast, or stop it immediately, using brakes. This will ensure a safe ride.

   The bicycle is like your emotions. When you get angry and want to hurt someone, you need to slow down or stop immediately. This is to avoid all the negative impacts on yourself and others.

2. Discuss the importance of controlling your anger, which is being compared to using brakes to stop a bicycle.

   The members share different methods of controlling anger:
   - Count 1-10 and tell oneself to forgive and stay calm.

Practising stage

Each member chooses a method of controlling anger most suitable for themselves, then plans on how to use it and keeps a personal record.

Example:
If I was bullied by my friend, I would:
1. Count 1-10 in my mind.
2. Tell my friend nicely that it is better to discuss our problem over than use force.

Record form

Period of activities – From…..to ……

Date	Plan	Result	
		Able to do it	Unable to do it

3. How would you evaluate yourself?

   ……..

   - If you could not accomplish your plan, what method are you going use instead?

     ……..……...

     Evaluate yourself again.

     ……..……...

   - If you could accomplish your plan, what would you do to maintain it?

     ……..……...

Evaluation Criteria:
Active participation of all members.

10. Being careful/aware not to make inappropriate decisions

Objectives:

1. To understand different levels of seriousness of a problem.
2. To identify the cause of a problem.
3. To be able to compare different solutions to a problem.
4. To be able to choose the most appropriate solution to a problem.
5. To be able to suggest a solution to a problem to one's friends.

Materials:

1. Information sheet "Process of making a decision and solving a problem".
2. Case study "Which way?"
3. Activity sheet 1 and 2.

Process:

1. The activity leader gives a lecture on the information sheet "Process of making a decision and solving a problem".
2. The leader reads the case study "Which way?"
3. In groups, discuss activity sheet 1.
4. Each group sends a representative to report the result of the discussion.
5. In groups, discuss activity sheet 2.
6. A representative from each group reports the result. The leader draws conclusions from the activity.

Evaluation Criteria:

1. Active discussion in each group.
2. Satisfactory report by each group.

Case Study "Which way?"

Pramote is a student in the eighth grade. His parents got divorced and his mother was married to another man. Pramote lives with his father and his elder brother.

Later, his father was married to a widow with one child. Pramote often fights with his stepmother because she does not give money to him and his brother. Pramote has no money to use for his school activities and personal matters. His friends all know he has financial problems.

One day, Nikom, his classmate, suggests Pramote sells *ya baa* so that Pramote would not have to depend on his stepmother anymore. Pramote is reluctant to sell *ya baa*, knowing it is wrong.

If you were Pramote, what would you do?.....

Information sheet "Process of making a decision and solving a problem"

Making a decision is choosing one of different solutions to a problem. The decision made effects not only you but others. It might also lead to success or failure. To be able to make an appropriate decision, you need to have information which is accurate, up-to-date and sufficient.

There are 5 steps of making a good decision:

1. Identify what is the real problem.
2. Understand the cause of the problem. Find different solutions to the problem.
3. Compare all possible solutions. Consider if they are practical. Try to predict the outcome of each solution. Find more supporting information if needed.
4. Make a decision based on the information you have and also on ethical standards, values and laws.
5. After the action is taken, identify its negative points, if any, and suggest a way to solve them.

Activity sheet 1

In groups of 4 persons, discuss the case study "Which way?" following the 5 steps of making a good decision:

1. What is Pramote's problem?.....
2. What is the cause of the problem?.....
   Identify different solutions
   a. .....
   b. .....
   c. .....
3. Compare different solutions.
   Solution 1…….....
   Positive points…….....
   Negative points…….....
4. What is the decision that Pramote should make?.....
5. How can any problems caused by such a decision be solved?.....

Activity sheet 2

In groups, discuss the stories below:

1. Good profit
   Pa-yup is 14 years old and in the eighth grade. He tells his friend, Udom, that one of his neighbours went to a northern province and came back as a surprisingly richer man. His neighbour sells *ya baa* to workers in a nearby factory. The actual cost of *ya baa* is 5-6 baht per tablet but he could mark the price up to 60-130 baht per tablet. This makes a very good profit.

   The neighbour asks Pa-yup to help him sell *ya baa* because Pa-yup has many friends at school. He suggests Pa-yub charges a lower price to sell in a larger amount. Pa-yub is considering if he should sell *ya baa*.

2. Should I?
   Banchorn is a student in the seventh grade. He has a nice complexion. He is friendly and always speaks politely. He is quite tall but bony. His parents got divorced and both have new families. Banchorn lives with his elder brother, who is dependent on *ya baa* and has been selling *ya baa* for 3 years. His eldest brother is now in prison for selling *ya baa*. Both of his brothers completed only primary education. They expect Banchorn to complete higher education so he would not have to sell drugs like them. One day, Banchorn is alone at home. He sees *ya baa* and wants to try it. If you were Banchorn, what would you do?.....

3. A friend's advice
   Kannikar is in the ninth grade. Her parents always fight with each other violently. Lately, Kannikar has been isolating herself from her friends. Panee, who is her neighbour, suggests Kannikar smells some glue like Panee does. Panee says it helps her forget her problems. Kannikar is reluctant to try the glue….

Test on decision making skills

Read the story below and choose the answer that you think is most correct.

Situation:

Bancha is in the eighth grade. He is poor. He works after school as a waiter until 11 pm everyday. He does not have time to do homework or read textbooks. He does not perform well at school and often falls asleep in class. Chingchai, his classmate, suggests Bancha uses *ya baa*. Chingchai says *ya baa* clears his mind, makes him happy, and keeps him up all night. It would help Bancha finish his homework in time. Chingchai keeps asking Bancha to try *ya baa*.

What you would do if you were Bancha:

1. What do you think is Bancha's problem?
   a. He might have an accident because of his lack of sleep.
   b. He works too hard.
   c. He is at risk of using drugs.
   d. He cannot focus on studying.
   e. Others. Please specify:……..

2. What is the cause of Bancha's problem?
   a. He is lazy.
   b. Chingchai keeps asking him to try *ya baa*.
   c. He is afraid that his parents might scold him.
   d. He cannot focus on studying.
   e. Others. Please specify:……..

3. If you were Bancha, you would:
   a. Ask a friend to tutor you.
   b. Try *ya baa* as Chingchai suggests.
   c. Stay at school to finish your homework before going to work.
   d. Stop working until your grade improves.
   e. Others. Please specify:……..

4. Write down both negative and positive points of all answers in No. 3.

5. After analyzing all the solutions in No. 3, what is your final decision:
   I would ……
   The way to solve the problems caused by my decision is…….

11. Obstacles in life

Objective:
To realize what behaviours might be obstacles in life.

Materials:
1. Story of "Koh's life".
2. Activity sheet 1 and 2.
3. Information sheet for the activity leader.

Process:
1. The activity leader reads the story of Koh's life.
2. The leader asks questions in activity sheet 1.
3. In groups of 3-4 persons, answer the questions.
4. Each group sends a representative to report the result of the group discussion.
5. The leader asks questions in activity sheet 2.
6. A representative from each group reports the result of the group discussion.
7. Each member asks themselves if they have any behaviour that is not accepted by their parents or teachers. Are these habits considered obstacles in their lives?
8. The leader picks a few members to report their observations.
9. The leader gives additional explanations and draws a conclusion from the activity.

Evaluation Criteria:
Active discussion in each group.

Koh's life
Koh is a student in a secondary school. His parents are both teachers and are very strict with him. His mother loves and cares about him. However, she always gets involved in every aspect of his life and does not care much about how he feels. Koh thinks his mother is dictatorial. He wants to do things against her will. They always have arguments.

At school, Koh, as a good-looking boy, always participates in various school activities. Koh is outstanding at school. When he is in the ninth grade, Koh notices some friends talking about *ya baa*. Koh would like to try *ya baa*, assuming it does not cause his friends any harm. Koh starts to be addicted to *ya baa* because it keeps him up all night. One day, his school conducts a urine test among students. Koh is found to be using drugs. From that day, though he stops using *ya baa*, his teachers no longer ask him to do any school activities. His mother also criticizes him. Koh is disappointed, thinking nobody loves or understands him. He takes an overdose of sleeping pills. Luckily, his parents save him in time and take him to a rehabilitation centre. Koh tells his mother his feelings towards his family and school. His mother understands and changes the way she treats her son.

Activity sheet 1

1. How do you feel after listening to Koh's story?
2. If you were a group leader, how would you feel if one of your members used drugs?
3. If you were a parent, how would you feel if your children used drugs?
4. How do you feel towards the friends who brought Koh to drugs?

Activity sheet 2

1. What caused Koh to use drugs?
2. What caused you to use drugs? How could you avoid such causes?
3. Discuss how using drugs is an obstacle in life?

Information sheet for the activity leader	
Topics of discussion	Expected outcome
1. What caused Koh to use drugs?	Both internal and external factors cause people to use drugs. After learning about Koh's life, the members should realize they can be like Koh if they do not fully understand the danger of drugs.
2. What caused you to use drugs? How could you avoid such causes?	People often use drugs because of internal or personal factors. The members can avoid using drugs by learning how drugs affect themselves, their families and their society.
3. Discuss how using drugs is an obstacle in life.	Drugs affect one physically and mentally. Using drugs is also against the law.

12. How to prevent relapse

Objectives:
To use lessons learned on drugs as guidelines in making a clear decision not to use drugs again.

Materials:
Activity sheet 1.

Process:
1. In groups, discuss in which situations or circumstances members might return to drugs.
2. Group representatives report on how their attitudes towards drugs, especially *ya baa*, have changed after learning more about drugs.
3. Each member writes a short essay on "My decision on *ya baa*".
4. The activity leader explains to the members that, although they make a clear decision today not to use *ya baa* again, there might be some situations in the future that trigger them to return to *ya baa*. However, this would not necessarily mean the end of the world.

Evaluation Criteria:
1. Completed activity sheets.
2. Active group discussions.

Activity sheet:
My decision on *ya baa*
(Please specify what attitudes have been changed and whether you would return to *ya baa*.)
……..……..

13. Refusal skills

Relapse prevention

Objective:
To understand refusal skills.

Materials:
A big sheet of paper or a board.

Process:
1. The leader explains that people are persuaded to do things in different situations many times a day.
2. The leader asks participants to come up with as many of such situations as possible, then writes all ideas on a big sheet of paper or a board.
3. In groups of 6 persons, the members discuss what situations they think they would "do it", "hesitate to do it" or "not do it".
4. The leader randomly selects groups to report on their answers. (The leader has to check first if the situations of which answers are "would do it" or "would hesitate to do it" are not risky or dangerous ones. If they are, the leader has to open a round of discussion to find a proper solution.)
5. The leader draws a conclusion according to the information sheet.
6. The leader raises a question "How would you say "no" without losing a friend?", then writes all refusal sentences on the sheet of paper or the board.
7. The leader talks about "refusal skills" and gives examples of refusal sentences.
8. The members analyze each sentence.
9. In the same groups of 6 persons, discuss a situation that requires refusal skills and come up with different refusal sentences. Each member of the groups takes turns to practise persuading and refusing.
10. The leader chooses a group to perform refusal skills and asks others to give evaluations.
11. Summarize the process of effective refusal. The leader talks about what to do when someone pushes you to do something.

12. Summarize the process of effective refusal. The leader answers questions, if any arise.

Evaluation Criteria:

1. Active participation of all members.
2. Active group discussions.

Information sheet:

There are three situations in which you should always say "no":

1. When you are invited by a stranger.
2. When you are asked to do something that might be dangerous to your health.
3. When you are asked to do something illegal.

Refusal skills:

To refuse means to say "no" or to avoid risky or dangerous activities without losing your relationship with others. Being able to refuse is a fundamental right of an individual. Therefore, when you refuse, you should not feel guilty.

There are three steps of refusing:

1. Express your feelings, such as concerns or worries. You might also give some supporting reasons. The other person can hardly argue with how you feel. However, if you state your reasons only, the other may find other better reasons to convince you.
2. Make a clear refusal statement like "I'm not going". or "I don't want to go".
3. Ask for the other's opinions using questions like "What do you think?", "You understand me, right?" "Are you OK with this?" to maintain your relationship.

Examples of refusal sentences:

Situation

Chid: Let's hang out together after school, Chob.
Chob: I'm afraid my mom would be worried about me. I won't go. I hope you understand me, right?
"I'm afraid my mom would be worried about me". – express your feelings.

"I won't go." – make a clear refusal statement.
"I hope you understand me, right?" – ask for the other's opinions

Situation – You were asked to try smoking.
Chid: Try this, will you?
Chob: I don't like it. I'd rather not. Do you see my point?
"I don't like it." – express your feelings
"I'd rather not." – make a clear refusal statement
"Do you see my point?"– ask for the other's opinions

When you are successful in using your refusal skills, which means the other stops pushing you to do something, you should say "thank you" which is an appropriate social expression and helps maintain a good relationship.

When someone keeps on pushing you:

1. Refuse again and walk away immediately.
   Chid: Let's hang out together after school.
   Chob: I'm afraid my mom would be worried about me. I won't go. I hope you understand me, right?
   Chid: Come on. It's OK. You don't go out very often, do you?
   Chob: I said no. I'd better go home now. (Then walk away)

2. Negotiate. Propose another option which is more appropriate.
   Chid: Come on. It's OK. You don't go out very often, do you?
   Chob: Let's have something to eat and then we both go home.

3. Postpone the time.
   Chid: Come on. It's OK. You don't go out very often, do you?
   Chob: Later, OK? (Then walk away)

14. Successful refusal

Relapse prevention

Objectives:

1. To be able to say no without losing a friend.
2. To understand how to refuse politely when being persuaded to do something wrong.
3. To act properly when being pushed to do something.

Materials:

1. Pencils.
2. Erasers.
3. Activity sheet 1 and 2.
4. Information sheet.

Process:

1. The activity leader randomly asks the members what are their past experiences in refusing their friends.
2. The leader randomly picks a member to do a role-play based on their true experience.
3. In groups of 5 persons, discuss the role-play according to activity sheet 1.
4. A representative from each group reports on the groups' discussions.
5. The leader summarizes the main points.
6. In groups of 3 persons, practise according to activity sheet 2.
7. The members evaluate the activity.
8. The leader again summarizes the main points.

Evaluation Criteria:

1. Number of participating members.
2. Role-plays of members.

Activity sheet 1

In groups of 5 persons, discuss the following points:

1. Did the member refuse successfully? And why?
2. Is the refusal skill used appropriate? And why?

Activity sheet 2

In groups of 3 persons, each takes turns to do a role-play.
One persuades, one refuses and one acts as an observer.

1. The role-play is about a person pushing one's friend to use *ya baa*. The one who refuses should act according to the three steps of refusing.
2. All members discuss if the refusal methods used are appropriate and what are the weak points.

Information sheet:

How to refuse:

1. Use your gestures, voice tones and words to show that you are being serious.
2. Use your feelings as a supporting reason. If you use only reasons, the other might find other better reasons to convince you.
3. Ask for the other's approval. Say thank you to maintain your relationship.
4. If you are being pushed to do something, you should not give in but try to find another way out:
   - 4.1. Refuse again and walk away.
   - 4.2. Negotiate. Suggest another option.
   - 4.3. Postpone the time.

Information sheet for the activity leader	
Topics of discussion	Expected results
1. Did the member refuse successfully? and why? Is the refusal skill used appropriate? and why?	- Most members would understand if the refusal is successful, considering only the outcome and not the methods used. - Some members might not understand what good refusal skills are. The leader might need to ask leading questions, e.g., "Did he make his friend angry?"
2. Do a role-play about a person pushing their friend to use *ya baa*. All members discuss if the refusal methods used are appropriate and, if any, what are the weak points.	- During the rehearsal, the leader needs to advise the members doing the role-play to use proper refusal techniques. The situations used should be different to fit different target groups. If there are many small groups, the leader should use more than one activity sheet. - The leader evaluates the role-play according to refusal techniques and compliments the groups which perform well to create more confidence.

15. A very good mother

Family relationships

Objectives:

1. To express one's feelings and any deep emotional distress towards one's mother.
2. To understand one's problems and also problems of others, which leads to proper solutions.

Materials:

1. Activity sheet 1, 2 and 3.
2. Information sheet 1 and 2.
3. Pencils, pens.

Process:

1. The activity leader and the members introduce themselves.
2. The leader distributes activity sheet 1.
3. The members fill their answers in the blanks provided.
4. The leader asks for around four volunteers to share their answers for activity sheet 1.
5. The leader draws a conclusion according to information sheet 1.
6. The leader divides the members into groups of 5-6 persons, then distributes activity sheet 2.
7. Each group discusses activity sheet 2.
8. A representative from each group reports the result of the group's discussion.
9. The leader summarizes using information sheet 2.
10. The leader asks the members to write letters to their mothers, or any persons who are like their mothers, according to activity sheet 3.

Evaluation Criteria:

1. Active discussion among all members.
2. Active participation of all members.
3. Works in each member's personal file.

Activity sheet 1
When I see a mother taking her child for a walk in the park, I feel
……..…….……..
Name……..……..…….…….
(Time – 15 minutes)

Activity sheet 2
When my mother is very angry and nagging me, I would
……..…….……..
Group……..……..…….…….
(Time – 15 minutes)

Activity sheet 3
Write a letter to your mother, or someone who is like a mother to you.
……..…….……..
Name……..……..…….…….....
(Time – 10 minutes)

Information sheet 1:
Apart from talking to somebody, writing is another way to release your suffering. It helps you relax.

Information sheet 2:
To solve a problem, you need to understand first if the problem is caused by yourself or others. If it is you who causes the problem, you need to change or adapt yourself accordingly.

A problem between a mother and a child always happens. It depends on oneself to find a proper solution to it.

16. Love letter

Family relationships

Objectives:

1. To release one's tension through writing a letter.
2. To learn how to truly understand oneself and others.
3. To see one's true self, heal the wounds in one's heart and change any distorted facts about oneself.

Materials:

1. Pencils, pens.
2. Paper, notebooks.
3. Information sheet.
4. Examples of letters.

Process:

The activity leader asks the members to write "A letter from me to my mother" and "A letter from my mother to me". The members should practise writing in each topic until they are able to write meaningful and expressive letters.

A letter from me to my mother:

1. Give the members stationery including notebooks.
2. The activity leader is suggested to use the following sentences:
   "Today, let's write letters to our mothers (or fathers)."
   "Close your eyes. What do you think our mothers (or fathers) are doing right now?"
   "Let's think back together. What did we do that made our mothers (or fathers) sad, angry or happy? What have we done together with them?"
   "Now, open your eyes and let's write letters to our mothers (or fathers)?"
3. Use the following method if the members are not able to write the letters:
   "If you think it is difficult to think back to your past, think of now, for example, 'what upsets your mother (or father)', 'what your mother (or father) finds out about you that you do not want her (or him) to

know', 'what your mother (or father) overhears', 'what you mother (or father) does to you', 'what you do to your mother (or father)'. Write down your feelings."

A letter from my mother to me:

1. Give the members stationery, including notebooks.
2. The activity leader is suggested to use the following sentences:
   "Let's become our mothers (or fathers) for once."
   "Close your eyes. What do you think our mothers (or fathers) are doing right now?"
   "Let's think back together. What did we do that made our mothers (or fathers) sad, angry or happy? What have we done together with them?"
   "What do our mothers (or fathers) think about their children? Let's think from their point of view."
   "Open your eyes. If you were your mothers (or fathers), what would you write to your children?"

Examples of letters

From me to my mother:

"You only care about my little brother. You and I always fight with each other. Why can't you pay any attention to me sometimes?"

From my mother to me:

"It's you who never listens to me. You always cause problems. Don't you know how much trouble you've been giving everyone?"

From me to my mother (2nd time)

"I don't know if I cause any problems to anyone, but it's you who made me start doing all the bad things. It's you!"

From my mother to me (2nd time)

"Have you ever considered how people feel, or how I feel? I have to work hard and take care of all of you. Do you know how difficult it is?"

From me to my mother (3rd time)
"I never listen to you because I want you to pay attention to me sometimes. That's why I always do something bad. I'm so lonely. No matter what I do you wouldn't care anyway."

To practise "Role Lettering" (RL) makes the members think more from others' point of view.
- The activity leader urges the members share their opinions, then draws a conclusion from the activity.

Evaluation Criteria:
1. Content of letters.
2. Expressions and emotions of participating members.
3. Active discussion among members.

Information sheet:
"Love letter" is an activity which applies the process of "Role Lettering" (RL). Each member, playing two roles as their writing partner and themselves, writes letters back and forth. Role Lettering allows the members to express their deep emotional distress. It helps them to identify and fix their negative feelings. It also promotes better acceptance of others among the members. The members would understand more the concept of self-realization and independence. They would be able to control themselves and use internal forces to heal any wounds caused by physical changes, lack of love and other painful experiences. They would have more control of their feelings and also more responsibility of their thoughts and actions. After practicing RL over and over, their negative feelings for others would gradually disappear. New positive feelings would emerge. (For example, "Actually she is being fussy because she loves me. I am the one who is being biased and subjective.") The members would become more objective and think more rationally.

Caution:

1. There is no restriction in style of writing and content.
2. The activity leader may provide guidelines and convince the members to write the letters. However, the leader should not force the members to write if they do not want to.
3. When reading the letters, the leader should avoid giving any qualitative evaluations, e.g., "This letter is very good/bad". Instead, the leader should clearly express personal feelings and empathy using sentences like "It must be tough for you". or "I think what you need is just some attention".
4. The leader should try to change any wrong attitudes of the members, especially those who do not want to participate.
5. The leader should create a friendly atmosphere that allows the members to express their feelings freely.
6. The leader needs to listen carefully and try to understand the members.

17. Sympathy for your mother

Family relationships

Objectives:
To learn to feel sympathy for others.

Materials:
1. Article "Noi's story".
2. Pencils/pens.
3. Activity sheet 1 and 2.
4. Explanatory sheet.
5. Information sheet.

Process:
1. The activity leader asks how the members feel after listening to "Noi's story".
   a. "How do you feel towards the story?"
   b. "How do you feel towards Noi and his mother?"
2. In pairs, discuss the explanatory sheet.
3. In groups of 5 persons, discuss activity sheet 1 and find conclusions.
4. A representative from each group reports the group's conclusion.
5. The leader draws a conclusion and asks for group opinions.
6. In same groups of 5 persons, discuss activity sheet 2.
7. The leader gathers the results and gives comments.

Evaluation Criteria:
1. Number of participating members.
2. Reactions of members while participating in the activity.

Noi's story
Noi is sentenced to one year imprisonment for using *ya baa*. He is on probation. He is required to report to the probation officer every month and not allowed to use any drugs.

Noi was due to report to the probation officer but did not show up. Seven days later, the officer sent him a warning. Noi often stole money from his mother to buy *ya baa*. Noi's mother, who was a

businesswoman, became short of money. She had to borrow money from her neighbour and had to pay a high rate of interest. Later, Noi had a motorcycle accident while he was trying to flee from policemen. He broke his arms and legs. His mother tried hard to find money to pay his medical bills. She was heavily in debt, and although Noi was in a better condition, he would surely receive a prison sentence. Noi's mother was very upset. She suffered from high blood pressure and was later hospitalized……...

Explanatory sheet:
In pairs, discuss the following points:
1. Have you heard of any similar stories about families suffered from *ya baa*?
2. If you have never heard of such stories, think about your own family. How did your family members feel when they knew you used *ya baa* and were on probation?

Activity sheet 1:
In groups of 5 persons, discuss the following and send one representative to report on the discussion:
How do you feel towards your family members affected by you using *ya baa*:
- I feel sympathy for them because..…….…….…….……
- I do not feel sympathy for them because.…….……..
- Others…….…….…….…….……..

(15 minutes)

Activity sheet 2:
In the same groups of 5 persons, discuss the following and send one representative to report on the discussion:
How could you express your sympathy for your family members?

(10 minutes)

Information sheet for the activity leader	
Topics of discussion	Expected results
1. Have you heard of any similar stories about families suffered from *ya baa*? If you have never heard of such stories, think about your own family. How did your family members feel when they knew you used *ya baa* and were on probation?	- Most members would have heard of similar stories before. Ask the members to share their personal experiences.
2. How do you feel towards your family members affected by you using *ya baa*?	- The members would feel sympathy for their family members because they are all affected in different ways, e.g., losing money and respect from others.
3. How could you express your sympathy for your family members?	- Stop using *ya baa*. Stop seeing people using *ya baa*. - Be firm. Do not believe those trying to convince you to use *ya baa*. - Listen to your parents. Find a job. - Take part in your favourite hobbies.

18. My father

Family relationships

Objectives:

1. To let go of any negative feelings towards one's father.
2. To understand problems of oneself and others and to find proper solutions.

Materials:

1. Case study "Moss's father".
2. Activity sheet 1 and 2.
3. Information sheet 1 and 2.
4. Pencils/pens.

Process:

1. The activity leader and the members introduce themselves.
2. The leader talks about the case study "Moss's father".
3. In groups of 5-6 persons, discuss the case study according to activity sheet 1.
4. The leader randomly selects a few groups to report on their discussions.
5. The leader draws a conclusion according to information sheet 1.
6. The leader asks for a couple of volunteers to tell stories on the topic "My father". Other members have to promise not to tell the stories to anyone outside the class and not to tease the volunteers.
7. After the volunteers finish their stories, the leader asks them if they felt ashamed when they told the stories. The leader encourages other members to give the volunteers applause.
8. The leader draws a conclusion according to information sheet 2.
9. Each member writes a letter to their father following activity sheet 2.

Evaluation Criteria:

1. Active participation of all members.
2. Active group discussions.

Activity sheet :
In groups of 5-6 persons, discuss the case study "Moss's father" as follows:
How do you feel towards the story?.....
What would you do if you were Moss?.....

Case Study "Moss's father"

Moss is a twelve-year-old boy. He is the middle child in his family. His father is a bus driver in the village. Moss's father likes to drink alcohol, and when he is drunk, he scolds Moss and his mother. He often hits Moss when he is angry. Moss's father is also a gambler. He gambles on the horses and lotteries. He is heavily in debt. Moss is very upset but keeps all the problems to himself.

Information sheet 1:
Every family faces problems and disappointment. You should not feel ashamed to express your feelings.

Information sheet 2:
You should not feel ashamed to express your feelings. It would help release your stress, like releasing air from a balloon about to explode.

Activity sheet 2:
Write a letter to your father (5 minutes).
……

19. My house

Family relationships

Objectives:

1. To learn to be proud of oneself.
2. To understand oneself systematically.

Materials:

1. A4 paper.
2. pencils/pens.
3. Erasers.
4. Instruction sheet.
5. Information sheet.
6. Activity sheet.

Process:

1. The activity leader and the members introduce themselves.
2. Paper, pencils, pens and erasers are distributed to the members.
3. The members close their eyes and think about their imaginative houses for 2 minutes, then open their eyes and draw the houses on the activity sheet. The pictures do not need to be beautiful.
4. The leader randomly selects 4-5 members to tell stories on the pictures they drew. Other members express their opinions.
5. The leader concludes the activity according to the information sheet.

Evaluation Criteria:

1. Active participation of all members.
2. Active group discussion.

Instruction sheet

Ask the members to draw their imaginative houses. The activity leader needs to inform the members of the following:

- The houses can be big or small.
- The members are free to picture the interiors and exteriors of their houses.
- The members are free to choose any materials to build their houses.

Information sheet
Every family has its good and bad points. We can be satisfied or dissatisfied with our families. Families can be anything depending on us. If we understand our own weak points and try to fix them, we can always develop our personal and family lives.

Activity sheet
Draw your imaginative house (5 minutes).

Name……..

20. Took and Tui (Took-ka-Tui): Two-way communication

Objectives:
1. To understand the importance of two-way communication.
2. To identify problems and obstacles in communication.

Materials:
Participating members.

Process:
1. In pairs, each person thinks of their favourite story.
2. The two persons each tells their story simultaneously, then ask each other if the story is understood.
3. Each person tells their story again consecutively and checks if the other person understands. Discuss the differences between the first and the second round of communication.

Evaluation Criteria:
1. Number of participating members.
2. Behaviours of members while participating in the activity.

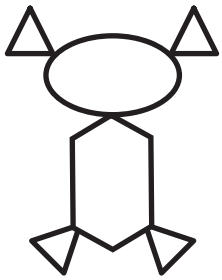
21. Drawing a picture following instructions: Two-way communication

Objectives:
1. To understand the importance of two-way communication.
2. To identify problems and obstacles in communication.

Materials:
1. Picture.
2. Blank paper.
3. Pens or pencils.

Process:
1. Blank paper and pencils or pens are distributed to all members.
2. The activity leader tells each member to draw a picture following instructions. The member is neither allowed to see the picture nor ask any questions.
3. After the member finishes the picture, the activity leader shows the correct picture.
4. The leader concludes that the effective way of communication is two-way communication which ensures that any information conveyed is not distorted.

Correct picture



Evaluation Criteria:
1. Active participation of all members.
2. Active discussion and opinion sharing among members.

22. Polite talk
Respectful communication

Objectives:
1. To learn how to use appropriate words to create positive effects on oneself and others.
2. To understand the importance of meaningful words.
3. To be able to use appropriate words in everyday conversations.

Materials:
1. Poster paper.
2. Magic pen.

Process:
1. In pairs, each comes up with:
   a. One word with positive meaning (such as "beautiful", "cute", "good", "smart").
   b. One word with negative meaning (such as "terrible", "stupid", "naughty", "ineffective").
   The activity leader writes all the words on a piece of poster paper.
2. In groups of 4 persons, discuss the followings:
   a. In your daily life, what kind of words do you often use? What kind of words do you like/dislike?
   b. How the words you like/dislike affect the speaker/listener.
3. A representative from each group reports the results. The activity leader concludes according to the information sheet.

Evaluation Criteria:
1. Number of participating members.
2. Active participation and discussion among members.

Information sheet
Words mean more than their positive or negative literal definitions. They have great effects on thoughts, actions and values of oneself and others. They can create a sense of happiness, pleasure, satisfaction and respect in oneself and others.

23. Hunt the killer

Objectives:

1. To realize the significance of organizing one's work systematically following a clear and well-established process.
2. To understand how to solve a problem using scientific methods.
3. To learn the importance of team work and realize the value of oneself as a team member.
4. To be aware of the importance of human relations when working as a team.

Materials:

1. One set of "Hunt the killer" puzzles per group.
2. Information sheet.

Process:

1. Form groups of 15-20 persons.
2. The activity leader explains as follows:
   The activity's name is "Hunt the killer". Each member will receive 1-2 puzzles containing information in relation to a murder.
   When the member receives the puzzles:
   2.1. The member cannot show the puzzles to anyone.
   2.2. In groups, the members have to find out in 45 minutes:
      a. Who was the killer?
      b. What was the weapon used?
      c. Where the murder took place?
      d. When the murder took place?
      e. What was the cause of the murder?
3. The leader writes the 5 questions above on a board.
4. The puzzles are distributed to all members. The members start working in groups.
5. After the activity is done, all members gather into one big group.
   The activity leader leads the following activities:
   5.1. Each group leader presents the answers.
   5.2. Each member expresses their opinions on team work.

5.3. The activity leader asks about the feelings of each member which have or have not been specifically expressed.
5.4. The activity leader asks if the members would do the same if they had to do the activity again and why.
5.5. All members discuss the working process and problem solving methods used.

6. The activity leader gives additional information, as appropriate, to conclude the activity.

Evaluation Criteria:

1. Active participation of all members.
2. Active discussion.

Information sheet

1. There are 2 important factors in every work situation; people and the system. These two factors must work in cooperation with each other to ensure effectiveness. If one factor is missing, the work might be delayed or unfinished.
2. Well-organized work needs clear objectives and working methods based on common understanding among team members.

"Hunt the killer" puzzles and answers

Puzzles (25 pieces)

1. Mr. Manoo took away some customers from Mr. Jaroong. Mr. Jaroong's business, therefore, was in trouble.
2. Mr. Jaroong once threatened to kill Mr. Manoo.
3. Ms. Saichai saw Mr. Manoo arrive at Mr. Jaroong's apartment at 23:40 hours.
4. There were many empty liquor bottles in Mr. Jaroong's room.
5. An elevator man said he often saw Mr. Manoo's wife walk from the building together with Mr. Sawai.
6. Policemen found Mr. Manoo's body in the Lumpini Park.
7. Mr. Manoo had a serious wound on his back. He also had a bullet buried inside his right elbow.
8. Doctors said Mr. Manoo died half an hour before his body was found.
9. Mr. Manoo's wife disappeared after the murder took place.

10. There were footsteps and dragging marks on Ms. Saichai's lawn.
11. The elevator man said he saw Ms. Saichai at the apartment's hallway when he finished his shift.
12. The bullet found in Mr. Manoo's body was of the same type as the ones Mr. Jaroong used to shoot a criminal.
13. There were fingerprints of Mr. Sawai on a knife stained with Mr. Manoo's blood.
14. The elevator man saw Mr. Manoo staggering by with blood slightly dripping from his right elbow.
15. The policemen tried to find Mr. Jaroong but he disappeared.
16. The policemen found a knife stained with Mr. Manoo's blood in Ms. Saichai's lawn.
17. Ms. Saichai often walked together with Mr. Manoo.
18. The elevator man saw Mr. Manoo walk to Mr. Sawai's room at around midnight.
19. The policemen found Mr. Manoo's body at 24:30 hours.
20. Mr. Jaroong's gun was used to shoot out only 1 bullet.
21. Mr. Manoo's body had a faint alcohol odour.
22. The policemen could not find Mr. Sawai after the murder took place.
23. Mr. Manoo's body was full of scratches as if he was dragged from somewhere.
24. Mr. Jaroong shot into Mr. Manoo's room at around midnight.
25. The policemen found stains of Mr. Manoo's blood on the carpet near Mr. Jaroong's room.

What happened?:
Mr. Manoo went to talk to Mr. Jaroong at Mr. Jaroong's room. After drinking some alcohol, both fought over some business matters. Overwhelmed with anger, Mr. Jaroong shot Mr. Manoo in his right elbow. Mr. Manoo ran to Mr. Sawai's room to ask for help but found his wife with Mr. Sawai. Mr. Sawai, seeing that Mr. Manoo was already injured, stabbed Mr. Manoo until he died. Mr. Manoo's wife was also an accomplice. Mr. Sawai then dragged Mr. Manoo's body down an elevator to Ms. Saichai's lawn. He left his knife there and drove to Lumpini Park to dump Mr. Manoo's body.

Questions:

1. Who was the killer?	1. Mr. Sawai
2. What was the weapon used?	2. A knife
3. Where did the murder take place?	3. At Mr. Sawai's room
4. When did the murder take place?	4. Around midnight
5. What was the cause of the murder?	5. Adultery

24. Group story telling

Objectives:
1. To learn to work as a team.
2. To be more creative.

Materials:
1. Information sheet.
2. Activity sheet 1 and 2.

Process:
1. The activity leader and the members introduce themselves.
2. All members sit in a circle.
3. The leader asks each member to contribute one sentence to create a story. The first person would say "Once upon a time..." and the last person would say "This story teaches you that…"
4. The leader asks for a volunteer to begin the story.
5. After the story is finished, the leader randomly selects 5 members to share their feelings and opinions.
6. The leader asks the members to discuss for 3 minutes on a new story.
7. The groups start telling a new story. This round, the person who started and the person who finished the former story would switch their positions.
8. In groups, the members share their ideas and opinions towards both rounds of story telling according to activity sheet 1.
9. The leader randomly selects 3-4 groups to present their results. Any groups with different opinions are also invited to participate.
10. The leader draws a conclusion according to the information sheet.
11. Each member thinks of and lists other activities which require tactical and creativity skills according to activity sheet 2.
12. The leader invites members to briefly talk about one of the activities they listed to the rest of the group.

Information sheet

Successful work requires various tactics, creativity and also listening skills in order to quickly understand key points to work in cooperation with other team members. Without effective work planning and clear goals, working can be difficult and complicated. All work needs good planning based on common understanding among team members. Every member has to perform his or her own duty well and at the same time listen to others. This will ensure greater accomplishments.

Activity sheet 1

Differences between the first and the second round of story telling:

1……

2……

3……

4……

5……

Group……

Activity sheet 2

Give examples of activities which require tactical and creativity skills (5 minutes).

1……

2……

3……

4……

5……

Name……

25. Roads and lanes
Stress management

Objectives:
1. To understand the effects of stress.
2. To observe one's emotional stress.

Materials:
None.

Process:
1. In pairs, measure each other's pulse.
2. The activity leader asks for 2 volunteers to play as a policeman and a thief.
3. Other members form 5 rows. Each row has 6-8 persons. The members should not stand too close to one another.
4. When the activity leader says "lane", each member places their right hand on the left shoulder of a person on their right. When the leader says "road", each member places their right hand on the right shoulder of a person in front of them. The policeman will try to catch the thief who is running through rows of members forming as "roads" and "lanes" according to what the leader says. A new round will start once the thief is caught.

   In the same pairs, measure again each other's pulse after playing the game. Discuss any feelings occurred during the game and also the effects of emotional stress on one's body.

Evaluation Criteria:
Ideas sharing among members on how to deal with stress.

26. Meditation to reduce stress

Objectives:
To practice easy meditation exercise to reduce stress.

Materials:
1. Comfortable chairs or soft cushions.
2. Information sheet.

Process:
1. The activity leader explains the definition and benefits of meditation practice to reduce stress and then invites the members to a practice meditation exercise.
2. The leader informs the members to prepare themselves as follows:
   2.1. Choose one of the sitting positions below:
      - Sit on a chair where you can relax your legs and arms. Sit straight. Do not stretch your chest or torso. Do not bend your shoulders. Do not lean against the chair's back.
      - Sit cross-legged on a cushion or directly on the floor.
      - Sit on your heels, Japanese style. Your toes touch or cross over each other. Your heels and knees separate enough to form a triangle-shaped base. Place your body weight on your feet. You can use a cushion to support your bottom.

   2.2. Sit straight and relax. Let the weight of your head be supported by your backbone.
   2.3. Rock yourself gently from left to right for a few times like a pendulum to balance yourself.
   2.4. Prepare yourself for meditation practice by focusing and relaxing each part of your body.
      - Move your toes to relax them.
      - Check if your calves are tense. Relax them.
      - Check if your waist, hips, pelvis and thighs are tense. Relax them as much as you can.
      - Breathe deeply a few times. Breathe in and out slowly to feel more relaxed.

- Swallow a few times. See if your throat feels hurt or tense. Move your head around clockwise and counter-clockwise for a few times to relax your neck muscles.
- Shift your focus to your head area. See if any parts of your head feel stressed. Check the upper part of your head, your temples, areas around your eyes and inside your eye sockets.
- Check your jaws if you are biting your teeth or folding your lips. Check your ears and, again, your head, to ensure maximum relaxation.
- Observe your entire body again.

3. Start meditation practice by choosing one of the following methods (Choose the one you feel most comfortable with)

Method 1

1. When your mind is distracted, observe it silently. Let your heart feel everything that comes into your perception, e.g., sounds, smells, emotions, your physical feelings from the past, etc. Let your heart wander freely. Do not attach yourself to any thoughts in particular. Do not judge which thoughts are right or wrong, but pay equal attention to all of them. Tell yourself "I hear all these noises around me…here and now".
2. Understand that your heart is the source of all thoughts. You need to step back and observe these thoughts objectively without being controlled by them.
3. Tell yourself "I understand my thoughts and my physical conditions. I know what my feelings are right now. I live my own life and I am facing it at the moment."
4. Live in the above stage of understanding and realizing your own feelings and thoughts for 10 minutes, then review your experience. What did you think about most? What does it tell about you? What can/cannot you and should/should not you do about it? Always remember that you are more than just your thoughts and perceptions. You are the person who experienced them and now you are observing them objectively. You are going to learn more about yourself and accept who you are.

5. Practise this method until you are able to do it without difficulties, then move on to the next step. You can choose this method as a part of your breathing practice programme.
6. Practise this method in various situations, e.g., on the bus, in a queue, etc.

Method 2

This method is practised in many places around the world. It is suitable for deep relaxation and also for creating self discipline.

1. Find a quiet and peaceful place for practising. Sit down in a firm and comfortable position. Pay attention to different parts of your body. See if any parts are tense, then relax them. You can close your eyes or look down at a certain spot on the ground around 1-2 metres away from where you sit.
2. Breathe in through your nose and stop for a while before breathing out. Breathe in deeply and feel the air coming down naturally to the bottom of your lungs. Be focused and aware of your own breaths.
3. When you breathe out, count 1 in your mind. Count 1 every time you breathe out.
4. When your mind is distracted, keep concentrating on your breathing pattern and keep counting 1. Practice this for 10 or 20 minutes.
5. After finishing each exercise, sit quietly for 3 minutes. Do not stand up and leave immediately. Close your eyes and sit there for a while. Giving yourself a period of time to appreciate the results of your breathing practice is also a significant part of this method.
6. Do this exercise 5-7 times a week. Try it for a month and then decide if you would stick to this method or change to another.
7. There are also other methods that can be used instead of that in point 3 above:
    - Count 1 when you breathe out, then say "and" and count 2 when you breathe in. ("one…and…two…one…and…two")
    - Count every time you breathe in from 1 to 4 and then start from 1 again.
    - Say "in" and "out" in your mind when you breathe in and out respectively.
    - Observe your breathing pattern without saying anything.

The activity leader evaluates the activity by asking the members how they feel after the practice. The leader should encourage the members to practise regularly to release stress.

Evaluation Criteria:

1. Active participation of all members.
2. Successful breathing practice of all members.

Information sheet

Benefits of meditation practice

Meditation practice keeps your mind focused on only one thing. It helps you establish your life goal more effectively. When you become more experienced in meditation practice, you will be able to contribute more to whatever you do.

It is found that meditation practice creates deep relaxation within a short time. Your body's metabolism would be slowed down. The rate of oxygen use, carbon dioxide generation, heart beating and blood pressure would decrease. Moreover, lactic acid, which is created when your muscles work and is related to anxiety and stress, would also reduce. Alpha brain wave found in deeply relaxed persons would increase. This is because focusing your mind only on one single thing helps lessen external and internal stimulations.

Meditation practice can be used in prevention and treatment of high blood pressure, heart disease and Cerebral Vascular Accident or stroke. In addition, it can help decrease obsessive-compulsive disorder, anxiety, anger and sorrow. It can make you feel more energetic and focused.

Basic meditation practice

There are 4 simple rules in every type of meditation practice

1. You should be in a quiet and peaceful place, especially if you are a beginner. You should separate yourself from everyday chaos.
2. Meditation practice is be easier if you are in a comfortable position. You should be able to stay in that position for at least 20 minutes without feeling tense. Do not practise meditation within 2 hours after meals since your relaxation process might be disrupted by your body's metabolism.
3. Focus on something in particular. It can be a word, a sound, an object or a symbol for you to look at and think about. When your mind is distracted, shift your mind back to your chosen object.
4. The most significant thing to help you relax is to be open-minded and calm. When you start practising meditation, do not be annoyed or angry if you cannot do it. Do not criticize yourself or the method you use or you will waste your time and never have a chance to practise it seriously.

27. Breathing to reduce stress

Objectives:
To understand breathing practice to reduce stress.

Materials:
Information sheet.

Process:

Understanding stage

1. The activity leader explains several circumstances in daily life which cause stress. The leader then asks the members to share their experiences on stress.
2. The leader explains "the power of breathing" to reduce stress.
3. The leader demonstrates breathing practice according to breathing principles. The method chosen should be easy for beginners.

Practicing stage

4. The members practise breathing together with the leader.
5. The members should practise breathing regularly for 1-2 minutes before starting the actual process.
6. The leader should follow-up with the members on how they use breathing practice to reduce stress.

Analysis and discussion stage

Deep breathing is easy to do in your daily life. You should do it at least 10 times a day. Try to connect breathing practice to your work. Do it regularly when you feel stressed at school, at work, when your headaches, etc. This will create a good habit to reduce stress.

Evaluations:

1. Active participation of all members.
2. Active discussion and breathing practice of all members.

Information sheet

The power of breathing
Long and deep breathing is a correct way of breathing. It is good for your health. It increases the amount of oxygen in your blood. It strengthens your stomach muscles and colon. When you feel stressed or angry, your breathing pattern becomes slow and inconsistent. Your heart beats faster. However, if you breathe long and deep, your heart beat slows down.

A correct breathing pattern is adapted into various forms of breathing. You can learn about and use the forms of breathing in your hectic daily life. Do not wait until a serious and stressful situation happens in order to start your breathing practice. When you are tense, you tend to forget to breathe and automatically tighten your chest muscles and diaphragm. Try breathing in deeply and slowly and you might be surprised to see how soon your stress evaporates.

Breathing practice to reduce stress
Place one hand slightly underneath your ribs (the upper part of your stomach). Breathe in deeply once. While breathing in, observe the movement of your hand if it moves inward and outward or moves at all. If you breathe in correctly, your stomach should expand. See how deeply you can breathe in.

When you breathe for relaxation, breathe in through your nose. Feel the air slowly fills your lungs. Feel the movement of your stomach. Then breathe out through your mouth. Feel the warm breath being released from your body. Start breathing deeply instead of shallowly and frequently down only to your throat and chest. After breathing in, hold your breath for 10 seconds. Feel the tension in your throat and chest. Then breathe out through your mouth and sigh lightly. The most silent and peaceful part of breathing is when you breathe in. If you can feel a sense of tranquillity when you

breathe out, it shows that you are able to relax. Then breathe in again, and release your breath with a light sigh. When you breathe out heavily, feel all your stress and tension disappear. Notice the stillness and peacefulness between your breaths. Whenever you feel stressed, remember this feeling and try to recreate the feeling of tranquillity.

Patterns of breathing
There are certain breathing patterns to reduce stress:

1. **Count from 1 to 8**
   Breathe in deeply once and close your eyes. Breathe out heavily to release all air from your lungs. While breathing in again, picture the number 1 in your mind and at the same time focus on your breath. Hold your breath for 3 seconds. Then breathe out heavily and picture the number 2 in your mind while doing so. Repeat these steps until you count to the number 8, then repeat the whole process again from 1 to 8. Open your eyes slowly.
2. **Count 1 to 4**
   Breathe in deeply once and breathe out heavily to release all air. Breathe in again. Count 1 to 4 while breathing in. Hold your breath and count 1 to 4. Then count 1 to 4 while breathing out very slowly. Repeat the process 4 times.
3. **Count 5 to 1**
   Picture the number 5 in your mind. While focusing on the number 5, breathe in deeply and slowly. Make sure your lungs are filled with air. Then breathe out to release all the air. Picture the number 4 in your mind and breathe in again. While breathing out, tell yourself "I am more relaxed than when I pictured the number 5". Repeat these steps until you count down closely to number 1. You would feel more and more relaxed when you approach number 1.

4. **Three-part breathing**
   Breathe in deeply using your diaphragm. Imagine your lungs are divided into three parts. The lowest part of your lungs should be filled with air. Use only your diaphragm. Your chest should stay still. Next fill the middle part and then the upper part of your lungs with air until your lungs are completely filled with air.

   Raise your shoulders gently and moved them backwards. Breathe out all the air. While the upper part of your lungs is deflated, your shoulders should drop down a little. Feel your ribs shrink to squeeze the remaining air out of the lower part of your lungs. Repeat the process 4 times.

5. **Breathing with one nostril at a time**
   When you feel more familiar with three-part breathing, try another exercise. Close your right nostril with your right index finger. Breathe in deeply, letting the air run through your left nostril. Feel your lungs being inflated with air. Remove your finger and close your left nostril with your left index finger instead. Then breathe out through your right nostril. Repeat the process 10 times.

28. Developing relationships in the family

Objectives:

1. To understand and be able to identify the roles and relationships of family members.
2. To evaluate one's role as a family member.

Materials:

1. Activity sheet 1 and 2.
2. Information sheet.

Process:

1. The activity leader and the members sit in a half-circle.
2. The leader mentions that each human being is born with certain roles and duties towards their family.
3. Each member thinks of the roles and duties which they have performed in the past. What are they and how would they evaluate them? Are they satisfied with their roles and duties, including their relationships with other family members? (Activity sheet 1)
4. Each member tells which role and duty they would like to change, and then shares their opinions (Activity sheet 2).
5. The leader draws a conclusion on duties as a family member and also on relationships in the family according to the suggestions made by the members.

Evaluation Criteria:

1. Active participation of all members.
2. Active opinion and idea sharing among members.

Activity sheet 1

In groups of 4-5 persons, discuss the following:

1. What is your duty as a family in the past?
2. Are your duty and also your relationships with other family members appropriate?
3. Are you satisfied with your duty and your family relationships?

Activity sheet 2
Describe the roles and relationships with other family members that you would like to change (in groups of 4-5 persons).

Information sheet
Realizing your role as a family member and understanding the significance of relationships in your family help create better self-esteem. It makes you feel proud of yourself and encourages you to fix any of your inappropriate behaviours.

29. Final activity

Learning objectives:

1. To review knowledge, attitudes and life technical skills learned.
2. To conclude and evaluate all the previous group activities.
3. To conclude relationships.

Behavioural objectives:

1. To review various ideas in relation to different aspects of *ya baa*.
2. To review the effects of *ya baa* on oneself as follows:
   a. Effects on physical and health conditions.
   b. Effects on mental conditions, such as loss of social and self respect.
   c. Effects on future studies and career.
   d. Effects on lifestyle, financial status and freedom.
3. To review how to reflect one's responsibility towards oneself, one's family and society.
4. To review how to create better self-esteem.
5. To draw conclusions on how to effectively communicate with others.
6. To review how to deal with emotional stress and anger when not using *ya baa*.
7. To review how to refuse a person asking you to use *ya baa*.
8. To plan and set up goals in life to ensure a better life after probation.

Group process:

1. Final lecture and farewell activities.
2. Review of various points according to behavioural objectives.
3. Schedule of next meeting to follow up on the results.
4. Evaluations:
   a. Feelings after attending the previous group activities.
   b. Benefits gained from group activities.
5. Farewell activities:
   - e.g., Singing a song.

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

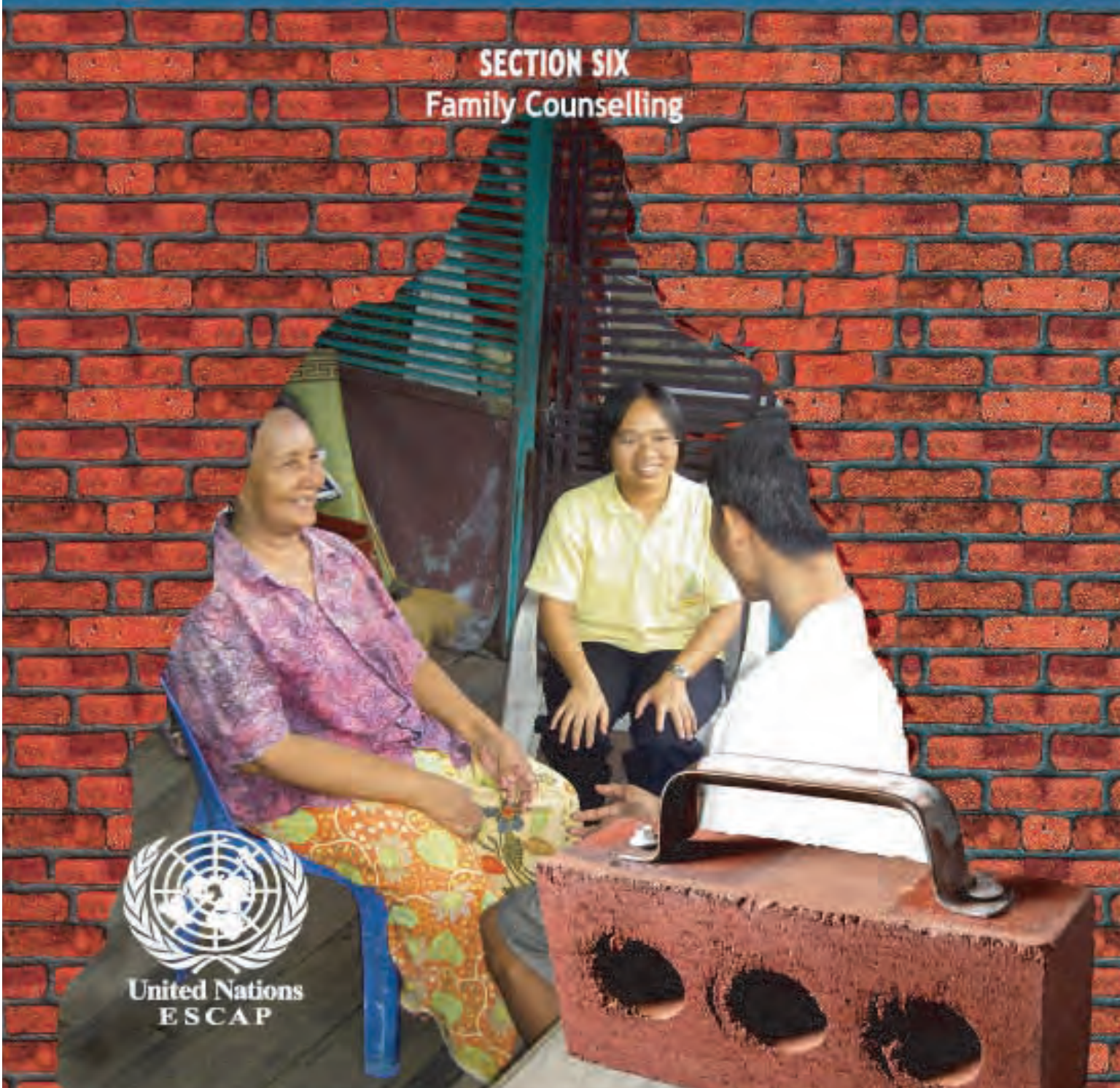
Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION SIX

Family Counselling



United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Six

Family Counselling 5

1. Principles and methods of family counselling 6

2. Why family counselling? 10

3. Family and carers support group: an example of 10-session intervention 14


A TOOL KIT

Section Six

Family Counselling

This section is a brief overview of the more specialized family counselling interventions. It also includes some ideas and techniques about how to run family group sessions, and a larger group support programme for a number of families at the same time.

1. Principles and methods of family counselling

As part of their counselling manual, UNDCP (2000) provide much useful guidance of family interventions, which appears below, with amendments. Following this, material from Mika Niskanen (2005) outlines some more useful information on family interventions, and finally some suggestions from TNF Family and Carer Group meetings are provided. A resource booklet developed by a number of agencies in New South Wales, Australia is included in one of the CDs of this tool Kit as an example of IEC material which could assist families and carers.

1.1. Why should we involve the family?

[Adapted from UNDCP (2000)]

People who use drugs often live with their family. Even when they live on their own, there is nearly always a family member or close friend in their life. The effects of the young person's drug use may have large consequences on family members and significant others. Often it is somebody other than the drug user who first seeks help.

In most families where there is a drug user, the family suffers from severe stress and conflict. All the members who interact with the drug user suffer directly or indirectly from his/her behaviour. Family members suffer because they may not understand the dynamics of drug dependence and lack the helpful skills to cope with the behaviour of the drug-dependent person. Family counselling aims to help the family members understand and better cope with the situation and to enlist their support in achieving the recovery goals of the drug dependent person.

A major challenge for the family counsellor is to encourage the family members (who may or may not be using drugs or alcohol themselves) to attend counselling sessions. Even if all the members of a family do not turn up for counselling sessions, you can start working with those who do – in order to assess the family situation.

Very often a relapse is provoked by a family member's negative attitude or behaviour towards the young drug user. This occurs because he or

she does not understand how fragile the young person may be during the early stages of detoxification and rehabilitation. In numerous cases, negative family conditions might have contributed to the drug dependence of one member. Family counselling aims to reduce these tensions and to enlist the whole family in the rehabilitation process, and to assist the family obtain what they might need to help them to improve their situation (e.g., food, housing, support).

1.2. The challenge of engaging the family in counselling

Family members usually experience the following anxieties when confronted with their relative's drug problems:

Denial: Parents may deny that a member of their family has a drug problem even when faced with strong facts. As a counsellor, you need to be careful not to reinforce this denial by your disapproving, judgemental words or attitude.

Shame: Whether the drug is socially acceptable, such as alcohol, or is illicitly obtained, people in the family often feel ashamed. Their first response to the problem may be an effort to hide it.

Self-blame: Some families often feel they are to blame for the situation and reproach themselves. Parents may feel they have failed. "This is the child on whom so many hopes have been pinned but perhaps I got it wrong. Did I over-indulge him/her or did I sometimes neglect his/her real needs?"

Anger: Blaming others is another common family response. The school, friends, society as a whole, the bar, or dealers are all blamed. Alternatively, a family member may be blamed. For instance, a son who is taking amphetamines daily may blame his father, who drinks too much, for all the difficulties in the family.

Confusion: Family members often feel conflicting and confusing emotions. While they strive to protect the user from harm or criticism, they may feel angry that he or she has been "so stupid". Some people

deny these unpleasant feelings by saying, “There must be some mistake”. “Even if it is true, I am not going to let it upset me”.

1.3. Ways of offering help to family members

A variety of strategies are available for helping the relatives of drug users. These include:

- To provide individual support, counselling or casework to the relatives;
- To work with the family, which may include the use of family therapy techniques;
- To teach them what they could do, and what they should not do in their relationships with the young drug user.

It may also be important to provide clear information to the family about drugs, the stages leading to the problem drug use, tolerance, physical and psychological dependence, rehabilitation and how this can be a slow process that may require many attempts.

It is important to let family members know that they should try to not:

- Remain isolated;
- Take a judgemental attitude;
- Give money to the young person;
- Pay off the young person’s debts;
- Move out from where they live;
- Habitually compare the drug dependent member to others who are healthy or successful.

Encourage family members to:

- Maintain contact and care for the drug user;
- Be understanding and compassionate toward the drug user. Recognize his/her habit as an illness to be healed with love and hard work;
- Confront the problem and not the person;
- Remain confident and hopeful.

1.4. Supportive members of the family

There may be members of the family who continue to show a genuine concern for the condition of the young drug user. They want to understand and to help. Start by working with these supportive family members. Arrange to meet with them (in the absence of the young person, if possible) to explain drug use and physical and psychological dependence, so that they understand the compulsive behaviour of the young drug user. The more disturbed the emotions of the family, the less adequate their help and support will be.

During such sessions, members of the family are informed about progress achieved and problems encountered by the young person during the recovery journey. Eventually the supportive members will realize the importance of adopting and practicing new ways of relating to both the young person and one another. Equipped with the necessary coping skills, they become active partners of the rehabilitation team, helping the whole family adopt and practise a healthier lifestyle. Your aim is to support this process and improve family communication, provide information and teach skills as necessary.

By having the family members and the substance user in the same counselling sessions you can also find out whether your client is sticking to his/her rehabilitation goals or not. Here you must avoid taking sides, rather you need to maintain and nurture the respect and confidence of both the young person and the family, to help them progress and grow together.

When family relationship starts to stabilize, we need to help the young person and the family discover new pleasures and rediscover old ones in family life.

2. Why family counselling?

[Adapted from Mika Niskanen (2005)]

- Usually problems and challenges affect all family members, all need support.
- Often problems and challenges are created and maintained by many family members.
- Family counselling may reveal "real" problems that are behind someone's symptoms.
- To mobilize all family members' knowledge, views and skills to solve problems.
- Family counselling is one effective form of psychotherapy.

2.1. Key issues related to (systemic) family counselling

- Every family member's contribution is valuable.
- A goal is to avoid seeing one family member as a "problem person", but to understand the problem in a wider context.
- Gives the family more information on itself.
- Change is possible/a small change can be enough for a recovery process.
- Family counselling can be used as the only therapy method, or together with other therapies.

2.2. Different approaches of family counselling

- Structural: "Problems occur when the family *structure and roles* are are not in order".
  - Strengthening parents' and children's roles here and now.
- Strategic: "Problems stay when a family uses *a wrong strategy* to solve a problem".
  - Changing the problem solving strategy, changing the behaviour sequences.
- Systemic: "There are invisible underlying issues, the *problem is only a symptom*".
  - Trying to understand the problem in a new way (Who needs the problem?)
- Narrative: "The family has a problem, because it has *a negative story* of itself".
  - Helping the family to change the story into a more positive one.

- Reflective: "Families have a problem, because they have *only one explanation* to it":
  - Encouraging creating many different explanations and views to the situation.

2.3. Basic structure of a family counselling session

1. **Joining (10-15 minutes)**
   - Introduction of the counsellors.
   - Introduction of the session: length, what will happen, rules and recommendations.
   - Introduction of the family members.
   - Positive remarks about the family and family members.

2. **Exploration of the problem (10-20 minutes)**
   - It is important to let the family define the problem.
   - Exploring when the problem started and how it affects all family members.
   - Exploring explanations for the problem.
   - Exploring how the family has tried to solve the problem this far.
   - Asking the family to define the goal situation.

3. **Working through the problem (10-20 minutes)**
   - Exploring alternative ways to solve the problem/to behave.
   - Exploring alternative ways to understand the problem and problem behaviour.
   - Paying attention to positive aspects and positive steps in relation to the problem and family interaction.

4. **Ending the session**
   - Note: there can be a break before closing the session.
   - Giving positive notions about the session.
   - Asking what the family sees as a conclusion and as next steps to do.
   - The counsellor's conclusion and possible suggestions for next steps.

2.4. "Circular questioning"

This can be useful tool for counselling.

1. **Talking on behalf of other family members:**
   - "What do you think your son/daughter sees as the main concern in your family?"
   - "Is that so?" (turning to the son/daughter)
   - "How do you think your mother would like to solve this problem?"
   - "Is that so?" (turning to the mother)

2. **Putting family members in an order**
   - "Who in your family noticed this problem first, who then, who the last?"
   - "Whom does this problem affect the most, whom then, whom the last? Does everyone agree?"
   - "Who has the most power to change the problem, who then?"

3. **Exploring behaviour patterns**
   - "When the problem appears, what does the father do, what does the mother do, siblings, other family members?"
   - "What would happen if they did something different?"

4. **Exploring the problem and family relations**
   - "Who was the closest to the father before the problem appeared? Who is the closest now?"
   - "Who agrees?"

5. **Visioning the future**
   - "If the problem disappeared, who would notice it first? Who then?"
   - "Who would be the happiest if the problem disappeared, who the least happy?"
   - "Who would be the most surprised if the problem disappeared? Who the least?"

6. **Other questions**
   - "If the grandmother were here, what would she advise?"
   - "Who do you think in your family agrees with you in that 'Noy has a bad character'?"
   - "You can make one wish for your son/daughter to make things a bit better. Your son/daughter can make one wish for you to make things a bit better."

2.5. Reflective talk

If there is more than one counsellor, they can take some distance from the family after a while, and just discuss between themselves. The family will listen. The counsellors can discuss the family's strengths and the reasons for and solutions to the problem. Finally, the family is given an opportunity to comment on what the counsellors have talked about.

2.6. Typical problem situations in family counselling

- A family member does not arrive
  - "What would he say if he were here?"
- A family member does not talk
  - "What do others think that 'Boun' sees as the main problem?"
- One family member dominates
  - "What do you think your wife thinks about this?"
  - "Who do you think agrees with you in this family?"
- A family member is constantly seen as the "problem person"
  - Future oriented questions
  - Encouraging talk about positive sides of him/her
- Relapse in the problem behaviour
  - Explanations for the relapse
  - Much focus on the moments/days when the problem did not exist anyway

3. Family and Carers Support Group: an example of 10-session intervention

3.1. Introduction

The "Family and Carers Support Group Package" was developed from conversations among various Ted Noffs Foundation staff with the parents and facilitators from existing Family and Carers Support Groups.

3.2. Some principles

We believe that we as facilitators and counsellors are not the experts on the lives of young people, parents and carers. Each family, carer and young person will have created for themselves their own meanings of their life situations, experiences and relationships with themselves and others, which in turn will not be the same as our own experiences. This package is not a parenting programme – it invites us to walk along side the parent and/or carer.

3.3. To assist in introductions of new group members

- Introduction of service and facilitators.
- Introductions of group members, names.
- What the group can offer:
  - Your maintaining of choice to talk or not, or to attend or not is important for your safety.
  - You **don't have** to keep to each meeting's theme.
  - You can tell your story your own way and the way most helpful to you.
  - **Facilitators** – they are here to assist in the sharing of your own knowledge and gather together your own helpful ideas in a safe way.
  - **Safety.** What things do you think you will need (from others and yourself) to be able to speak more comfortably with others in the

group? Do you think you would need time to get to know others in the group? How much time do you think you would need to have you feeling safe and comfortable to speak?
  - **Confidentiality.** What is this? What does confidentiality look like? What isn't confidentiality? (Discuss the facilitators' limits of this).
  - **Support.** What type of support would people like from each other… and from the worker/facilitator?

- What the group will be like:
  - **Group members** are encouraged to feel as though they belong to the group and use the group space for them to bring concerns and needed conversations.
  - There may be new group members attending at different times. How do you think you may be able to assist their joining in membership with you as you all find supports and strengths from each other?
  - Different themes each meeting to help encourage conversations if required.
  - Handouts and information will be provided.
  - Health breaks with water/tea/coffee and the sharing of food will occur.
  - Everyone is encouraged to participate in a way that invites comfort.

- What things do you want to be different by attending the group? (List these for every person).

3.4. Conversation time:

- What has bought you to the group?
- What strengths have you noticed about others and others noticed about you, as you have listened to peoples' stories?
- What is it like to hear this about yourself?
- What things might you take with you from this meeting that will assist you?

3.5. During subsequent meetings:

- **Introduction of and welcome to any new members.**

- **Check for safety and comfort.**
  - Were there things that you thought about following the last meeting that you wanted to speak of?
  - Were there things less helpful? (List these for each person).
  - Were there helpful things? (List these for each person).
  - In what ways did you find these helpful?
  - What differences did they possibly make for you?

Reminder that each meeting will allow space for sharing your concerns and telling your story.

- Your maintaining of choice is important for your safety.
- You don't have to stick to each session's theme.
- You can tell your story your own way and the way most helpful to you.

Session 1: Does change happen? Is it possible?

Reminders:

- Each meeting will allow space for sharing your concerns and telling your story.
- Your maintaining of choice is important for your safety.
- You don't have to stick to each session's theme.
- You can tell your story your own way and the way most helpful to you.

Discuss cycle of change (use Stages of Change Model in Section Three)

- I'm feeling overwhelmed! (Developing practical strategies for dealing with stress and feeling overwhelmed): Share with each other some of the things you already do to help with stress and feelings of being overwhelmed.

- Do magic wands exist? Have you ever wanted one? In your search for a magic wand, what has been the effects/influence on you? Did you find one?

- When drug and alcohol problems come into family life, what effects do they have on your family life? List them.

Then consider ….

- Have there been times when you have noticed changes in the young person you care about, even changes that at the time may have appeared small?

- Has the idea of the drug and/or alcohol PROBLEM been so strong that these changes, either small or large, have been made invisible?

- Can you think about what difference there might be if you were able to notice and remember more of the smaller changes?

Let's list a few of the changes that you may have noticed and spend time thinking about them:

- What difference might it make if you were to think about these changes more often?

- What things were you doing as a family member, parent or carer that assisted in these changes happening?

- Did you notice that at different times different things you did worked?

Reflect back over the cycle of change conversation:

- Can you begin to see certain things happening for you that may fit in with the cycle of change?

- Does this assist you to see some of the things you were doing that assisted in your relationship with the young person you care about?

- What might you call this?

Consider the conversations we have had during this group, is there something you might like to say, add to what we have been talking about?:

- Have there been any discoveries for you as we have talked?

- What will you take with you from this meeting and think about until the next meeting?

Session 2: Information on drugs

Myths and facts:

- What have been some of the things you have heard about alcohol and other drugs use?
  - List these ….....…..…..…..…..…..……..…..

- What have been some of the things you have heard about young people who use drugs?
  - List these ….....…..…..…..…..…..……..…..

- What have been some of the influences on you from hearing these things?
  - List these ……....…..…..…..…..…..……....

- Which of the things on the lists do you believe are true? Why do you believe them? What is the evidence? (facilitators can correct myths with information)

Session 3: Shame/guilt

Shame and guilt can be very strong emotions and influence your life and actions in many ways:

- Does the drug problem in your life have you experiencing feelings of shame/guilt?
- In what ways do these drug problems have you feeling shame/guilt?
- Once the problem of drugs has brought shame/guilt into your life and thinking, does it bring back to your mind other related feelings and reminders of shame/guilt?
- How does shame/guilt influence the way you see yourself as parents and carers?
- What belief about parenting exists in our culture that supports a shaming of your attempts to parent?

Let's list some of these ideas and assumptions and consider them:

- How does shame/guilt get in the way of relating with the young person you care about in your life?
- How does shame/guilt influence the way you view the young person you care about?
- What influence does shame/guilt have on your relationships with other family members and friends?
- Does the "Perfect Family" really exist?
- Does the "Perfect Parent" really exist?
- Does the "Perfect Young Person" exist?

- Does “Perfection” exist and if we hold onto the ideas of the existence of perfection what influence do these ideas have over us?

- With talking and exposing some of the influences of shame/guilt and perfection, has this made a difference to how you view…

  - The young person you care about?

  - Yourself as a parent and carer?

- What things might you carry with you from this meeting and shared conversations that you feel may assist you?

Session 4: Isolation – alienation: "I'm feeling alone"

Discussion:

- Do drug and alcohol problems have you isolating and alienating yourself?
- How does the drug problem in your life have you isolating and alienating yourself?
- When you are in the grip of isolation, what does this feel like for you?

  In small groups, discuss and give some answers to the above questions.

  Bring back to the larger group.
- Do other members in your family experience isolation and alienation as a result of the drug and alcohol problem/s?
- Does the young person you care about experience isolation and alienation as well?
- What things do you think the young person has become isolated from?

Comments…..

- If isolation and alienation is happening to others in your family, what's happening to relationships?
- Are relationships in isolation too?

Comments….

- What things have the whole family become isolated from?

In small groups:

- Have there been times when you have felt connected and have been relating well to those in your family?
- At these times, have you noticed any difference to how you may have approached problems related to alcohol and drug use?
- What differences did you notice?
- What things helped at these particular times?
- What things might you keep thinking about from the conversations we have had about isolation?

Session 5: Re-establishing limits (rules)

Limits:

- What does a limit look like?
- When and how do you know a limit has been breached?
- How does the breaking of a limit affect your thinking?
- How does the breaking of a limit affect your emotions?
- Where do you become aware of these things in your body?
- In what ways does alcohol and drug use influence the breaking of limits?
- Does this breaking of limits or rules invite from you a response and desire to bring in control?
- What does control look like?
- What impacts does this "control" have on your relationships with young people and others in your life?
- What type of conversations do you have with young people when you start to control?
- What are the differences between controlling and the negotiating of limits and rules?
- What does it feel like when think you have no control?
- Does it have you working harder for control?
- How do the young people you care about in your life experience control?

- What impact does control usually have on young people?
- What are the possible differences of having limits and negotiating these as compared to having control?
- Are limits a fixed thing that remain black and white?
- If you see limit setting as not fixed, but movable and negotiable, does this give you more opportunities to have conversations with the young people you care about?

Session 6: Acknowledging strengths

Acknowledging strengths:

- What things have you tried to continue to do to help you survive (e.g., spending time with friends, gong for a walk)?
  - o In small groups or in pairs discuss this question, than bring your lists back to the large group to share.
- Have there been times when it has been harder to do these things?
- If so, have you been able to come back to these things and start doing them again?
- What has helped you to do this?
- In small groups or in pairs again discuss the things you have done to assist you to re-claim the things that help you in harder times?
- Share these then with the larger group.
- When things have appeared harder, have you found yourself looking for the problems more when looking, listening and being with the young person you care about?
- What happens or would happen if you were to pay more attention to your young person when they are not being as influenced by the problems and harder times? (i.e., catching them smiling, laughing etc).
- Let's talk about some of the times you have seen beyond the problems and share what things you have seen.
- What differences does it make with talking and sharing these times?
- What things might you take with you from the group tonight?
- What things might you try to notice about yourself and your relating to the young person/s you care about following this group?

Session 7: Identifying support

Identifying support:

- What are some of the support networks you have around yourself at the moment?
- What other support do you think you need to add to this existing support network?
- How will you go about adding to your existing support network?

List local support networks available in your local community:

- How can we remember the supports and helpful conversations experienced throughout this group?
- In what ways can you hold onto them and remember them?
- List these up as your own resource, noting that you can add to and refer to the list when needed.

Session 8: Where are you in all of this???

Over a period of time experiencing what is problem after problem and with struggling to get assistance, struggling to be heard, struggling with your own thoughts you can easily forget you are a person and have your own needs:

- Did you ever think you would be a parent experiencing such concerns?
- Can you recall your first thoughts when you found yourself experiencing the impacts of alcohol and other drug problems affecting the young person you care about?
- Can you share these with the group?
- Did your thoughts start to remind you of certain decisions you had made previously about how you wanted to raise your children?
- How did you come to making these decisions about how you would like to raise your children?
- Did some of your own personal life stories and experiences have an influence on the ideas you developed around how you wanted to raise your children?

Now in small groups or in pairs, discuss how some of your own personal experiences may have shaped how you respond to the problems you are having with the young person in your life today? Such as:

- The decisions to be firm about certain behaviours.
- The decisions made to not have drugs in your house.
- The decisions made to allow some drugs into your house.
- Have there been personal experiences of your own that have shaped your stand about these things?

- Can you share these back to the large group after you have discussed in pairs.

- What differences has it made for people to have heard from others about how they have come to make certain decisions about their children?

- What has it been like to have shared more personal stories with each other in the group?

- What might you take with you from this group and how might this influence your thinking?

Session 9: Maintaining hopeful connections

At times when all that seems to be around you are the problems related to drug and alcohol use, the connections between people in relationships can become strained, the connections can even appear to be non-existent, or only described as a "problem". The times when there were none or only a few difficulties in relationships are not talked about often and do not get acknowledged as much as they could be:

- What are some of the things you have done to maintain connectedness with the young people in your life?
- In the face of cannabis, alcohol and/or other drugs how have you managed to keep and maintain this connectedness?
- What have been some of the qualities you have held onto in the keeping of these connections?
- What are some of the qualities you might want to bring into your life that may assist in the maintaining of connectedness?
- What have/do these connections mean to you?
- What do they bring you in your life?
- How do you hang onto these connections and not loose hope or feel like you are alone?

Session 10: Why??? "Forget the WHY question"

Researching *WHY* questions:

- How often do you find yourself asking yourself the *"why" question? Why is my son using drugs? Why did I let this happen? Why this? Why that? Why?*
- How do you ask yourself these *"why" questions*, such as in what tone of voice?
- When you give yourself a *"why" question*, what influence does this have over your thinking?
- What does the *"why" question* do to your mind?
- Does the *"why" question* start you thinking there must be one answer?
- Do you get any answer when asking *"why" questions*? What do you get?
- Has the *"why" question* existed in your life over time?
- Have there been other times in your life when you have asked yourself the *"why" question*?
- Are you giving too much room for *"why" questions* to take over your thinking and problem solving?

What if there wasn't just one easy answer?

- What might be other ways you could avoid the *"why" question?*
- Have you ever done this before?
- What have you done to assist you avoid *"why" questions?*
- How recent has this been?

- How can you be supported to hold onto this belief that you can avoid or not listen to *"why" questions?*

- What can you do to STOP asking the *"why" question* and work at moving forward and taking charge of NOW?

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444

Economic and Social Commission for Asia and the Pacific

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion

SECTION SEVEN

Relapse Prevention Planning

United Nations
ESCAP

A Tool Kit for:

Building Capacity for Community-based Treatment and Continuing Care of Young Drug Users in the Greater Mekong Subregion


A TOOL KIT

Contents

Section Seven

Relapse Prevention Planning 5

1. Introduction 6

2. Example of a relapse prevention plan tool 7

3. Example of a completed relapse prevention plan tool 10

4. HIV prevention among IDUs 14

5. Women and drug use 17


A TOOL KIT

Section Seven

Relapse Prevention Planning

This section illustrates how relapse prevention plans can be developed. Most material in this section comes from the Ted Noffs Foundation (2006) and PSI, Kunming (2005).

1. Introduction

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 compulsory residential treatment 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.

What follows are examples of Relapse Prevention Plan, including one for Noy.

2. Example of a relapse prevention plan tool

My *Relapse Prevention Plan* for managing my_(type of drug)_ use is as follows;

EARLY WARNING SIGNS

Early warning sign	Thoughts and feelings	Coping strategy
E.g., getting bored	I want some fun	Think – I can find something good to do without drugs. Go to youth centre and maybe talk to peer educator/counsellor.

HIGH RISK SITUATIONS 

Triggers	Coping strategy
People *e.g., – Zhong*	Tell Zhong you are busy and have to get home or to see peer educator.
Places e.g., – at club	Go with good friend who does not use drugs. Go to the youth centre.
Thoughts *e.g., – no one understand me or just use one more time*	Remember how many changes you have made, feel proud and look at photos of good drug-free times. Talk to peer educator/counsellor. Not worth it – remember what happened when I got arrested.
Feelings *e.g., – sad and lonely*	Listen to music, talk to friend. Talk to peer educator/ counsellor.
Situations *e.g., – fight with girlfriend and parents*	Think – I have learned how to be calm and negotiate. I must try to do that NOW. Go to youth centre to join in fun activities, and maybe talk to peer educator/counsellor.

SUPPORT PEOPLE

Person	Contact details

Name : _____ **Date:** _____

BACK-UP PLAN

If any lapses occur before… (a date when plan is due for review) I will:

(1) Think of the experience in a positive and constructive way and understand that a lapse is not a total relapse. I will avoid letting it get me down or letting it undermine my efforts to manage my drug and alcohol use.

(2) I will inform _____ of my lapse and seek their support.

(3) I will then contact my counsellor/peer educator/support person to talk about it
- To work out how it happened
- And to work out how it could be prevented next time, and what I will need to do differently.

(4) Extend my period of abstinence by _____ month(s), with support of _____.

3. Example of a completed relapse prevention plan tool

My relapse prevention plan – NOY

My *Relapse Prevention Plan* for managing *ya baa*, alcohol and cannabis use is as follows:

(1) To abstain from using *ya baa.*

(2) To abstain from using cannabis.

(3) To use alcohol occasionally, every second weekend on one night only unless there are parties on 2 weeks in a row.

(4) In maintaining these goals I will seek regular support of my family and counsellor/peer educator and other chosen support people.

(5) After 12 months of following this Relapse Prevention Plan I will revise my overall Plan with the assistance of my counsellor/peer educator. I will decide whether I wish to continue with the original plan or change it.

(6) If I lapse during the time between leaving counselling and the end of the 12 month period. I will follow the *Back-up Plan*.

BACK-UP PLAN

If any lapses occur before 30th June 2007, I will:

(1) Think of the experience in a positive and constructive way and understand that a lapse is not a total relapse. I will avoid letting it get me down or letting it undermine my efforts to manage my drug and alcohol use.

(2) I will inform my counsellor/peer educator of my lapse and seek support.

(3) I will then contact my counsellor/peer educator to talk about it
- To work out how it happened.
- And to work out how it could be prevented next time, and what I will need to do differently.

EARLY WARNING SIGNS

Early warning sign	Thoughts and feelings	Coping strategy
Hanging out with people who use all the time	That I think it's OK to use because I'm around it all the time	Think, Nah this is no good, we'll have to part company! Just because they do it doesn't mean I do! Go to the youth centre and join in fun activities. Talk to my peer educator/ counsellor.
Having a fight with family/ girlfriend	Wanting a drink, or to use *ya baa* or cannabis	Solve fight or cool down. **DO** think before acting. Talk to my peer educator/counsellor.
Bad day	Wanting to get drunk	Punch my boxing bag. Go to the youth centre and join in fun activities. Talk to my peer educator/counsellor.
Feeling it creeping back up on me	Think that I NEED *ya baa*	Go off and sit by myself to think it over. I don't NEED that crap! Go to the youth centre and join in fun activities. Talk to my peer educator/counsellor.

Noy's secret coping strategy: "I am the chosen one!! I can paint and play my music. I can do boxing AND I am using my brain!"

HIGH RISK SITUATIONS

Triggers	Coping strategy
People *Nong*	Tell Nong I am busy and have to get home any see peer educator.
Places *Party where people are using ya baa*	Mingle in with the crowd, have a dance. Think, nah, I can't do those drugs anymore - I go to school now.
Thoughts Yeah, look at me, I can't help myself, always in trouble. Life is no good!	Who am I kidding! Yeah, I'm me and I'm at school and I'm going to represent my country in sport, get a great job and a mad car. You just watch me! It will get better if I want it to! It's up to me! Talk to the peer educator/counsellor. Go to the youth centre and join in some fun activities.
Feelings I'm bored and want to get drunk.	Play video games, go to the youth centre, watch TV, walk the dog, ride my bike, talk to my peer educator/counsellor. Think nah, there's heaps to do that won't ruin my life! I MUST go and see if I can get that part-time job at the market.
Situations Having an argument with girlfriend , feel wild and think I don't care, I'm going to get drunk.	Call my brother to come and pick me up. Talk to the peer educator/counsellor.

SUPPORT PEOPLE

Person	Contact details
Counsellor	
Peer counsellor/youth centre	
Mum	
Nan	
Sister	
Friends from school	

Signed: _____ **Date 11.01.07**

4. HIV Prevention among IDUs

[Adapted from PSI, Kunming, (2005)]

4.1. What is HIV (Human Immunodeficiency Virus)? What is AIDS (Acquired Immune Deficiency Syndrome)?

- HIV is the name of the virus that causes AIDS.
- The HIV virus destroys the system which protects our body against diseases.
- After a person has been contaminated with the HIV virus, the virus can stay for many years inside the body before the AIDS disease starts.
- During this period, it is impossible to see that this person is contaminated with HIV since he/she looks healthy.
- BUT THIS PERSON CAN ALREADY TRANSMIT THE VIRUS TO OTHERS.
- When the HIV virus has progressively weakened the system that protects a person's body against diseases, AIDS begins: that person starts to catch easily any kinds of diseases.
- There is no vaccine for HIV/AIDS.

4.2. How can you get HIV?

- HIV can be transmitted through the following unprotected sexual contacts:
  - o Vaginal sex between a man and a woman.
  - o Anal sex between a man and a woman or between a man and a man.
  - o Oral sex (penis in the mouth, or mouth touching a woman's genitals), between a man and a woman, between a man and a man, or between a woman and a woman.

REMEMBER:
- THE PRESENCE OF BLOOD DURING SEXUAL CONTACTS INCREASES THE RISK OF HIV TRANSMISSION (cuts, scratches open sores or ulcers on the genitals, bleeding gums…)
- HAVING ANOTHER SEXUALLY TRANSMITTED DISEASE (SUCH AS SYPHILIS, HERPES, GONORRHEA, ETC.) INCREASES **BY 10 TIMES** THE RISK OF GETTING OR TRANSMITTING HIV
- ANAL SEX IS MORE DANGEROUS FOR HIV TRANSMISSION THAN VAGINAL SEX, WHICH IS MORE DANGEROUS THAN ORAL SEX

HIV can be transmitted through blood contacts

- o Sharing injecting equipment (needles, BUT ALSO OTHER EQUIPEMENT: syringes, tourniquets, mixing surfaces, water, filters).
- o Unscreened blood transfusions.
- o Unscreened organ transfers.
- o Tattooing, piercing (if using un-sterilized instruments).
- o Sharing razors (quite low risk of transmitting HIV, but very high risk of transmitting hepatitis).

HIV virus can be transmitted from mother to baby

If a pregnant woman has HIV, there is a 1/3 risk that she will transmit the virus to her baby at the three following moments:

- Pregnancy
- Delivery
- Breastfeeding.

HIV cannot be transmitted through air or water, or through touching – unless there is exchange of body fluids.

4.3. How can I know if I have been infected with HIV?

- If you think you might have been infected, protect your loved ones, protect your children: get an HIV blood test as soon as possible!
- Only a blood test can tell you if you have been infected with HIV.

Now there are many ways to make HIV positive people live a better and longer life.

4.4. Prevention of "sexual transmission of HIV/AIDS"

4.4.1. How to prevent sexual transmission of HIV/AIDS?

- Abstinence,
- To be 100% faithful to one partner,
- Consistent and proper use of high quality condoms for any sexual contact can prevent almost all of the transmissions of HIV/AIDS:
  - Remember to use high quality condoms,
  - Remember to use the condom properly (see guidelines on the next page),
  - Remember to always check the manufacture/expiration date on the condom package,
  - Remember to store in a cool and dry place,
  - If possible use a water-based lubricant (not an oil based one as it might cause the condom to break).
- People can have the choice between male or female condoms.

4.4.2. How to prevent the transmission of HIV/AIDS through blood contact?

- No sharing of injecting equipment,
- No sharing of razors,
- If you get tattooed or pierced, be careful that the instruments have been sterilized!

5. Women and drug use

What are the specific problems?

- The use of drugs can have an influence on the sex life and the menstrual cycle. But drug-using women can still become pregnant, even though the menstrual cycle might be disrupted.
- Women can suffer from a "dry" vagina when using certain drugs (e.g., amphetamines). The use of a lubricant during vaginal sexual contacts is strongly advised to avoid wounds and injuries.
- While high on drugs (including alcohol), there is a greater chance for risk taking and thus unsafe sex. Furthermore, certain drugs, such as methamphetamine, cocaine and Ecstasy can give rise to prolonged and/or "violent" sex and enhance the risks for STIs.
- **Drug use is dangerous during pregnancy and breastfeeding**. It would be ideal to stop using drugs during pregnancy and breastfeeding. Nevertheless, a sudden stop in drug use might be very difficult to achieve. If possible, seek medical follow-up!
- Stimulants, like amphetamines, are among the most dangerous drugs to use during pregnancy: great risk of miscarriage, premature birth and birth defects.
- With heroin and other opioids, miscarriages and premature birth can also happen, especially when the mother is sick or goes through withdrawal.
- Breastfeeding is dangerous during drug use as many drugs can enter the mother's milk. Babies can experience many health problems, sometimes even overdose.
- Feelings of guilt and depression are common during pregnancy or after delivery, greatly increasing relapse risks.


A TOOL KIT

Printed in Bangkok
November 2007 – 940

United Nations publication
Sales No. E.07.II.F20
ISBN: 978-92-1-120515-2
ST/ESCAP/2444