



UNODC

United Nations Office on Drugs and Crime



COUNSELLING IN TARGETED INTERVENTION FOR INJECTING DRUG USERS

– A Facilitator's Manual





UNODC

United Nations Office on Drugs and Crime



COUNSELLING IN TARGETED INTERVENTION FOR INJECTING DRUG USERS

– A Facilitator's Manual

Year of Publication: 2011

A publication of

United Nations Office on Drugs and Crime, Regional Office for South Asia
AND
Tata Institute of Social Sciences, Mumbai

Authors

The publication was authored by Atul Ambekar*, Ravindra Rao\$,
Debashis Mukherjee\$ and Swati Kedia*

* National Drug Dependence Treatment Centre, AIIMS, New Delhi

\$ UNODC, ROSA

© UNODC & TISS

All rights reserved. The text of this publication may be freely quoted or reprinted
with proper acknowledgment.

Disclaimer

The opinions expressed in this document do not necessarily represent the official
policy of the United Nations Office on Drugs and Crime. The designations used
do not imply the expression of any opinion whatsoever on the United Nations
concerning the legal status of any country, territory or area of its authorities,
frontiers and boundaries.

Designer and Printer

Macro Graphics Pvt. Ltd.
www.macrographics.com

CONTENTS

Before Beginning...	1
Training Agenda	5
Session Details for Day One	7
Session Details for Day Two	35
Session Details for Day Three	75
Session Details for Day Four	101
Session Details for Day Five	119
Session Details for Day Six	147

Annexures

Annexure 1: Multiple Choice Questions for Pre/Post Test Assessment	159
Annexure 2: High Risk Behaviour Scale	177
Annexure 3: Individual Risk Assessment Activity Worksheet	179

BEFORE BEGINNING...

Pre & post training evaluation

This helps in assessing the effectiveness and outcome of the training programme. This can be carried out using a self-administered questionnaire. A set of 98 questions on different topics covered in the training, as well as those related to attitude and skills are provided (Annex-1) for the purpose. The questionnaire has questions with multiple choice answers – where the participants have to ‘tick’ the correct answer/s. The correct answers are underlined except in case of the questions related to the attitudes and skills. The marks are provided within brackets for questions related to attitude and skill. For each training programme the facilitator needs to choose 20 questions – giving equitable importance to each topic and thereby develop a pre/post evaluation questionnaire. Care should be taken to remove the underlines and the marks in brackets before printing them out. The pre-training needs to be done after the ice-breaker on the first day and the post-training on the last day before the valediction. The facilitator distributes the questionnaires – explains how to answer them and allots 15 minutes for completing the ‘test’. The participants should have the option of not writing their names on the answer sheets. The same questionnaire is used in both the pre/post phase to enable easy comparison and outcome assessment.

The completed questionnaires are evaluated using the answer keys and the total marks obtained are noted. The facilitator finds the average marks obtained by all the participants for ‘pre’ and ‘post’ test. The average marks obtained at the ‘pre’ and ‘post’ evaluation may be compared to see the change brought about by the training.

A note on using the power point presentation

Some of the power point slides have notes for the facilitator – sometimes to help him/her explain what has been written in the slides, sometimes to point out things that the facilitator should do next – like do a role play or ask a few questions.

These notes are provided at the bottom of the slides in the presentations. For ease of reference they have been also provided at the end of the sessions details as **‘Notes on power point slides’**.

Feedback on the day's session

This is to be done at the end of every day. Feedback from the participants will help in making changes at the micro level – like modifying the timing of certain sessions to accommodate local prayer times or changing the language or adding translations in the local language for better participation.

One of the facilitators can take the lead in asking the questions for the feedback session while the others help in noting down the feedback. This can be done on flip charts/chart paper. The feedback from the participants may be collected under three heads:

1. What did you like in the sessions today?
2. What did you not like in the sessions today?
3. What could have been done better today?

The facilitators/training coordinators should meet up, post this session to discuss whether any modifications are needed and incorporate them if, any.

Recap sessions

These are to be held every morning from the second day onwards, preferably first thing in the morning. They are aimed at recapitulating the inputs from the previous day to facilitate learning.

The facilitator of the first session on each day (excluding the last day of the training) invites two volunteers from among the participants – one for the pre-lunch sessions and the other for those held post-lunch. The volunteers will then, present the important highlights of the sessions held on the previous day. Care should be taken to encourage new volunteers every day.

During the recap session, after the volunteers have briefed the group, the facilitator requests the rest of the participants to add-on any point(s) that was missed by the volunteers, details (briefly) and also correct anything that has been wrongly said. The facilitator should see to it that the major issues discussed on the previous day are covered.

Energisers

The facilitator should use energisers and mood-changers to break the monotony of the training sessions. Used judiciously as and when needed, energisers help in rejuvenating the participants and refresh their minds. The facilitator should motivate all to participate and take care that nobody is hurt – either physically or mentally.

Here are some common energisers that the facilitators may use in between sessions or to begin the post-lunch session, or when shifting from one topic to another as he/she deems fit.

Fruit salad

The facilitator asks the participants for names of four to five fruits like apples, oranges, guavas and bananas etc. and divides the participants into groups bearing the names of those fruits. Participants then sit in a circle. One person must stand in the centre of the circle and shout out the name of one of the groups, such as 'guava', and all of the 'guavas' must change places with one another. The person who is standing in the middle tries to take one of their places as they move, leaving

another person in the middle. The new person in the middle shouts another fruit and the game continues. Once everyone has changed seats call the group 'fruit salad'.

Coconut

The facilitator shows the group how to spell out C-O-C-O-N-U-T by using full movements of the arms and the body. All participants then try this together.

Body writing

The facilitator asks the participants to write their name in the air with a part of their body. They may choose to use any part of their body like the elbow, leg etc. and change for some other until everyone has written his or her name with several body parts.

Who are you?

Ask for a volunteer to leave the room. While the volunteer is away, the rest of the participants decide on an occupation for him/her, such as a driver, or a fisherman. When the volunteer returns, the rest of the participants mime activities. The volunteer must guess the occupation that has been chosen for him/her from the activities that are mimed.

Clap and point

Participants form a circle. The facilitator sends a clap all the way around the circle, first in one direction, then in the other direction. The facilitator then shows participants how they can change the direction of the clap, by pointing the clapping hands in the opposite direction. Repeat this until the clap is running smoothly around the group and changing direction without missing a beat. Finally, show how you can 'throw' the clap by pointing the clapping hands at someone across the circle.

Countdown

Ask participants to form a circle. Explain that the group needs to count together from one to 50. There are a few rules: they are not to say 'seven' or any number which is a multiple of seven. Instead, they have to clap their hands. Once someone claps their hands, the group must count the numbers in reverse. If someone says seven or a multiple of seven, start the counting again.

Taxi rides

Ask participants to pretend that they are getting into taxis. The taxis can only hold a certain number of people, such as two, four, or eight. When the taxis stop, the participants have to run to get into the right sized groups. This is a useful game for randomly dividing participants into groups.

Five islands

Draw five circles with chalk on the floor, big enough to accommodate all of the participants. Give each island a name. Ask everyone to choose the island that they would like to live on. Then warn participants that one of the islands will sink into the sea very soon and participants on that island will be forced to move quickly to

another island. Allow the suspense to build and then call out the name of the island that is sinking. Participants run to the other four islands. The game continues until everyone is squashed onto one island.

Mood-changers

Apart from energisers the facilitators can also use mood-changers like having volunteers from the participants to share a joke or sing a song, etc.

TRAINING AGENDA

DAY One

Session No.	Duration	Session
	8.45 – 9.15 AM	Registration of the participants
1	9.15 – 9.30 AM	Introduction to the training
	9.30 – 10.15 AM	Ice-breaking session
2	10.15 – 10.30 AM	Objectives of the training – participants expectations & ground rules
	10.30 – 10.45 AM	Coffee break
3	10.45 AM – 12.00 PM	Targeted Intervention (TI) for IDUs – an overview
4	12.00 PM – 1.30 PM	Understanding drugs
	1.30 – 2.30 PM	Lunch
	2.30 – 3.30 PM	Understanding drug use disorders
	3.30 – 3.45 PM	Coffee break
5	3.45 – 5.00 PM	Understanding injecting drug use
	5.00 – 5.30 PM	Feedback on the day's sessions

DAY Two

Session No.	Duration	Session
	9.00 – 9.45 AM	Recap of Day One sessions
1	9.45 – 10.45 AM	Basics of HIV/AIDS & STIs
	10.45 – 11.00 AM	Coffee break
2	11.00 AM – 1.00 PM	Approaches to address drug use problems
	1.00 – 2.00 PM	Lunch
3	2.00 – 4.00 PM	Assessment and diagnosis
	4.00 – 4.15 PM	Coffee break
4	4.15 – 5.15 PM	Basics of counselling, counselling skills and techniques
	5.15 – 5.30 PM	Feedback session

DAY Three

Session No.	Duration	Session
	9.00 – 9.45 AM	Recap of Day Two sessions
	9.45 – 10.45 AM	Basics of counselling, counselling skills and techniques...contd.
	10.45 AM – 11.00 AM	Coffee break
1	11.00 AM – 1.00 PM	Risk-reduction counselling related to injections
	1.00 – 2.00 PM	Lunch
2	2.00 – 4.00 PM	Counselling IDUs on safer sexual practices
	4.00 – 4.15 PM	Coffee break
3	4.15 – 5.15 PM	Counselling IDUs on HIV-related issues
	5.15 – 5.30 PM	Feedback session

DAY Four

Session No.	Duration	Session
	9.00 – 9.45 AM	Recap of Day Three sessions
	9.45 – 10.45 AM	Counselling IDUs on HIV-related issues...contd.
	10.45 – 11.00 AM	Coffee break
1	11.00 AM – 1.00 PM	Counselling for motivation enhancement
	1.00 – 2.00 PM	Lunch
2	2.00 – 3.30 PM	Counselling on drug treatment
	3.30 – 3.45 PM	Coffee break
	3.45 – 5.15 PM	Counselling for relapse prevention
	5.15 – 5.30 PM	Feedback session

DAY Five

Session No.	Duration	Session
	9.00 – 9.45 AM	Recap of Day Four sessions
	9.45 – 10.45 AM	Counselling for relapse prevention...contd.
	10.45 – 11.00 AM	Coffee break
1	11.00 AM – 1.00 PM	Counselling for co-morbid conditions
	1.00 – 2.00 PM	Lunch
2	2.00 – 3.30 PM	Crisis management counselling
	3.30 – 3.45 PM	Coffee break
3	3.45 – 5.15 PM	Family counselling in the context of IDUs
	5.15 – 5.30 PM	Feedback session

DAY Six

Session No.	Duration	Session
	9.00 – 9.45 AM	Recap of Day Five sessions
	9.45 – 10.45 AM	Family counselling in the context of IDUs...contd.
	10.45 – 11.00 AM	Coffee break
1	11.00 Am – 1.00 PM	Addressing burnout issues
	1.00 – 2.00 PM	Lunch
2	2.00 – 3.30 PM	IDU TI counsellor – roles and responsibilities
	3.30 – 3.45 PM	Coffee break
	3.45 – 4.30 PM	Feedback and clarification/comments (including post-test questionnaire)
	4.30 – 5.00 PM	Valedictory session

SESSION DETAILS FOR DAY ONE

Session One

INTRODUCTION & ICE-BREAKERS

Objectives of the session

- ◆ To introduce the participants to one another
- ◆ To begin the process of communication among the participants

Duration of session: 45 minutes

Methodology of conducting the session

The facilitator requests the participants to stand in order of their birthdays. The facilitator pairs up participants from the two extremes – i.e. one with first birthday in January with one with last birthday in December. The pairing continues in the same manner for the rest. The pairs are asked to interview each other and elicit the following information within two minutes:

1. Name of the partner
2. Organisation and place where he/she is coming from
3. One incident in life he/she will want to forget
4. One place he/she will want to visit

Next the facilitator invites the pairs to introduce each other to the rest. At the end of the round the facilitator asks the participants if they faced any difficulty during the interview and probes especially about the question regarding the 'one incident he/she will want to forget'. The facilitator also checks to see if any of the participants changed the order of the questions between numbers three and four and if done what were the effects (– did it help?). The facilitator finally wraps up the session sharing with the participants the need for rapport- building before asking sensitive questions and opening with generalised questions which are more likely to have positive responses and help make the interviewee comfortable.

Objectives of the session

- ◆ To help the participants share about their expectations from the training
- ◆ To acquaint the participants with the objectives of the training and clarify which portions of their expectations can be met by the present training
- ◆ To draw up a set of “Ground Rules” for the training programme to be abided by all

Duration of session: 15 minutes

Materials/Aids required

- ◆ Flip chart/chart paper
- ◆ Flip chart stand
- ◆ Flip chart marker pens

Methodology of conducting the session

The facilitator requests the participants to share their expectations from this training programme and his/her partner records them on flip chart/chart paper. Once all possible expectations are shared the facilitator revisits them and requests participants to check with their programme schedule for this training programme and ticks off all those matching. The facilitator revisits those not covered in this programme and discusses why it has not been covered.

The facilitator lists out the ground rules in discussion with the participants and writes them down on a flip chart/chart paper.

Some suggested ground rules:

- ◆ Maintain punctuality
- ◆ Everybody to participate
- ◆ Mobile should be on silent mode
- ◆ Respect each other's views
- ◆ There are no wrong answers – no idiotic questions in the training programme
- ◆ Maintain confidentiality

Session Three

TARGETED INTERVENTION FOR IDUs

AN OVERVIEW

Aim of the session

- ◆ To orient the participants on the Targeted Interventions (TI) for IDUs

Objectives of the session

- ◆ To make the participants understand on why is it important to work with HRGs
- ◆ To provide the participants on the conceptual understanding of a Targeted Intervention
- ◆ To detail out the activities carried out in an IDU TI

Duration of session: One and half hours

Materials/Aids required:

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

Interactive discussion using the presentation (**Day 1 Session 3 - TI for IDUs**) aided by the notes on the slides.

Notes on power point slides (Day 1 Session 3 - TI for IDUs)

Slide 4: Before presenting this slide, the facilitator should ask the participants, whether they have worked/interacted with HRGs before. If the trainees reply that they have worked with IDUs, then they should be asked, if they have worked/interacted with FSWs and MSMs. Then, they should be asked – How are HRGs different from the general population? By initiating this discussion, the facilitator should try to evoke the responses as listed down in the slide.

Slide 10: Before presenting this slide, the facilitator should ask the participants about the benefits of using peer educators for providing services. The facilitator can note the responses on a chart paper, and once most of the responses are elicited, show the slide.

Slide 13: The facilitator when presenting the points on services should elicit from the participants as to what they think are/should be provided in an IDU TI. The responses can be noted down on a chart paper and then the facilitator should present the rest of the content on services provided.

Slide 16: The facilitator should ask the participants why a DIC is required in an IDU TI? Once the responses are elicited, the facilitator should continue with the rest of the contents of the slide.

Day One

Day Two

Day Three

Day Four

Day Five

Day Six

TARGETED INTERVENTIONS FOR IDUs AN OVERVIEW

Targeted Interventions for IDUs – an overview

Background

- In Asia, 4.7 million people were infected with HIV (UNAIDS, 2009)
- Half of the HIV infected people (2.31 million) in India
- Prevalence among general population: 0.34% (NACO, 2008)
- 88% of HIV infection among people between 15 – 49 years age

Targeted Intervention for IDUs – an Overview

2

- Sexual route predominant mode of transmission (>85%)
- Injecting accounts for only 1.7% of all HIV transmission
- HIV present in all the states of India
- Spread of HIV not uniform
 - Some states more affected
 - Some population groups more affected and at higher risk as compared to others e.g. young, male
 - High Risk Groups (HRGs) – Female Sex Workers, Men having Sex with Men, & Injecting Drug Users (IDUs)

Targeted Intervention for IDUs – an Overview

3

Characteristics of HRGs

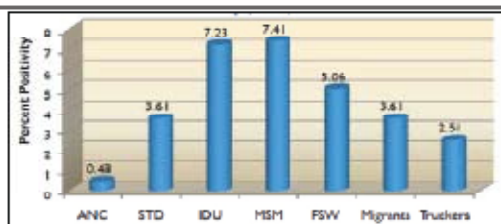
- Involved in behaviours which make them prone for HIV infection
- Behaviour practices are not legal
 - HRGs are targeted by police officials
- Stigma & discrimination of the HRGs
 - HRGs do not come out and seek risk reduction services.
- HRGs are reluctant to seek services designed for the general population

HRGs become vulnerable to contract HIV and remain hidden from the mainstream services

Targeted Intervention for IDUs – an Overview

4

HIV among HRGs



- HIV prevalence among HRGs more as compared to general population
- HIV rates differ among different HRGs; highest in MSM & IDU
- Current data (2008) shows highest in IDU (>9%)

Targeted Intervention for IDUs – an Overview

5

HIV prevention among HRGs – Approaches

- Reluctance among HRGs to access mainstream services (e.g. general hospitals,) due to stigma and discrimination
 - Services specifically for HRGs to be provided – **Targeted Intervention (TI)**
- Principles of TI:
 - are for people within the community who are most at risk of HIV infection.
 - are adapted to be culturally and socially appropriate to the target audience.
 - focus on limited resources and where they can be used to the best benefit.

Targeted Intervention for IDUs – an Overview

6

HIV prevention among HRGs – Approaches

Principles of TI...contd

- effectively use the language and culture of the people being targeted.
- acknowledge that barriers to accessing health-care services exist for some populations within communities.
- acknowledge that people who are at risk of HIV infection are often marginalized from the broader community, stigmatized and discriminated against

Targeted Intervention for IDUs – an Overview

7

HIV prevention among HRGs – Approaches

- HRGs do not come out and actively seek treatment/services, in spite of a TI approach,
 - stigma and discrimination
 - Fear of police officials
- HRGs have to be actively sought out in the community where they are
 - **OUTREACH**
- Outreach – providing services to the HRGs at their doorstep i.e. where they are likely to be in the community

Targeted Intervention for IDUs – an Overview

8

HIV prevention among HRGs – Approaches

- Two ways of providing outreach services
 - By members of the general community
 - By members who are themselves part of the high risk community: '**peer education**' approach
- Peer education approach seen to be the better approach to reach out to HRGs

Targeted Intervention for IDUs – an Overview

9

HIV prevention among HRGs – Approaches

- Advantages of using peer educators for providing services:
 - Identification of the HRGs becomes easy
 - The services provided are more acceptable as the HRGs
 - One of their own is providing services and advising on behaviour change.
 - Easy trust and warmth from the HRG community,
 - Easy penetration into the network of the HRGs.
 - Stigma and discrimination is minimal
 - PEs – a role model for the HRGs
 - Emulate reduced risk behaviour

Targeted Intervention for IDUs – an Overview

10

National AIDS Control Programme III

- NACO: nodal agency to deal with HIV prevention and care in India
- NACP III phase: 2007 – 2012
- **Goal:** Halt and reverse the HIV epidemic by the end of NACP III.
- Objectives:
 - Prevention of new infections
 - Care, support and treatment
 - Strengthening capacities
 - Building strategic information management system

Targeted Intervention for IDUs – an Overview

11

National AIDS Control Programme III

- Enhanced focus on preventive efforts
- 2/3rd of budget on prevention
- Major boost to TI programme
 - Universal coverage for all HRGs
 - 80% of all HRGs to be covered with HIV prevention activities to halt and reverse the epidemic
- TIs run by NGOs contracted by State AIDS Control Societies (SACS), funded by NACO

Targeted Intervention for IDUs – an Overview

12

IDU Targeted Intervention

- Approach: Harm Reduction
- Services:
 - Behaviour change communication
 - Risk reduction materials: Needle syringes, abscess prevention materials (spirit swabs, distilled water, etc.), and condoms
 - STI – detection & treatment
 - Treatment of general medical conditions, abscess management, etc.
 - Counselling on drug related aspects

Targeted Intervention for IDUs – an Overview

13

IDU Targeted Intervention...

Services contd...

- Opioid Substitution Treatment (OST), if the TI accredited for OST
- Referral to appropriate agencies for other services:
 - HIV related services: ICTC, ART, etc.
 - Drug relates services: detoxification, rehabilitation, OST
 - Others: night shelters, vocational training,
 - Facilitating formation of support groups, self help groups

Targeted Intervention for IDUs – an Overview

14

IDU Targeted Intervention...

- Service provision – two pronged strategy
 - Mobile based services: through an outreach team
 - Outreach workers (from IDU/non IDU background) and Peer educators (current/ex-IDUs)
 - Visit to 'hotspots' – areas of IDU congregation
 - Activities:
 - Befriend IDU clients,
 - Collect basic information about the IDU
 - Providing risk reduction materials
 - Basic behaviour change communication.
 - Motivation to visit the DIC for receiving additional services

Targeted Intervention for IDUs – an Overview

15

IDU Targeted Intervention...

Service provision...contd

- Static based services: through Drop-in-Centre (DIC)
 - Physical space established by NGO close to the hotspots
 - 3 – 4 rooms: rest & recreation, counselling, doctor's room, and dressing room
 - Staff: ANM/Counsellor, doctor, outreach worker
 - Activities
 - Screening – STI, abscess and other general medical conditions, and treatment as required
 - Abscess management – including dressing and cleaning

Targeted Intervention for IDUs – an Overview

16

IDU Targeted Intervention...

Service provision, Activities...contd

- Counselling for risk reduction and other drug related issues
- Rest for IDUs
- Recreation by provision of recreational materials such as television, carom board, etc.
- Group discussions and facilitation of support group formation
- Provision of risk reduction materials, including Needle/syringe and condoms

Targeted Intervention for IDUs – an Overview

17

IDU Targeted Intervention...

- A programme manager for overall management
 - Guiding the team for daily activities
 - Planning the activities of the TI
 - Monitoring & supervision of the project
 - Advocacy with relevant stakeholders
 - Building referral linkages and networking
 - Regular reporting to relevant authorities

Targeted Intervention for IDUs – an Overview

18

Session Four

UNDERSTANDING DRUG USE AND DRUG USE DISORDERS

Objectives of the session

- ◆ To familiarise the participants with various drugs/substances of abuse; similarities and differences between their effects
- ◆ To bring about attitudinal changes in participants regarding drug users; specifically, to enable them to see drug dependence as an illness

Duration of session: One and half hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

1. Begin by asking the participants the names of various addictive drugs known by them. Note all the names on the flip chart, in such a way that it helps in categorisation.
2. Ask, “What are the similarities among these drugs?” generate discussion.
3. Stress the point that “basic similarity among these drugs is that, all of them produce certain effects in the brain/mind which are perceived as pleasurable or relaxing. Another similarity is that after taking these drugs repeatedly, the user gets habituated or addicted to them.”
4. Use presentation (**Day 1 Session 4 – Understanding Drug Use**) to continue the interactive discussion with the participants. Follow the notes on the slides to guide the discussion.

Notes on power point slides (Day 1 Session 4 – Understanding Drug Use)

Facilitator discusses Part 1, *Types of drugs* of the presentation interactively with participants.

Slide 2: Facilitator explains to the participants – “As we were just discussing, all those substances (which all of you just listed) that affect the brain or mind and have a propensity to cause habituation or addiction are collectively called ‘drugs’ or psychoactive substances.”

Slide 5: Facilitator discusses with the participants the various alcoholic beverages available and their similarities and differences. Follows up by asking – What are the effects of alcohol and notes them down on the flip chart/chart paper categorically under the heads of physical, psychological, socio-legal and economical.

Slide 6: Facilitator asks “If alcohol is a brain depressant, why do people start behaving as if they have more courage and strength now, after drinking? i.e. why do people appear excited after drinking?” He explains – “All human behaviour is

Day One

Day Two

Day Three

Day Four

Day Five

Day Six

controlled (reined in) by our sense of judgment or sense of what is the appropriate behaviour in a certain situation. Since alcohol is a brain depressant, one of the first brain functions depressed by alcohol is these reins, which leads to loosening of our inhibitions.'

Slide 8: Facilitator describes briefly how opium is extracted from the poppy plant, mentions the long history of opium cultivation and use in India. Emphasises that India is the largest legal producer of opium globally.

Slide 9: Facilitator discusses the modes of consumption of heroin (smoking, chasing and injecting).

Slide 10: The facilitator emphasises that like heroin, many substances do not produce a pleasurable feeling on first use. In fact, for some substances an individual has to learn to experience the high produced by it. The facilitator also highlights differences between the intoxication produced by alcohol and opioids.

Slide 12: Discuss how the cannabis plant in India is easily available (particularly in the north and north east). The facilitator follows up with – “What are various cannabis products you know of ?”

Slide 13: Here, the facilitator should emphasise that cannabis can be used to produce a number of different intoxicating products. Of these, only *bhang* is a legal substance due to its traditional use on religious occasions in some parts of the country. All the rest are illicit and much more potent than *bhang*.

Slide 14: The facilitator asks – “What are the effects of cannabis?”

Slide 15: The facilitator asks the participants “What are the various pharmaceutical products that you know of, which can be used as intoxicants?”

Slide 17: The facilitator explains – “These substances are pharmaceutical products which are generally available only on the prescription of a registered medical practitioner. However, a certain degree of over-the-counter sale of these drugs does take place and hence users of these substances are able to procure them. The effects of these drugs are not similar and mimic the effects of substances discussed earlier depending upon the class of drug.”

Slide 20: The facilitator elaborates – “Cocaine is another substance which is available in a variety of formulations: tablets, capsules, powder, etc. this substance can be consumed orally, snorted or injected through the intra-venous route. At present, cocaine and ATS are very costly in India and hence their use is limited. However, we should remain geared up to deal with cocaine and ATS abuse in the near future.”

Slide 21: The facilitator asks – ‘What are the various professions or kinds of jobs in which we would like people to be alert, excited with no need of sleep or to eat? Probable answers – ‘Soldiers’. The facilitator shares, that during World War-I, some countries used to provide stimulants to their soldiers. However, it has been realised that such strategies actually harm the user in the long run and hence, they have been discontinued. He also discusses the link between stimulant use and violent crimes/risky sexual behaviour.

Slide 23: The facilitator explains – “These are substances that produce distortions of perception in the user. The user may start seeing things or hearing sounds which others cannot see or hear. Many of these substances are used by young college-going students and under the influence of these substances they are highly vulnerable to risky sexual behaviour. Most users of such drugs use them as recreational agents; addiction to these drugs is not so frequent.”

Slide 25: The facilitator elaborates – “Tobacco products are the most common substances used by mankind. Tobacco can also be consumed in various ways which includes smoking, snorting, chewing, etc. In our country, the use of beedi and chewable tobacco is much more common than other forms of tobacco use, especially among the rural population.”

Slide 27: The facilitator shares with the participants – “These are generally petroleum products which are used for a variety of purposes. The most commonly used volatile substances are ink-removing fluids, glues, and paint sprays. This form of substance use is most commonly seen amongst adolescents who have not yet experienced other higher forms of substances. One basic difference between inhalants and all other drugs we discussed so far is the fact that, while all other drugs are also harmful to human beings THEY HAVE BEEN DEVELOPED FOR HUMAN CONSUMPTION. On the other hand inhalants are those chemicals, which are not intended to be used in this manner. Thus, they can be and indeed are one of the most harmful substances for human health.”

Yet another difference is that though the medical community does recognise their addictive and harmful nature, inhalants are not categorised as drugs under the legal and policy frameworks. Thus they remain legal and unregulated substances.

Slide 29: The facilitator should emphasise that although some substances are legal i.e. they can be purchased and consumed legally; all substances can produce dependence and lead to harmful consequences to the individual and the society.

Slide 30: The facilitator introduces the survey briefly.

Slide 31: The facilitator explains that the study was designed to capture representative data from the whole country alongwith data from hidden/special populations so – NHS added with RAS, DAMS and FTS and different techniques were used to elicit information – implicit assumption that each component has a unique focus of attention.

Slide 32: The facilitator highlights that though, in terms of percentage the figures may appear small, in terms of absolute numbers, the number of users in India is huge.

Slide 33: The facilitator should clarify that – not all users are dependent. The survey also looked into figures for dependence, and even these figures are very huge and represent a big gap between treatment demand and service provision in the country.

The facilitator begins Part 2 of the session by asking, “why do people take drugs?” and noting the responses on a flip chart in a manner which permits easy grouping of the reasons into ‘positive’ (such as to feel happy, to enjoy, to enhance sexual pleasure, out of curiosity etc.) and ‘negative’ (such as to relieve boredom, frustration, anxiety, sadness, mental-tension etc.). This is followed by the slides of Part 2.

Slide 35: The facilitator explains that people generally take drugs to either feel good (sensation seekers, or anyone wanting to experiment with feeling high or feeling different) or to feel better (self-medicators, or individuals who take drugs in an attempt to cope with difficult problems or situations, including stress, trauma, and symptoms of mental disorders).

Slide 36: The facilitator asks the participants – “What makes some people more vulnerable to drug addiction? Many people try drugs without getting addicted, while others do become addicted – some quickly and easily.”

Slide 37: The facilitator explains “Drug addiction is a complex illness. It is determined in part by the way our brain functions.”

Slide 38: The facilitator clarifies – “Certain parts of the brain govern specific functions, just like in a house, there are different rooms designated for different activities.”

Slide 39: The facilitator shares with the participants – “One of these brain regions, called ‘brain reward system’ is involved in all the activities which we perceive as pleasurable, and which we feel like doing again (e.g, food, water, sex). The same system is also the site of action for many drugs.”

Slide 41: The facilitator explains – “It is clear today that addiction is the result of complex interactions not only among many genes but also between genes and a host of environmental factors.”

Slide 48: The facilitator begins the Part 3 of the presentation by asking the participants – “Are use, abuse, addiction, dependence – the same things? If not, how are they different?”

Slide 53: The facilitator discusses each criterion one-by-one, taking time, so that participants are familiar with the concept of dependence.

Slide 56: The facilitator emphasises that alcohol withdrawal, if untreated, can be fatal. Opioid withdrawals on the other hand, though very distressing are never fatal. So forcibly stopping an alcohol-dependent person from drinking may be fatal for him.

Slide 59: The facilitator highlights the fact that a number of factors affect an individual’s decision to start using a particular drug. Such factors can be external e.g. pressure from friends who use the particular substance or internal e.g. feelings of frustration or guilt after a life event.

Slide 62: The facilitator explains to the participants that similar to drug initiation, a number of factors, both internal and external, govern the progression of substance use from occasional use to regular and then dependent use. Any individual who experiments with a particular substance does not always become a regular or dependent user of the same. Many individuals may not use the substance again while some may only use it occasionally or in moderation.

Slide 63: The facilitator explains the graphic that illustrates a progression of substance use in terms of graduation from a less dependence-producing and more socially acceptable substance to more dependence-producing, illicit and harmful forms of substances. It is understood that any individual rarely starts his drug-use career with substances like heroin/IDU. Most individuals usually begin by using substances like tobacco, alcohol or cannabis and then gradually proceed to other substances. From this perspective, substances like tobacco, alcohol or cannabis open the window of entry into the world of substance use. This is known as the “Gateway Hypothesis.”

Slide 64: The facilitator highlights that for any substance most of the individuals who experiment with it remain at the use or abuse level and do not progress further. Comparatively smaller proportions of individuals eventually become dependent upon substances and are in immediate need of treatment services.

DRUG ABUSE: AN OVERVIEW

Drug Abuse : An Overview



Drug / Psychoactive Substance

- Any substance that when taken by a person modifies perception, mood, cognition, behaviour or motor functions
- This definition includes legal and illegal substances, that can lead to **dependence**

Part 1: Types of drugs

Classification

- Alcohol

Alcoholic beverages



- Alcohol is a brain depressant.
 - In small amounts it relieves anxiety.
 - it may also give a sense of strength and result in boisterous behaviour
 - It heightens the mood prior to intake, be it sadness or happiness.
 - Impairs judgement and performance

Classification

- Alcohol
- Opioids



Heroin (Smack)



Opioids: Psychological effects

- *The effects differ widely between new and dependent users*

New users

- Who is not in pain → an unpleasant reaction.
- Who has pain or anxiety → some relief

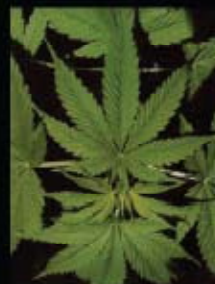
Dependent users

- Short lived intense experience – "rush".
- A state of profound euphoria.
- A dreamlike state lasting longer

Classification

- Alcohol
- Opioids
- Cannabis

Cannabis (Bhang, Charas, Ganja, Hashish)



Cannabis products

- | | |
|--|--------|
| • Bhang (leaves) | Oral |
| • Ganja (dried flowering stem of the plant) | Smoked |
| • Charas / Hashish (extracted from the resin covering the plant) | Smoked |
| • Hashish Oil (extracting THC using chemical methods) | Smoked |

Cannabis: Psychological effects

- A dreamy state with an increased tendency to fantasize
 - State of euphoria, well being and enjoyment.
 - Generally followed by a period of drowsiness.
- Perceptual and sensory distortions.
 - Can prolong reaction time and impair coordination
 - Sounds and colours may become more intense
- Restlessness, fear and even panic may spoil the experience ("bad trip").
- There may be driven activity (subject knows that one's activities are meaningless, yet is unable to control them).

Classification

- Alcohol
- Opioids
- Cannabis
- Sedative – hypnotics

Valium, Avil, Cough Syrups



Sedative – hypnotics & other pharmaceuticals

Medications for:

- | | |
|---------------------------------------|-----------------------------|
| • Sleep (Diazepam) | } General brain depressants |
| • Allergy (Promethazine, pheniramine) | |
| • Pain (Pentazocine, Propoxyphene) | } Opioid like actions |
| • Cough (Codiene) | |
| • Diarrhea (Diphenoxylate) | } Hallucinogen |
| • Anesthesia (Ketamine) | |

Classification

- Alcohol
- Opioids
- Cannabis
- Sedative – hypnotics
- Cocaine and other stimulants

Coca leaf and cocaine powder



Amphetamine Type Stimulants (ATS)



Stimulants: Psychological effects

- Immediately after smoking the drug or injecting it- extremely pleasurable 'rush' or 'flash'.
 - Enhanced mood and body movement, euphoria
 - Increased respiration
 - Increased heart rate, blood pressure
 - Insomnia
 - Reduced appetite

Classification

- Alcohol
- Opioids
- Cannabis
- Sedative – hypnotics
- Cocaine and other stimulants
- Hallucinogens

LSD



Classification

- Alcohol
- Opioids
- Cannabis
- Sedative – hypnotics
- Cocaine and other stimulants
- Hallucinogens
- Tobacco

Tobacco



Classification

- Alcohol
- Opioids
- Cannabis
- Sedative – hypnotics
- Cocaine and other stimulants
- Hallucinogens
- Tobacco
- Volatile solvents

Volatile solvents (Inhalants)

Inhalants



Classification

Depressants

- Alcohol
- Opioids
- Sedative – hypnotics
- Volatile solvents
- Cannabis

Stimulants

- Cocaine
- Amphetamine Type Stimulants
- Tobacco
- Cannabis

Hallucinogens

- LSD
- Cannabis

Types of drugs

Legal (licit):

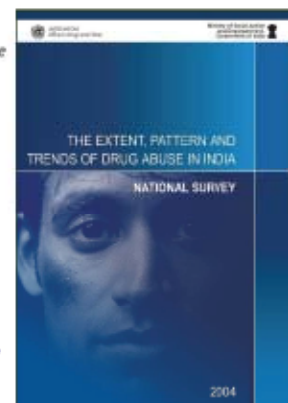
- Medicine
- Tobacco
- Alcohol
- Caffeine/tea
- Bhang

Illegal (illicit):

- Opium
- Heroin
- Cocaine
- ATS,
- Charas/Ganja



The Extent, Pattern and Trends of Drug Abuse in India: National Survey



Components of the survey

1. National Household Survey (NHS)
2. Drug Abuse Monitoring System (DAMS)
3. Rapid Assessment Survey (RAS)
4. Focused Thematic Studies (FTS)
 - Drug abuse and women in India
 - Burden on women through abusing family members
 - Drug abuse in rural population
 - Drug consumption in border areas
 - Drug abuse in prisons

1. DATA HIGHLIGHTS – NHS

Sample Size: 40,697 males (12-60 yrs)

Prevalence of 'current' use (i.e., during last month)

- Alcohol: 21% **62.5 m**
- Cannabis: 3% **8.7 m**
- Opiates: 0.7% **2 m**
 - (heroin: 0.2%)
- Any illicit drug: 3.6% (excl. tobacco and alcohol)
- IDUs ('ever'): 0.1%
- Poly-drug users: 22.3%

1. DATA HIGHLIGHTS – NHS



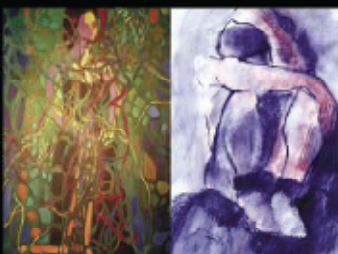
	Current use	Dependency	'Volume of Work'
ALCOHOL	62.5 m	16.8%	10.5 m
CANNABIS	8.7 m	25.7%	2.3 m
OPIATES	2.0 m	22.3%	0.5 m

Part 2: Why Do People Take Drugs?

Why Do People Take Drugs?

To feel good

To have novel:
feelings
sensations
experiences
AND
to share them



To feel better

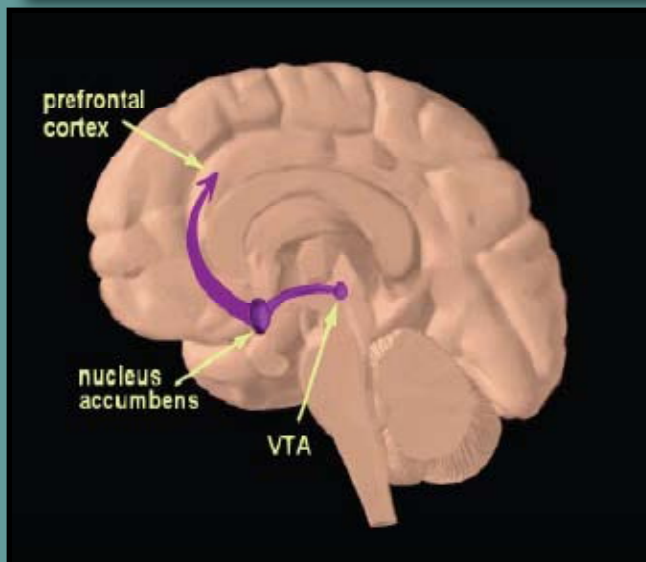
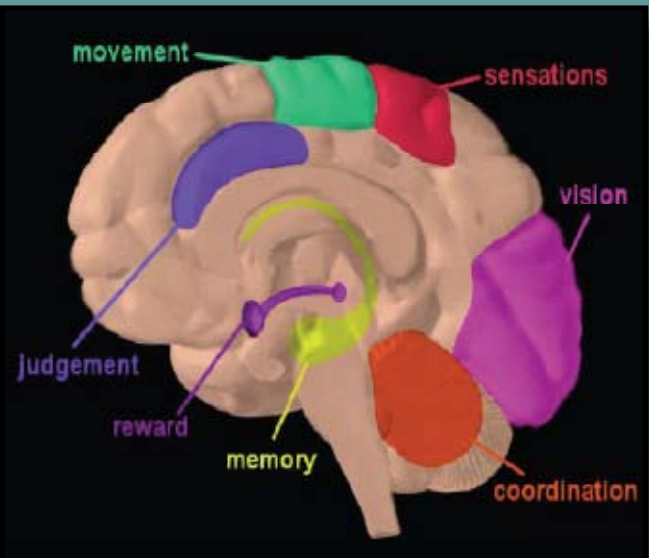
To lessen:
anxiety
worries
fears
depression
hopelessness

Vulnerability



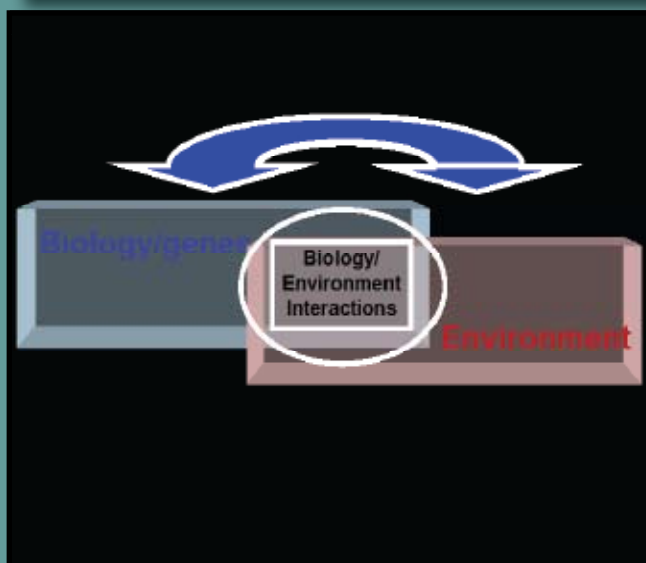
Why do some people become addicted while others do not?

DRUG ADDICTION IS A COMPLEX ILLNESS



There's a
Big **Biological / Genetic**
Contribution to
Drug Abuse and Addiction...

....Overlapping with **Environmental**
Influences that Help Make
Addiction a Complex Disease.



Environmental factors

- Drug related
- Individual related
- Society – community related

Drug related factors

- Availability
 - Legal and policy environment
 - Socio-cultural norms and attitudes
- Abuse liability
 - Reward or reinforcement
 - Non-toxic
 - route, duration of action

Drugs: The vicious cycle



Presence makes you
feel good... (euphoria)

Absence makes you
feel miserable... (withdrawal)



Individual related factors

- Self-medication theory
 - Co-morbid mental illnesses very common
 - Co-morbid symptoms even commoner
- Personality factors
 - ‘novelty seeking’

Society related factors

- Family influence
- Peer influence
- Cultural and religious sanction & proscription
- Legal & policy environment
- The setting

Part 3: Concept of Abuse

Terminology

- Use
- Misuse / harmful use
- Abuse
- Dependence
- Addiction - older term, still used

Terminology

- Use
 - The ingestion of alcohol or other drugs without the experience of any negative consequences.

If a student had drank a beer at a party and his parents had not found out we could say he had USED alcohol.

Terminology

- Misuse
 - When a person experiences negative consequence from the use of alcohol or other drugs it is clearly misuse.

A 40-year old man uses alcohol occasionally, his boss throws a party and the man drinks more than usual and on the way home he is arrested by police.

Terminology

- Abuse / harmful use
 - Maladaptive pattern of use resulting in physical, social, legal harm
 - Continued use in spite of negative consequences

The same 40-year old man continues drinking alcohol after the incident.

Terminology

- Dependence
 - Drug taken in larger amounts or over longer period
 - Persistent desire or unsuccessful efforts to cut down
 - A great deal of time is spent in:
 - obtaining the drug
 - using the drug
 - recovering from its effects
 - Important social, occupational, or recreational activities given up or reduced
 - Continued use despite harm
 - Tolerance
 - Withdrawal
- Addiction - older term, still used

Withdrawal symptoms

- Usually opposite of acute effects
 - Depressants: withdrawal-excitation
 - Stimulants: withdrawal-lethargy/'crash'

Alcohol withdrawal: mild

- Anxiety
- Restlessness
- Insomnia
- Tremors
- Craving
- Palpitation
- Sweating
- Breathlessness

Alcohol withdrawal: severe

Severe Alcohol Withdrawal: "Delirium Tremens"

- All features of mild withdrawal
- Disorientation (unawareness of self and surroundings – time, place and person)
- Hallucinations
- Seizures (fits – 'rum fits')
- Can be fatal

Opioid withdrawal

Very distressing, but never fatal !

- Opening of all holes !
 - Watering from eyes, nose
 - Vomiting
 - Loose motions
- Bodyache / pain
- Anxiety, restlessness, insomnia
- Premature ejaculation

Cannabis withdrawal

Non specific

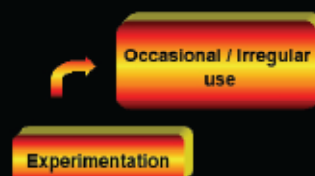
- General discomfort
- Intense craving
- Anxiety, restlessness

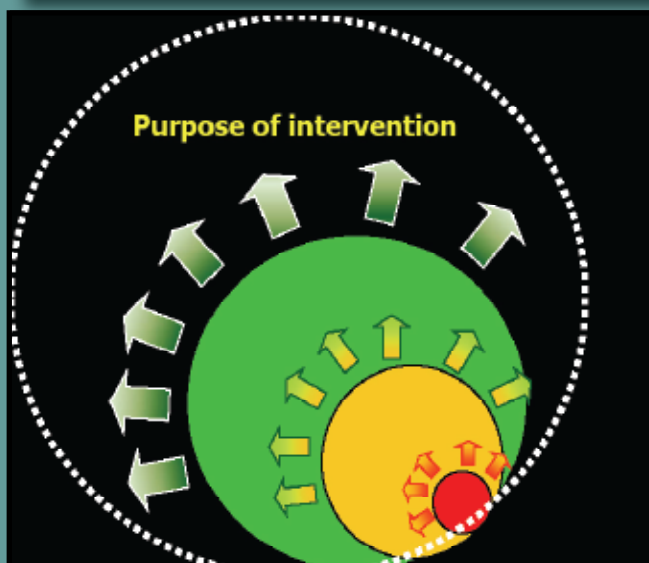
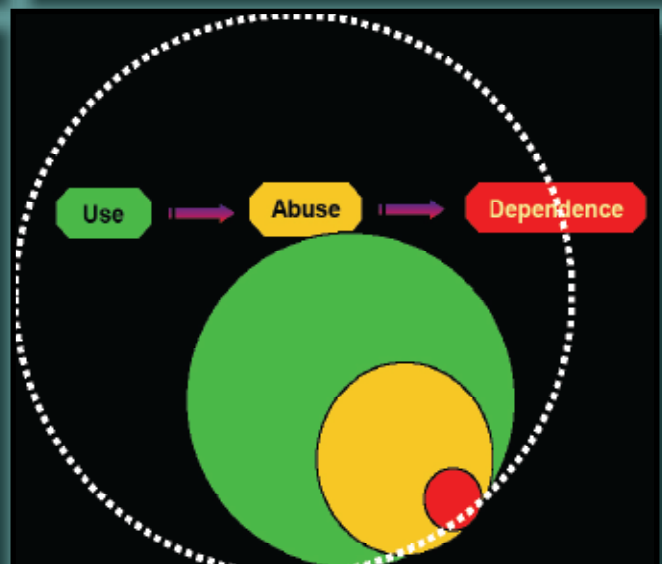
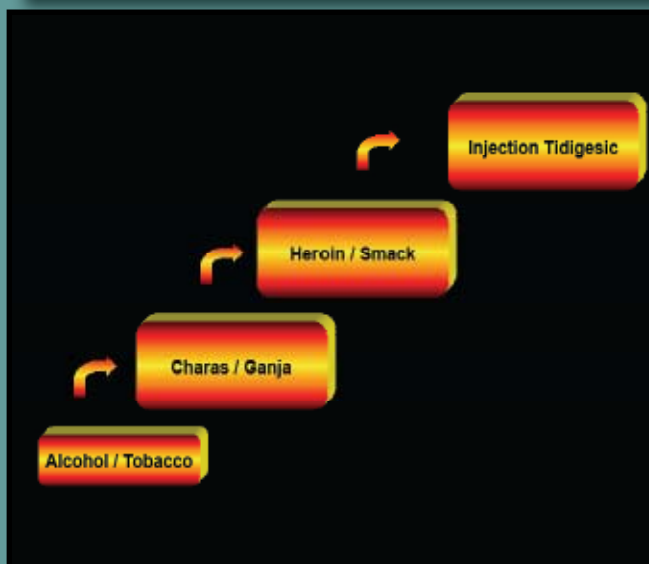
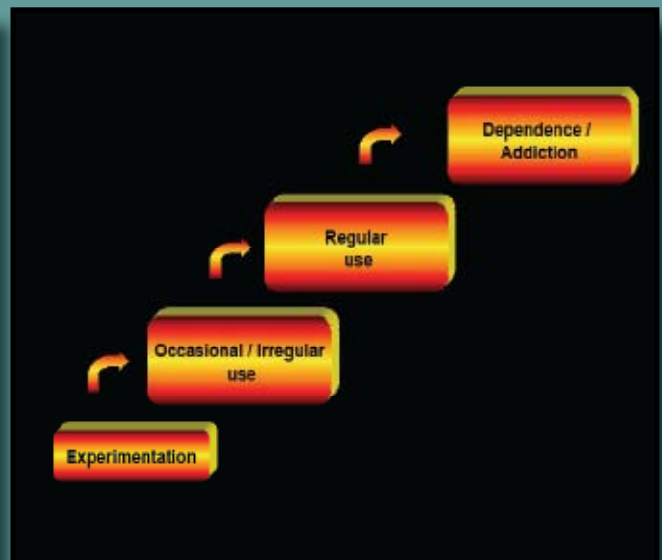
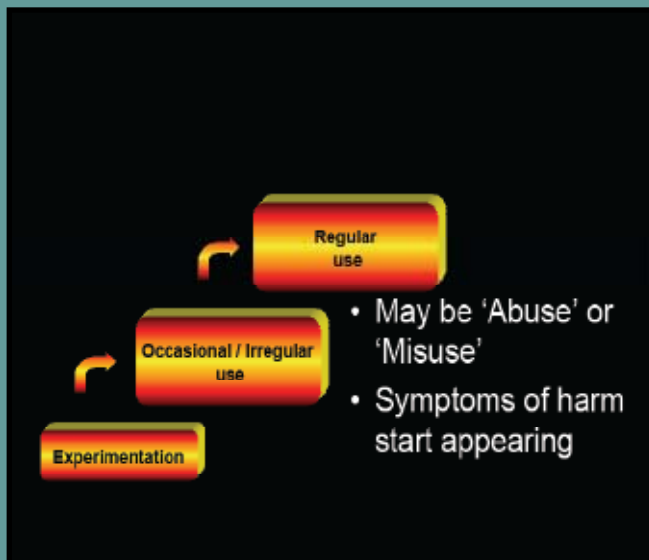
The usual drug-use 'career'

- Depends upon
 - Availability
 - Peer pressure
 - Socio-cultural norms
 - Psychological factors

Experimentation

- Depends upon
 - Initial experiences
 - Peer pressure





Thank You

Objectives of the session

- ◆ To enlighten the participants regarding the special characteristics of Injecting Drug Use
- ◆ To bring attitudinal changes among the participants on issues related to IDU

Duration of session: One hour 15 minutes

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

This is a group activity followed by discussion. Initiate by asking the group very simple and basic questions: what are various modes of drug intake? How do they differ?

Use the presentation (**Day 1 Session 5 – Understanding IDU**) and follow the notes below the slides.

Highlight that...

- ◆ IDUs may have varying profiles
- ◆ Typical IDUs in contact with an IDU TI, need help with not just risky behaviours but also with other areas of life
- ◆ There are many reasons for sharing. Providing needles and syringes will address only one of them
- ◆ Even if IDUs do not share, they remain at risk of various other consequences of injecting

Notes on power point slides (Day 1 Session 5 – Understanding IDU)

Slide 5: The facilitator begins by asking “what are the drugs that IDUs usually inject in your (participants’) areas? Note down responses on a flip chart pointing out the similarities and emphasising that almost all IDUs in India inject some type of opioid in combination with other sedatives.

Slide 7: The facilitator elaborates –“Historically, opium was cultivated, eaten, and drunk by all classes as a household remedy; It was used by rulers as an indulgence, and given to soldiers to increase their courage. Opium trade, particularly with China was a big source of revenue for the British government. After independence

and after the international drug control requirements the use of opium has been restricted.

Slide 8: The facilitator adds – “The decade of the 80s saw the dawn of the heroin use epidemic, which started in the larger metro cities, and gradually spread to smaller towns and eventually even to the rural areas.”

Slide 9: The facilitator explains – “This epidemic of heroin use in India was not surprising because of India’s proximity to the two main illicit opium cultivation areas of the world – the so called ‘**Golden Triangle**’ and ‘**Golden Crescent**’ in addition to the high production of legal opium in India.”

Slide 10: The facilitator adds on – In the 1990s injecting drug use of opioids made its appearance in the north-east and then spread gradually to other parts of the country. However, there has been always a distinction in the pattern of substance use in the north-east and elsewhere; while in the north-east pure heroin has been the drug of choice, elsewhere in the country a cocktail of pharmaceutical opioids (buprenorphine or pentazocine) and other sedatives (diazepam, pheniramine, promethazine, in various permutations and combinations) have been injected predominantly. Lately the trend of injecting brown sugar has also been observed.

Slide-14: The facilitator explains the graphic illustrating a progression of substance use in terms of graduation from a less dependence-producing and more socially acceptable substance to more dependence-producing, illicit and harmful forms of substances. It is understood that any individual rarely starts his drug use career with substances like heroin/IDU. Most individuals usually begin by using substances like tobacco, alcohol or cannabis and then gradually learn the use of other substances. Some users start taking opioid injections directly, without an intervening period of brown sugar chasing. Additionally, sometimes people are given prescriptions of opioid injections for health reasons (such as pain) by doctors. Some people thus, start taking opioid injections legitimately as pain-killer medications, but gradually develop dependence on it.

Slide 15: The facilitator asks what kinds of IDUs are usually seen at your TI?

Slide 16: The facilitator explains that while drug use and injecting is not limited to any particular demographic group, most vulnerable are those who belong to the underprivileged section of society. Since IDU represents a rather severe form of drug use, which is associated with many socio-occupational consequences, it is likely that the IDUs who require the services of an IDU TI are those who belong to the poorest section of society. Consequently, the typical IDU who would come into contact with an IDU TI, would be a man, in his productive years, but not likely to be regularly and gainfully employed. He may be married, but likely to have poor social support. Years of drug dependence would have led to severe dysfunction in almost all aspects of his life. It is not uncommon for a typical IDU TI to cater to poor, homeless IDUs, who may have limited means to sustain themselves, to maintain their hygiene, or even to obtain two square meals a day. Involvement with the criminal justice system is also common. In other words, many IDU clients serviced by an IDU TI would require help not just regarding their high-risk behaviour but also in many other areas of life. However, there are always exceptions and hence an IDU TI must be prepared to extend services to even those IDUs who do not fit this description – women IDUs, IDUs belonging to the middle or upper socio-economic strata, IDUs holding white collar jobs and staying with their families etc.

Slide 17: The facilitator elaborates “When injections are administered in a health-care setting, the usual aseptic precautions are observed. The location is usually clean and hygienic. The area to be injected is thoroughly cleaned with a disinfectant, the veins are made prominent, a sterile needle and syringe are used, and after injecting the site is pressed with a clean cotton swab for a few seconds (to prevent bleeding). However, for IDUs, it is not usually possible to administer injections with such precautions. Since injecting drugs is an illegal, socially-deviant act, IDUs usually inject at places which are hidden from the public view. These may include parks, public toilets, unused buildings or open spaces, garbage dumps, near drains, etc. Since such places are not clean, injecting at such places is associated with risks of acquiring infections.”

Additionally, IDUs also find it difficult to clean the skin at the injecting site prior to injecting. On many occasions, injecting takes place with a sense of urgency due to craving and/or withdrawal symptoms. This also increases the risk of infections.

Health damage due to IDU also depends on the site of the body chosen for injecting drugs. The peripheral veins (of the hands) are supposed to be the least unsafe for injecting. With repeated injections however, these veins get blocked which leads to searching for other suitable veins for injecting. In many cases, IDUs find that all the peripheral veins on their all four limbs have been blocked and are thus forced to inject in veins which are dangerous, such as those on the groin/thigh or neck. Injecting in these areas of the body is associated with the risk of excessive bleeding.

Slide 18: The facilitator generates a discussion on this. It would be observed that most people would be comfortable in sharing those objects which are not too intimate or too close to the body (such as a towel, plate of food, a dress etc.). Objects closer to the body would make people very uncomfortable, if these had to be shared (e.g. undergarments, spoon, toothbrush etc.)

Try to generate a similarity between these objects with injecting equipment. Even though a syringe needle may appear distant, it is much more intimate than even a toothbrush. Yet, in informal surveys, even IDUs who share their injecting equipment refuse to share their toothbrushes!

Slide 20: The facilitator discusses “Why do IDUs share?” with the participants.

Slide 22: The facilitator highlights that the risks listed in bold here are the risks associated with sharing. However, even without sharing IDU is associated with other risks, listed here.

UNDERSTANDING INJECTING DRUG USE

UNDERSTANDING INJECTING DRUG USE

Various routes through which drugs can be taken

- Only very few drugs can be taken through oral route
- In general oral route is one of the least efficient route of drug intake since
- A lot of drug is destroyed before it reaches the brain
- It takes substantially longer for the drug to reach the brain and exert its effects
- However, oral route is also least harmful for taking drugs, in general



Various routes through which drugs can be taken

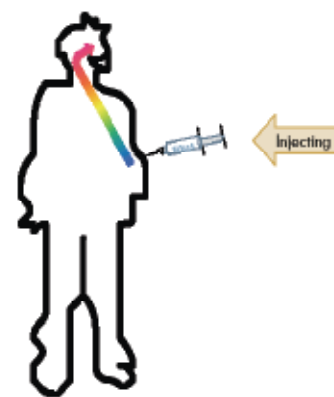
• Drug reaches the blood circulation through lungs and then onwards to the brain fairly early

• This route is harmful as it damages the linings of the lungs and can give rise to various respiratory diseases



Various routes through which drugs can be taken

- The most efficient route of drug intake
- Drug reaches brain fairly quickly and gives sudden effects
- Requires much less amount of drug (hence cheaper)
- Most damaging or harmful route of taking drugs



Common drugs injected in India

Heroin (pure/white heroin/ 'No. 4'): mainly in the northeastern states.

Heroin (Smack / brown sugar): not readily injectable as it comes in the form of crude, impure powder.

- Before injecting, a user has to prepare or 'cook' the drug.
- Most users mix the powder with an injectable sedative drug (like chlorpheniramine), boil it, filter it with a cotton swab and then inject it.

Buprenorphine (Tidigesc/Norphine) or pentazocine (Fortwin): probably the most popular drugs for injecting among IDUs in India.

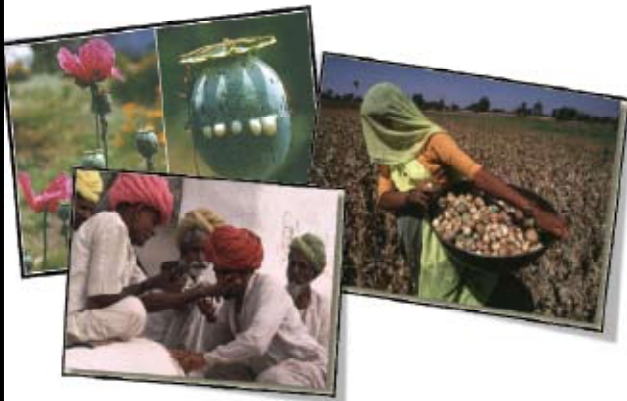
- Most users mix them with one or more of the following sedatives for enhancement of the effects:
 - Diazepam (calmipose),
 - Chlorpheniramine (Avil),
 - Promethazine (Phenargan).

Dextropropoxyphene (Proxylon / Spasmo-Proxylon / SP): available as capsules and NOT AS INJECTIONS.

- Users open the capsules, take the powder out, mix it with another liquid / drug and then inject it.
- Seen only in the northeastern states, very rare in other parts of the country

INJECTING DRUG USE IN INDIA

History



Opioids in modern India

- Early 1980s: Opium replaced with heroin
- Rural areas: Opium users continued with Opium, some switched to heroin
- Urban areas: Heroin use started spreading



Opium in modern India



India's proximity to 'Golden Triangle' and 'Golden Crescent'

Opioids in modern India



- Early 1990s: Injecting Drug Use started in North East India; gradually spread to other parts

IDU in India

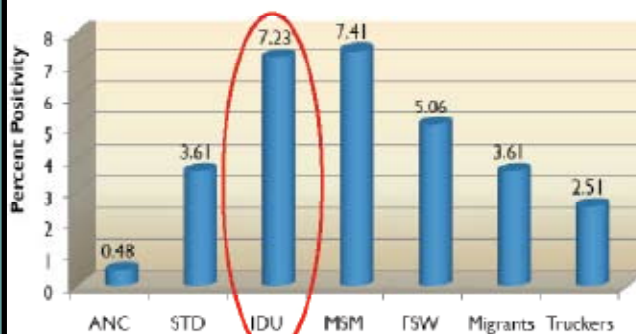
- Currently, India figures among the developing and transitional countries with the "largest populations of IDUs".
- The National AIDS Control Organisation estimates that currently there are about **2 Lakh IDUs in India**.

HIV among IDUs in India

- the HIV among IDUs is also progressing in India at an alarming rate.
- At the national level IDU is the vulnerable group (among other vulnerable groups such as Female Sex Workers and Men-Who-Have-Sex-with-Men) which has highest prevalence of HIV.
- The states / areas particularly affected by HIV among IDUs are:
 - Manipur, Nagaland, Mizoram, Punjab, Chandigarh, Delhi, Kerala, Tamil Nadu and parts of Orissa, Bihar, and UP.

HIV estimates in India, 2008

HIGH-RISK GROUPS: IDU – high prevalence



The usual drug use career



Profile of a usual IDU

- Most vulnerable: underprivileged section of the Society
- IDUs catered to by an IDU TI: belong to poorest section of the society
- The typical IDU
 - A man,
 - in his productive years, but not likely to be regularly and gainfully employed.
 - May be married, but likely to have poor social support.
 - Severe dysfunction in almost all aspects of his life.

Profile of a usual IDU

- Also likely that a IDU TI will encounter IDUs who are:
 - poor,
 - homeless,
 - may have limited means to sustain themselves, to maintain their hygiene, or even to have two square meals a day.
 - In conflict with law
- Thus, IDU would require help regarding
 - high-risk behaviours
 - many other areas of life.
- Exceptions, i.e. atypical IDUs which may require attention
 - Women IDUs,
 - IDUs belonging to better socio-economic strata, holding white collar jobs and staying with their families
 - IDUs which are also other HRG members (FSWs, MSM etc.)

Injecting practices

When injections are administered in a health-care setting → usual aseptic precautions

- Location: clean and hygienic.
- The area to be injected: thoroughly cleaned with a disinfectant,
- Body parts: safe for injecting
- Injecting equipment: sterile needle and syringe
- After injecting: the site is pressed with a clean cotton swab for few seconds (to prevent bleeding).

For IDUs → not possible to maintain aseptic precautions

- Location: hidden from public (parks, public toilets, unused buildings or open spaces, garbage dumps, near the drains and nullas etc.)
- The area to be injected: not usually cleaned
- Body parts: Unsafe parts of body such as groin / thigh or neck
- Injecting equipment: reuse or sharing

Sharing

- Which of the following YOU can share with a friend of yours?
 - A towel / napkin
 - A plate of food
 - A spoon
 - A glass for drinking a beverage
 - A dress
 - Undergarments
 - Toothbrush

Sharing

- Injecting is very often a group activity
- The sharing may involve:
 - Sharing needles
 - Sharing Syringes
 - Sharing injecting paraphernalia (i.e. the cookers or pots in which drug has been prepared for injecting).

Why do IDUs share?

- **Economic reasons:** Unavailability of injecting equipments - the drug may be procured from a drug-peddler, but the injecting equipment may be available only at a pharmacy, which may be reluctant to sell needles-syringes or may choose to sell them at a premium.
- **Psychological reasons:** Sometimes IDUs may choose to share their injecting equipments, just because they feel their bonding with each other will be strengthened by this act.
- **Poor awareness:** of consequences of sharing or of safe injecting practices also contributes to risky practices

Risks of sharing

- Transmission of blood borne infections such as
 - HIV
 - HBV
 - HCV

Risks of Injecting

- Risk of local (injection site) infections like Thrombophlebitis (blocked veins), abscess, gangrene, amputation etc.
- Risk of spread of local infection to other parts of body like septicemia, endocarditis, etc.
- Risk of accidental injury to arteries leading to severe bleeding
- **Risk of spread of blood borne infections like HIV, Hep-B and Hep-C**
- Risk of overdose and Toxicity

SESSION DETAILS FOR DAY TWO

Session One BASICS OF HIV/AIDS & STIs

Objectives of the session

- ◆ To educate the participants on general issues related to HIV transmission
- ◆ To educate the participants on general issues related to STIs and their prevention

Duration of session: One hour

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

This is a group activity followed by discussion

Steps

1. Initiate by asking the group very simple and basic questions about HIV/AIDS (e.g. "What is HIV? How does it differ from AIDS?" etc.)
2. Use the power point presentation (Day 2 Session 1 – HIV) and continue to discuss with the participants following the notes provided on the slides:

Notes on power point slides (Day 2 Session 1 – HIV)

Slide 4: The facilitator points out that HIV is name of a virus. It is NOT name of a disease.

Slide 5: The facilitator adds that other commonly known conditions like flu, diarrhea in children, dengue fever are also caused by different types of viruses.

Slide 6: The facilitator clarifies that viruses cannot be seen by the naked eye. However, if seen by special instruments, this is how HIV would appear.

Slide 8: The facilitator assures the participants – “We shall come back to more about AIDS in a few moments...”.

Slide 33: The facilitator mentions that these are just some examples. In AIDS, the general ability of the body to fight with many other infections goes down.

3. Conduct the risk hierarchy exercise with the group. Provide the group various situations depicting modes of HIV transmission. The situations may include the following:
 - ◆ Blood transmission from an infected to non-infected individual
 - ◆ Sharing of needles between infected and non-infected individuals
 - ◆ Men having sex with men
 - ◆ Peno-vaginal sex between infected man and non-infected woman
 - ◆ Peno-vaginal sex between non-infected man and infected woman
 - ◆ Oral sex between man and woman
 - ◆ Infected pregnant mother
 - ◆ Infected mother breast-feeding her baby
 - ◆ Infected father hugging the children
 - ◆ Infected and non-infected children playing together
 - ◆ A family sharing meals with some infected and some non-infected members
4. Now ask the group to place situations in one of the three categories (make three piles of situations “high risk” “low risk” and “no risk.” Generate discussion during the entire process.
 - ◆ Now pick up the situations in the “high risk” pile. Even among these generate a discussion on which situations have higher risks than others.

Highlight that...

- ◆ Infected penetrator is more likely to transmit infection than infected recipient
- ◆ Peno-anal sex has higher risk than peno-vaginal sex
- ◆ Direct blood contact has higher risk than contact with genital fluids

5. Ask “what are sexually transmitted infections?”
6. Are there some local names? Present: “Sexually Transmitted Infections” in an interactive manner.
7. Show the power point presentation about Sexually Transmitted Infections (Day 2 Session 1 -HIV)

HIV/AIDS: THE BASICS



HIV/AIDS: The Basics



Structure of presentation

- ⌘ What is HIV
- ⌘ What is AIDS
- ⌘ How does HIV spread (and does not!)
- ⌘ What happens after HIV enters body
 - The HIV test
 - AIDS
- ⌘ Treatment



Structure of presentation

- ⌘ What is HIV
- ⌘ What is AIDS
- ⌘ How does HIV spread (and does not!)
- ⌘ What happens after HIV enters body
 - The HIV test
 - AIDS
- ⌘ Treatment



HIV: Human Immunodeficiency Virus

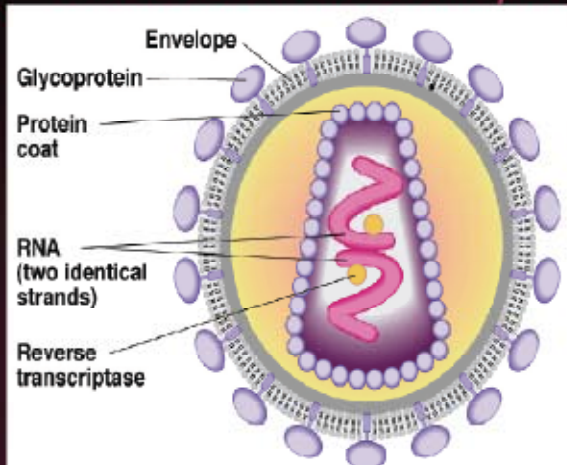


HIV: Human Immunodeficiency Virus

- ⌘ How are Virus Unique?
 - Virus are microorganisms
 - They are considered to be a connecting link between living and nonliving
 - Virus are fragile. Destroys rapidly out side cell



HIV: Human Immunodeficiency Virus





Structure of presentation

- ⌘ What is HIV
- ⌘ What is AIDS
- ⌘ How does HIV spread (and does not!)
- ⌘ What happens after HIV enters body
 - The HIV test
 - AIDS
- ⌘ Treatment



What is AIDS

- A** - Acquired (*to get from someone*)
- I** - Immune (*body's defense or resistance*)
- D** - Deficiency (*lack of resistance*)
- S** - Syndrome (*signs and symptoms of disease*)



Structure of presentation

- ⌘ What is HIV
- ⌘ What is AIDS
- ⌘ How does HIV spread (and does not!)
- ⌘ What happens after HIV enters body
 - The HIV test
 - AIDS
- ⌘ Treatment



HIV transmission

- ⌘ Requirements for transmission to occur
 - HIV must be present...
 - *Transmission can't occur from one non-infected individual to another*
 - In sufficient quantity...
 - *A small amount of blood is enough to infect. A larger amount of other fluids would be needed*
 - And it must get into the bloodstream
 - *Healthy, unbroken skin does not allow HIV to get into the body*



HIV transmission

- ⌘ **HIV Survival Outside The Body**
 - Length of time HIV can survive outside the body
 - HIV is very fragile, and many common substances, including hot water, soap, bleach and alcohol, will kill it
 - Exposure to air
 - Air does not "kill" HIV, but exposure to air dries the fluid that contained the virus, and that will destroy or break up much of the virus very quickly
 - Needles
 - HIV can survive for several days in the small amount of blood that remains in a needle after use



HIV transmission

⌘ **Infectious fluids in the body**

- Blood (including menstrual blood)
- Semen
- Vaginal secretions
- Breast milk
- Pre-seminal fluid

⌘ **Non-Infectious fluids in the body**

- Saliva
- Tears
- Sweat
- Feces
- Urine



HIV transmission

Infected individual

Non-Infected individual



- Sexual contact
- Direct blood contact
- Mother to baby



HIV transmission

Infected individual

Non-Infected individual



▪ Sexual contact



HIV transmission

⌘ Sexual Transmission: Risks

- Peno-Anal > Peno-Vaginal
- Peno-Vaginal > Oral sex
- Male to Female > Female to Male
- More in presence of injuries
 - Hence risk more in coercive / violent sex
- More in presence of STIs



HIV transmission

Infected individual

Non-Infected individual



▪ Direct blood contact



HIV transmission

⌘ Direct Blood Transmission: Risks

- Blood Transfusion
 - Also includes blood-product transfusion
- Sharing of Needles
 - Intravenous > Intramuscular
- 'Needle sticks': Accidental transmission in health care settings
- Shaving, 'Blade Injury', Tattooing, and Piercing: *Low but present*



HIV transmission

Infected individual

Non-Infected individual



▪ Mother to baby





HIV transmission

🎗 Mother to Baby

- Before Birth: *Baby shares mother's blood*
- During Birth
- Through Breast Feeding: Though quantity of virus is small in breast milk, enough to cause infection in the baby.



HIV transmission

Infected individual

Non-Infected individual



▪ How it **DOES NOT** spread

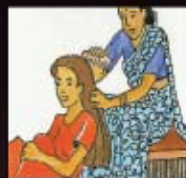
- "Social" Kissing
- Hugging / sharing clothes / food
- Insect Bite
- ? Human Bite



HIV does **NOT** spread through:



Shaking hands



Sharing combs



Eating from the same plate



Hugging



HIV does **NOT** spread through:



Towels or clothes



Sharing latrines or toilets



Sitting close to other people



Mosquitoes, bedbugs, other insects or animals.



Structure of presentation

- 🎗 What is HIV
- 🎗 What is AIDS
- 🎗 How does HIV spread (and does not!)
- 🎗 What happens after HIV enters body
 - The HIV test
 - AIDS
- 🎗 Treatment



What is HIV?



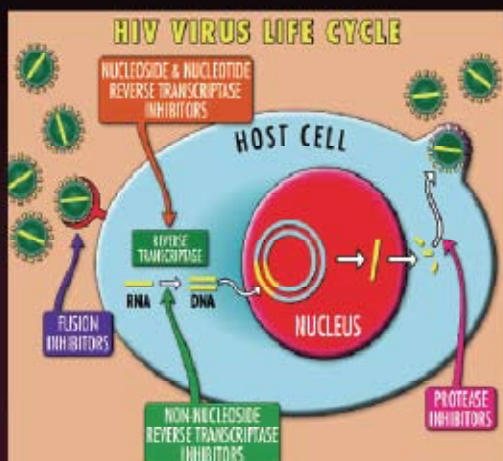
1. Our bodies are normally protected by white blood cells against diseases.



2. White blood cells help fight diseases that attack our bodies.



HIV: Life Cycle



HIV: Life Cycle

Human body produces certain specific chemicals:
Antibodies

HIV infects cells

HIV is recognized by immune system as 'Foreign'

Process
takes 3 to 6
months

Body produces antibodies

Antibodies are detectable

Test may
be -ve
"Window
Period"

"Positive HIV Test"



HIV infection: Symptoms

- ⌘ Significant weight loss
- ⌘ Persistent fever
- ⌘ Persistent diarrhea
- ⌘ Persistent cough
- ⌘ Persistent generalized swelling of lymph glands



What is HIV?



3. However HIV is a stronger germ than the white blood cells, it attacks and weakens the white blood cells.



4. So when our bodies can no longer have white blood cells to protect them, diseases can attack us and eventually kill us.



HIV: Life Cycle

There are certain cells in body called – T4 cells: responsible for immunity
HIV infects T4 cells

Production of more HIV

Reduction of T4 cells (CD4)

Reduction in immunity

Increased risk of infections & tumors

AIDS



What is AIDS

- A** - Acquired (to get from someone)
- I** - Immune (body's defense or resistance)
- D** - Deficiency (lack of resistance)
- S** - Syndrome (signs and symptoms of disease)



What is AIDS

⌘ Main feature of AIDS is increased susceptibility to infections: 'Opportunistic infections'

- Tuberculosis *
- Candidiasis
- Cryptococcal meningitis
- Neuro Toxoplasmosis
- CMV retinitis

⌘ Kaposi's Sarcoma



Structure of presentation

⌘ What is HIV

⌘ What is AIDS

⌘ How does HIV spread (and does not!)

⌘ What happens after HIV enters body

- The HIV test

- AIDS

⌘ Treatment



Treatment

⌘ "Treatment is available; Cure is elusive"

⌘ Treatment:

- Prolongs life
- Reduces infectivity
- Reduces likelihood of opportunistic infections
- Improves quality of life
- Is costly
- Needs to be long-term and sustained
- Is associated with side effects / resistance



Prevention is better than cure !



How to prevent HIV infection:



Do not share instruments such as razor blades, needles and syringes. If sharing can not be avoided, then insist on using sterilized instruments.



Cover cuts and wounds with water-proof plasters or a piece of clean cloth.



How to prevent HIV infection:



Do not have sex until you are married and then stay faithful to your partner.



If you can not avoid blood transfusion, then insist on blood which has been tested for HIV.



How to prevent HIV infection:



Women with HIV should seek advice before getting pregnant because they may pass on HIV to their babies.



How to prevent HIV infection:



Avoid multiple partners
If not possible, use condoms

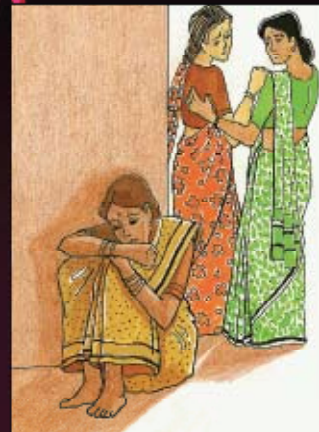


How to prevent HIV infection:



HIV positive mother can transmit HIV virus to her baby through breast feeding. However, breast feeding is the best food for your baby, as it protects against many other diseases.

Either the infected mother exclusively breast feeds her baby for not more than 3 months or only uses alternative feeds. Avoid mixing breast milk with other fluids or foods. Go to the health worker for advice on alternative feeds.



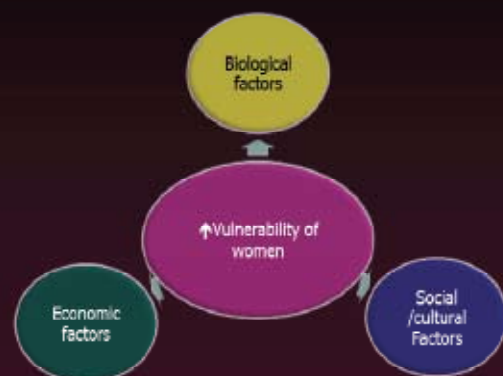
Anybody can get HIV/AIDS.
Even you !



Who is more vulnerable for HIV?
Men or Women?



Why are women more vulnerable to HIV?





↑ Vulnerability of women

Biological factors

- ⌘ The shape of female sexual organs – like a receptacle
- ⌘ More area of contact
- ⌘ Higher concentration of HIV in Semen than Vaginal fluids
- ⌘ Less physical power than males, hence vulnerability to forced sex



↑ Vulnerability of women

Social / Cultural factors

- ⌘ Position of women in society
 - Lesser bargaining power
 - Lower levels of education and literacy
- ⌘ The age difference between couples and trend of earlier marriage
- ⌘ Social values regarding sexual behaviour between men and women



↑ Vulnerability of women

Economic factors

- ⌘ Women have lesser say in economic matters
 - Hence lesser bargaining power
- ⌘ Sex trade (women as sellers and men as buyers)

Thank you

SEXUALLY TRANSMITTED INFECTIONS

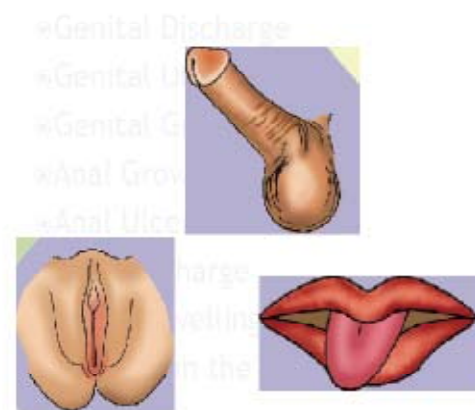
Presentation: Sexually Transmitted Infections

Notes on power point slides (Day 2 Session 1 – STIs)

Slides 4 & 5: The facilitator emphasises that STIs can affect all those body parts which are used for sexual activities. These include genitals as well as anus or mouth.

<h3>SEXUALLY TRANSMITTED INFECTIONS</h3>	<h4>INTRODUCTION</h4> <ul style="list-style-type: none"> • As the name suggests these are infections which transmit from one person to another through sexual route • These infections are usually caused by microorganisms such as bacteria or virus
<h4>COMMON STI</h4> <ul style="list-style-type: none"> • Syphilis • Gonorrhea • Chancroid • Herpes • LGV 	<h4>COMMON SYMPTOMS OF STI</h4> <ul style="list-style-type: none"> • Genital Discharge • Genital Ulcers • Genital Growth • Anal Growth • Anal Ulcer • Anal Discharge • Painful swelling of scrotum • Swelling in the groin

COMMON SYMPTOMS OF STI



SYNDROME

- **Syndrome**- Presentation of 2 or more symptoms
 - for example 'ulcer on the genital organ with lymph node swelling in the groin'.

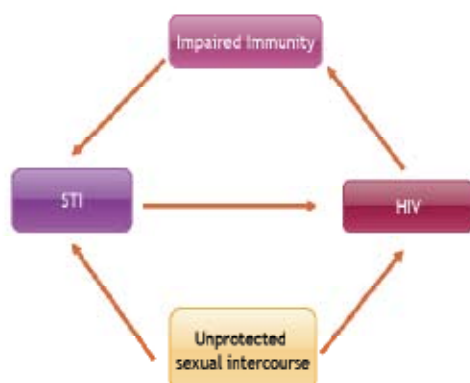
CONSEQUENCES OF STI

- Risk of transmission to partner
- Increase in symptoms leading to pain, disability
- Spread of infection to other parts of body
- **Increased risk of HIV**

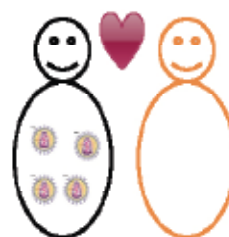
LINKAGE OF STI WITH HIV

- Persons suffering from STI have 2 to 4 times increased risk of getting HIV infection
- HIV decreases immunity and increases vulnerability to getting STI
- Genital ulcers -sores make it easier for HIV to enter the body

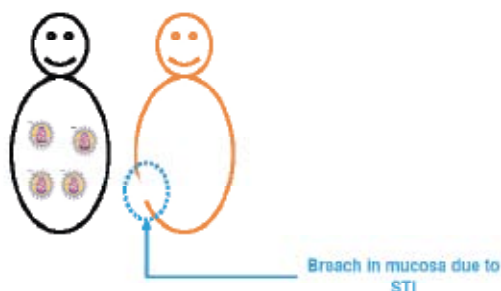
LINK BETWEEN STI AND HIV



INCREASED RISK OF HIV



INCREASED RISK OF HIV



INCREASED RISK OF HIV



SYNDROMIC MANAGEMENT

- 'Syndromic management of STDs' recommends that such medicines be given, which will cover all the possible organisms that might cause a symptom or a group of symptoms.

TREATMENT

WHO Recommends

- Oral single dose
- Drugs chosen on basis of no resistance amongst organisms
- No side effects
- Affordable

PREVENTION AND MANAGEMENT

- Educate
- Counseling for adherence to treatment
- Promote condom use
 - Some sexually transmitted infections (herpes, HPV or Human Papilloma Virus or warts) are passed through skin to skin contact so a condom will not provide protection.
- Provide HIV counseling and testing
- Emphasize treatment for the partner
- Return if symptoms persist

THANKS

APPROACHES TO ADDRESS DRUG USE PROBLEMS AND HARM-REDUCTION

Objectives of the session

- ◆ To familiarise the participants with basic principles and issues surrounding various approaches to address drug problems and specifically, Harm-Reduction
- ◆ To bring about attitudinal changes among participants regarding drug treatment and harm-reduction¹

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

Discuss with the participants using the power point presentation on **Day 2 Session 2 – Harm-reduction** and follow the notes provided on the slides.

Notes on power point slides (Day 2 Session 2 – Harm-reduction)

Slide 1: The facilitator begins by generating a discussion on what the participants think are the various harms related to drug use.

Slide 2: The facilitator should begin the presentation with a brief discussion of the various harms associated with substance use (in particular IDU) and then present the next slide for a quick revision of the same. Here, the facilitator should emphasise those harms which are more important from a community perspective and are easily preventable e.g. risk of HIV transmission.

Slide 3: The facilitator discusses the various drug-related harms.

Slide 4: The facilitator encourages a discussion amongst the participants and notes down all the suggestions given by them on a white board. While noting down the suggestions, the facilitator should take care to group them according to the three major strategies for curbing drug use and related harms: **Demand reduction strategies, Supply reduction strategies and Harm-reduction strategies**. After eliciting sufficient responses from the trainees, the facilitator should then show the next slide.

Slide 5: The facilitator shows the fictional situation of three communities ('A, B and C'), and generates a discussion on how drug problems in these three cities can

¹ Participants belonging to either of these two backgrounds – drug treatment and harm-reduction – often tend to view both these approaches as contradicting each other. Hence it is important to clear these misconceptions and bring about the understanding that both these approaches in fact complement each other.

be addressed? Once all the responses dry out the facilitator provides the Correct Response – B. The facilitator asks – What should be done for community A? (Likely answer: control the wine shops, remove them from residential areas, provide counselling and treatment to alcohol users [i.e. more of supply and demand reduction, link it to the next slides). The facilitator further asks – What should be done for community C? (Likely answer: increase awareness among adolescents, develop their life-skills to help them stay away from drugs [i.e. more of prevention – demand reduction, link it to the next slides).

Slide 6: After presenting this classification of various strategies to reduce drug-related harms, the facilitator emphasises that some drug-related interventions (e.g. education on HIV/AIDS) may be considered under more than one particular strategy. Hence, this classification is not strict but merely educational in nature.

Slide 7: After showing this slide, the facilitator should encourage discussing of the merits and demerits (including) feasibility and perceived effectiveness of Demand Reduction Strategies. While concluding it should be emphasised that no matter how well-applied, relying solely on this approach is not likely to be effective in preventing all the harms associated with drug use.

Slide 8: After showing this slide, the facilitator should encourage discussion on merits and demerits (including) feasibility and perceived effectiveness of Supply Reduction Strategies. Again concluding that however well-applied, reliance on only this approach is not likely to be effective in preventing all the harms associated with drug use. None of the countries in the world – even the superpowers – have been able to eliminate illicit drug use. Drug use remains a part of human civilisation. In fact, it should be emphasised that an over-zealous supply-reduction approach may even increase the harms by forcing drug users to go underground and making drug availability scarce and hence unsafe. Drug-using people branded as ‘criminals’ may find it difficult to access various essential services.

Slide 9: While being shown this slide, participants should be encouraged to think about the paradigm where drug use may be seen as acceptable while efforts are made to reduce the harmful consequences of drug use. Moreover, it should be emphasised that a Harm-reduction approach is not antagonistic but rather complementary to other approaches.

Slide 11: The facilitator should now ask the participants about their views on this issue. The presenter should note down these views on a white board and should then use some of these as examples (while presenting the next slide) to make the trainees understand why approaches other than harm-reduction cannot succeed in isolation in dealing with harms associated with drug use.

Slide 14: The presenter should emphasise here that the Harm-reduction approach encompasses a number of interventions and the idea is to provide the drug user with a basket of choices. The job of a harm-reduction worker is to first make the drug users aware of these options and then help them choose the best possible alternative with respect to the harms experienced by each individual user.

Slide 16: The facilitator should emphasise here that even though stopping drug use altogether would be the most effective way of reducing IDU-associated harms, but that may not be possible for all IDUs. Hence, the harm-reduction worker may have to lower the goal in such cases and focus upon how to prevent harmful consequences with continued drug use.

Begin by asking, what would be the most ideal and safest way for an IDU to completely eliminate the risk of all harms associated with drugs use? Show each of the options in the hierarchy one by one.

Slide 17: The facilitator explains to the participants – “As with IDU, the education on high-risk sexual behaviours focuses on the readiness of an individual to change his sexual practices. Even though abstinence from sex would be the most effective way of preventing sexually transmitted diseases (STDs) including HIV, it is not a practical option. So the educational intervention focuses upon reducing the number of sexual partners or at least consistent condom use with every sexual partner. While focusing on the last two options, the worker should always remember to impart education on STD/HIV testing and treatment services as they remain a possibility for those who have multiple sexual partners.”

Slide 20: The facilitator discusses – “Why should there be a component of exchange? Why not just distribute syringes and needles. (Answers: reducing the risk of contaminated equipment spreading in society, ensuring safe disposal and engaging the client in a give-and-take process which fosters, responsibility, decision-making and allows for more interactions for behaviour change communications).”

Slide 25: The facilitator explains that this is just for information. This strategy has not been adopted in India.

The facilitator should also discuss what the participants think is drug treatment (goals, approaches, modalities)? Ask the participants and note down their responses on a flip chart/chart paper or white board categorically i.e. grouping together responses under the heads of goals, approaches and modalities separately. This brief discussion gives an idea to the facilitator of the level of understanding of participants regarding drug treatment.

The facilitator completes the presentation.

Address the common misconceptions people may have about drug treatment:

- ◆ “Drug treatment inevitably means getting admitted to a restrictive setting for a long term”
- ◆ “Detoxification is removal of toxins from body”
- ◆ “Relapse means treatment failure”
- ◆ “Will-power is enough to quit drugs”
- ◆ “Most medications for treating drug dependence are themselves addictive”

HARM REDUCTION

Harm Reduction

Let us discuss, what are various drug related harms?

Drug related harms...

Physical Harms

- Infections – local (abscess), systemic (HIV)
- Poor nutrition, debility, weight loss
- Overdose, death

Occupational / Financial Harms

- Absenteeism from work
- Frequent changes of job, loss of job
- Losses suffered/debts incurred

Familial / Social Harms

- Marital disharmony, separation/divorce
- Loss of reputation, Social outcast
- Stigma and discrimination

Psychological Harms

- Guilt / shame, Lack of motivation
- Depression, anxiety
- Other mental disorders

Legal Harms

- Involvement in illegal activities
- Arrests, imprisonment
- Drug dealing (NDPS Act)

How can one possibly reduce these Harms?

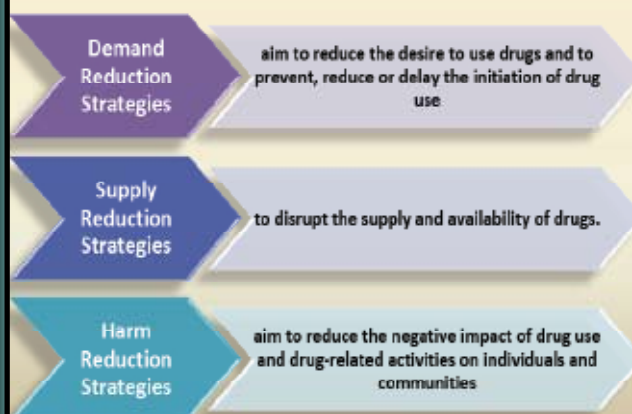
Let us do some brain mapping on this issue...

Interactive Session

Which of the following communities is in need of harm reduction services?

- Community A: less IDU, increasing number of wine shops in residential areas and alcohol using adults
- Community B: large number of IDUs, high prevalence of HIV/AIDS amongst IDUs
- Community C: recent trend of adolescents getting into smoking and occasional cannabis (ganja) use
- All of the above

Drug Abuse Management Strategies



Drug Abuse Management Strategies

Demand Reduction Strategies

Aim to reduce the desire to use drugs and to prevent, reduce or delay the initiation of drug use

Primary prevention

- Aimed at young people to discourage initiation of drug use

Treatment

- Identification of drug users; providing effective treatment for them

Drug Abuse Management Strategies

Supply Reduction Strategies

Aim to disrupt the supply and availability of drugs.

Regulated supply of legal drugs

- Alcohol only for certain people, in certain settings
- Medications available only through prescriptions

Total prohibition of illegal drugs

- Seizures of drug(s); punishment to drug dealers

Drug Abuse Management Strategies

Demand Reduction Strategies

aim to reduce the desire to use drugs and to prevent, reduce or delay the initiation of drug use

Supply Reduction Strategies

to disrupt the supply and availability of drugs.

Harm Reduction Strategies

aim to reduce the negative impact of drug use and drug-related activities on individuals and communities

What is 'Harm Reduction'?

"policies and programs that are aimed at reducing the harms from drugs, but not drug use per se"

Means 'reducing harm from drugs even more important than reducing drug consumption'

More effective:

- Seeks to achieve realistic, sub-optimal objectives rather than setting, fail-to-reach, utopian goals
- '80% of something > 100% of nothing'

Why Harm Reduction?

Why not eliminate all forms of drug use from the society?

Lets discuss...

Why can't drugs be eliminated?

- Substance use has been part of human society from the very beginning
- 'Zero Tolerance' based strategies such as
 - legal prohibition of substances and
 - abstinence-oriented treatment
 have not been able to eliminate substance use.
- making a drug illegal may even increase the harms associated with its use through marginalization and criminalization of drug users.

A drug free society:

impossible to achieve

As a result...

- There will always be some people using drugs
- Among these users
 - Some may not be willing to give up drug use altogether
 - Many others may have tried but failed
- All such drug using individuals are at continued risk of drug-related harms
- Harm reduction provides an alternative to deal with these individuals

Strategies for Drug-related Harms

Educational Interventions

- How to reduce risk
- Safer methods of drug use

Needle syringe exchange programmes

Substitution e.g. methadone, buprenorphine

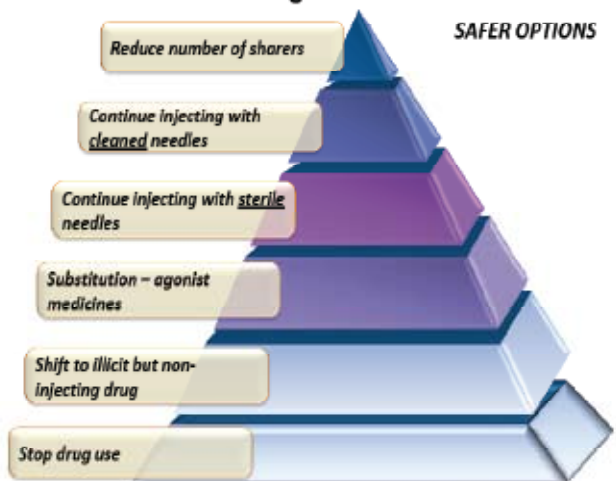
Other strategies

This entire package = 'harm reduction'

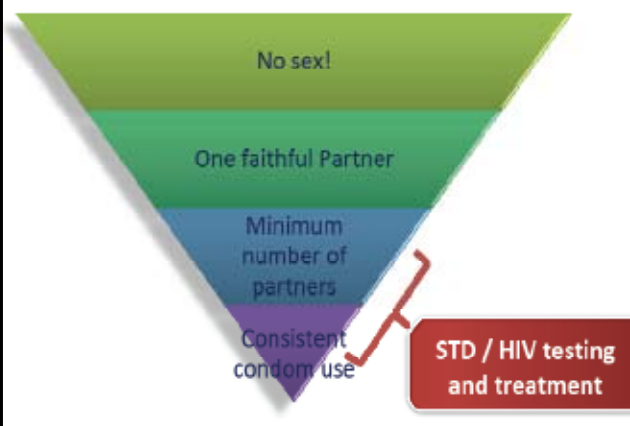
EDUCATIONAL INTERVENTIONS

- information given:
 - simple,
 - explicit,
 - peer-based,
 - factual

IDU Risk Reduction through education



Education on risky sexual behaviors



NEEDLE SYRINGE EXCHANGE PROGRAMMES

Needle Syringe Exchange Programmes

More readily associated with the harm reduction approach than any other type of intervention

Involves supplying new, clean needles and syringes to IDUs, in exchange of old used, needles and syringes.

Incorporate a variety of other preventive strategies such as outreach, risk reduction education, referrals to other health and social services, etc.

Philosophy of NSEP

Used Needles

- Unclean
- Infected
- Previously used by others
- Risk of HIV transmission

Replaced with

New Needles

- Clean
- Uninfected
- For use by patient only (expected)
- No risk of HIV transmission

Needle Syringe Exchange Programmes

Myths

- It does not reduce HIV
- It leads to an increase in drug use
- It does not reduce risky injection practices
- It discourages drug-abuse treatment
- It is costly

Needle Syringe Exchange Programmes

Evidence regarding Benefits

- Positive impact on HIV risk behaviors and HIV infection.
- Limit sexual transmission of HIV between IDUs as well as to their non-injecting sexual partners.
- Reach out to more marginalized drug users than any other intervention
- Some of the IDUs move on to maintenance treatment and even abstinence
- Does not increase drug use

Other Strategies

Other strategies

• Outreach Services

- Strategy to reach out to the hidden drug users
- Reaches to people within their own communities or closer to door steps

Finding drug users

Observing them

Establishing contact and rapport with them in their natural environments

Providing information about risk behaviours

Promoting and supporting safe behaviours

Other strategies

- **Safe injection facilities**
 - Also known as 'injection rooms'
 - Provide – not only the clean syringes or needles, but – a safe injection facility
 - Provides opportunities to IDUs to inject pre-obtained illicit drugs under the supervision of and/or by the medical staff
 - Could also include various other services e.g.
 - interventions for overdose
 - Risk reduction education
 - Condom distribution
 - Referral for medical complications

Extremely controversial strategy, used in few countries till date

AGONIST SUBSTITUTION TREATMENT

Coming soon

Conclusions

Harms associated with drug use can be dealt with in a number of ways

Harm reduction strategy provides the most practical and flexible approach to reduce these harms

Focus is on immediate and easily preventable harms rather than setting unrealistic goals such as complete abstinence

Agonist substitution treatment and NSEPs are the most common and effective strategies

Combination of strategies and individualization of intervention are important aspects of a harm reduction approach

THANK YOU

Session Three

ASSESSMENT AND DIAGNOSIS

Aim of the session

- ◆ To train the participants on how to carry out assessment of an IDU client

Objectives of the session

- ◆ To make the participants aware of the various methodologies of conducting assessment
- ◆ To train the participants on the areas to be explored for carrying out assessment
- ◆ To train the participants on the various terminologies and diagnostic terms to be used

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Presentation (the slides for the presentation are provided at the end of this session)
- ◆ Discussion with the participants during presentation on the lines described along with the slides
- ◆ Role play after powerpoint presentation (**Day 2 Session 3 – Assessment**)

Notes on power point slides (Day 2 Session 3 – Assessment)

Slide 8: The facilitator should emphasise that the counsellors may not be able to complete the entire details in the first session itself, and that repeated sessions may be required for completing the assessment.

Slide 9: Before presenting the slides, the facilitator should elicit responses from the participants on the various problems that can be encountered by the IDU due to drug use. The responses should be noted down on a chart paper. Later, the facilitator should try to group the responses into the 5 categories mentioned in the above slide as well as the subsequent slides on complications due to drug use.

Slide 23: When discussing the various diagnostic terms, the facilitator should remind the participants that the issue was also discussed in the session on various stages of drug use.

ASSESSMENT AND DIAGNOSIS

Assessment and Diagnosis

1

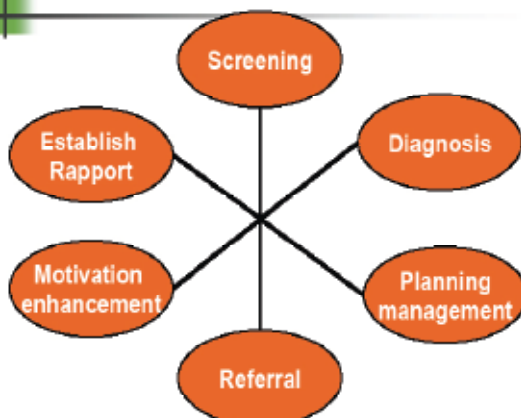
Assessment

Assessment forms the first point of contact for the counsellor with the client

Assessment and Diagnosis

2

Assessment: Benefits



Assessment and Diagnosis

3

Stages of assessment

- Assessment is not a one-time phenomenon



Assessment – tools

- Clinical:
 - Through history and examination
- Investigations
 - Performing certain tests
- Instruments
 - Use of standard tools/questionnaire for assessment

Assessment and Diagnosis

5

Clinical assessment

- Means of clinical assessment
 - Interaction with patient / client
 - Interaction with family member / companion
 - Examination
 - Previous treatment records

Assessment and Diagnosis

6

Clinical Assessment – History

- Socio-demographic profile
 - Name
 - Age
 - Sex
 - Marital status
 - Qualification
 - Occupation
 - Type of family
 - Place of residence

Assessment and Diagnosis

7

Clinical Assessment – History

- Details of drug use
 - Type of drug currently being used: the class of the drug (e.g. opioid) and the particular chemical composition (e.g. buprenorphine); in case the chemical composition is not understood, the local name used should be noted
 - Frequency and amount of drug currently used
 - Mode of use of the drug currently used
 - Last dose of drug used

Assessment and Diagnosis

8

Clinical Assessment – History

Complications associated with drug use

- Physical: health hazards associated with IDU
 - Local: redness/swelling at injecting site, wounds, sores, blocked veins, etc.
 - Systemic: hepatitis, lung diseases (e.g. chronic bronchitis), etc.
- Legal:
 - involvement in illegal activities to obtain drugs (e.g. thefts, pick pocketing)
 - Arrests/detainment by police
 - Charges under NDPS act for drug using/dealing
 - Driving under intoxication with drugs
 - Physical fights under intoxication of drugs

Assessment and Diagnosis

9

Clinical Assessment – History

Complications associated with drug use

- Occupational – financial
 - Inability to work productively
 - Accidents at workplace
 - Frequent absenteeism
 - Loss of job
 - Frequent change of job
 - Loss of income,
 - Debts
- Psychological
 - Guilt & shame
 - Anxiety
 - Depression

Assessment and Diagnosis

10

Clinical Assessment – History

Complications associated with drug use

- Marital/Familial/social
 - Fights with family
 - Neglect of household responsibility
 - Physical violence
 - Outcast from family
 - Separation/divorce
 - Homelessness
 - Stigmatisation in society

Assessment and Diagnosis

11

Clinical Assessment – History

High risk behaviors



Injection Related



Sex Related

Assessment and Diagnosis

12

Clinical Assessment – History

- Injecting related risk behaviors:
 - Sharing of needles
 - Sharing of syringes, cotton, vials, or other paraphernalia
 - Cleaning practices
 - Sites of injection use iv/im; any dangerous sites of use
 - Reuse of needles and syringes
 - Places where injections are taken
 - Needle site complications

Assessment and Diagnosis

13

Clinical Assessment – History

- Sex related risk behaviors:
 - Sexual intercourse without condoms
 - Multiple sexual partners
 - Sexual intercourse with female sex workers
 - Anal intercourse
 - Sex with a person who has STIs
 - Sex under the influence of drugs/alcohol
 - Sex work for procuring drugs

Assessment and Diagnosis

14

Clinical Assessment – History

- HIV related knowledge and beliefs
 - Knowledge on HIV
 - What is HIV?
 - How is HIV transmitted? Name the 4 modes of transmission of HIV
 - What is the difference between HIV and AIDS?
 - What happens when one is infected with HIV?
 - Does one gets HIV by touching and kissing?
 - Does one gets HIV by sharing food of others?
 - Can HIV be cured?
 - Can HIV be prevented? How?

Ask open ended questions

Assessment and Diagnosis

15

Clinical Assessment – History

- History of referrals sought, esp.
 - ICTC,
 - STI clinic,
 - Detoxification and other drug treatment services,
 - Tuberculosis centre

Assessment and Diagnosis

16

Clinical Assessment – History

- History of any medical illness & details
- History of any mental illness & details
- Current living arrangements
- Social support
- Motivation level

Assessment and Diagnosis

17

Clinical Assessment – Examination

- Evidence of drug use with respect to
 - Intoxication
 - Withdrawals
 - Route of drug use
- Evidence of physical damage due to drug use
 - Systemic examination

Assessment and Diagnosis

18

Assessment - Investigations

- Two types
 - To assess the degree of physical damage
 - Hemogram, Liver function test, Renal function test, HIV, Hep B & C
 - To confirm the presence / absence of drugs in the body
 - Screening of body fluids, most commonly urine

Assessment and Diagnosis

19

Assessment – Instruments

- Structured set of questions to assess an individual
- Act to validate assessment across time, place and person
- Examples
 - Addiction Severity Index
 - Clinical Opiate withdrawal scale
 - CAGE

Assessment and Diagnosis

20

Diagnosis

- Diagnosis should include the following:
 - Primary drug status
 - Secondary drug status
 - Physical co-morbidity
 - Psychological morbidity
 - Psychosocial issues

Assessment and Diagnosis

21

Diagnosis

- Drug status: Drug use syndromes
 - Abuse/Misuse
 - Dependence
 - Intoxication

Assessment and Diagnosis

22

Diagnosis

- Drug status: Drug use syndromes
 - Dependence
 - Abuse/Harmful use
 - Intoxication

Assessment and Diagnosis

23

Diagnosis of drug dependence

- Definition

*"A cluster of **physiological, behavioural and cognitive** phenomenon in which **use of a substance** or class of substance takes on a **much higher priority** for an individual **than other behaviours**...."*
- Three or more criteria to be present for some time in a one-year period.

Assessment and Diagnosis

24

Diagnosis of drug dependence: Criteria

1. Tolerance:

- Need for increasing the amount of substance consumed to achieve intoxication or the desired effect
- Markedly diminished effect with continued use of the same amount of substance

Example

A person 'X' started with one line of heroin smoking to get intoxicated; with time, he had to increase the dose to 1 pudiya per day to get the same amount of intoxication

A person 'Y' started with one peg of whisky and got high; with continued use, has to now consume 3 pegs of whisky to get the same high

Assessment and Diagnosis

25

Diagnosis of drug dependence: Criteria

2. Withdrawals

- Set of symptoms experienced on stopping or reducing the amount of the substance after prolonged use
- Every class of substance (e.g. alcohol, opioids, etc.) has its own unique set of withdrawal symptoms

Assessment and Diagnosis

26

Diagnosis of drug dependence: Criteria

E.g. opioid withdrawal

Early symptoms

- Anxiety
- Restlessness
- Yawning
- Nausea
- Sweating
- Running nose
- Running eyes
- Dilated pupils
- Abdominal cramps

Delayed symptoms

- Severe Anxiety
- Restlessness
- Diarrhea
- Vomiting
- Muscular spasm, pain
- Chills
- Increased heart rate, blood pressure
- Increased temperature

Assessment and Diagnosis

27

Diagnosis of drug dependence: Criteria

E.g. Alcohol withdrawal

- Anxiety
- Restlessness
- Increased heart rate
- Increased breathing
- Shaking (tremors) of hands and other body parts

- Sweating
- Sleeplessness
- Inability to concentrate
- Delirium tremens**
 - Confusion; disorientation to time, place and person; visual hallucinations; illusions; delusions
- Seizures / fits

Assessment and Diagnosis

28

Diagnosis of drug dependence: Criteria

- ### 3. Impaired control of behaviour associated with substance use in terms of its starting the use of the substance, stopping the use of the substance, or controlling the level of use

Example

A person 'X' had thought that he would consume only 1 peg of alcohol on a given day, but he is not able to stop after 1 peg, but continues to take more than peg: loss of control

A person 'Y' planned to stop his drug use, but is unable to do so: loss of control

Assessment and Diagnosis

29

Diagnosis of drug dependence: Criteria

- ### 4. Preoccupation with the use of substance: manifested as:

- Great amount of time spent in using the substance/procuring the substance/recovering from the effect of the substance
- Other activities which were pleasurable are given up as a result of the substance use
- Other interests/hobbies given up due to indulgence in substance use

Assessment and Diagnosis

30

Diagnosis of drug dependence: Criteria

5. Continuing use of the particular substance despite harmful consequence of the substance on the individual
6. Strong desire to use the substance: Craving
 - Craving can be spontaneous or in reaction to certain stimulus (e.g. place where the individual takes drugs, drug using friends, shop where the individual purchases drugs/alcohol, etc.). The craving in reaction to stimulus is called as 'cue induced' craving.

Assessment and Diagnosis

31

Diagnosis

- Drug status: Drug use syndromes
 - Dependence
 - Abuse/Harmful use
 - Intoxication

Assessment and Diagnosis

32

Drug abuse/harmful use

- Harmful use:
 - A pattern of use of substance, in which there is evidence of damage to the health of the individual
 - The damage can be physical or mental health damage
- Abuse: used in the USA system
 - A pattern of substance use, in which there is damage to legal, social and occupational spheres of the individual's life, in addition to the physical sphere.

Assessment and Diagnosis

33

Diagnosis

- Drug status: Drug use syndromes
 - Dependence
 - Abuse/Harmful use
 - Intoxication

Assessment and Diagnosis

34

Opioid intoxication

Mental/Behavioural effects

- Drowsiness
- Initial euphoria (happiness)
- Dysphoria (irritable mood)
- Impaired judgement
- Impaired performance
- Agitation or retardation
- Impaired attention
- Hallucinations

Physical

- Slurred speech
- Slow respiration
- Slow pulse
- Stupor/coma
- Pupillary constriction
- Pupillary dilation (anoxic)

Assessment and Diagnosis

35

Alcohol intoxication

Mental/Behavioural effects

- Drowsiness
- Impaired attention
- Impaired judgement
- Impulsive behaviour
- Inappropriate sexual behaviour
- Aggression
- Impaired performance
- Easy irritability or happiness
- Stupor / coma

Physical

- Flushed face
- Headache
- Rapid pulse
- Sweating
- Slurred speech
- Motor in-coordination
- Unsteady gait
- Respiratory depression

Assessment and Diagnosis

36

For successful assessment

- Assessment is a skill, and improves with practice
- For successful outcome of an assessment:
 - Establish rapport with the client
 - Have non-judgemental attitude
 - Effective communication
 - Patient listening
 - Maintain and reassure confidentiality of the response
 - Inform the client about the benefits of carrying out detailed assessment

Assessment and Diagnosis

37

Time for Role play

Assessment and Diagnosis

38

The facilitator follows up with Role play

The role play would be done by the facilitator and a co-facilitator.

Role – The facilitator will play the role of a counsellor, while one of the participants will play the role of an IDU client. The participant who has already worked in an IDU TI setting would be preferred. In case, none of the participants have worked in IDU TI settings, the facilitator should play the role of the IDU client, while the participant would play the role of the counsellor.

Setting – Would be that of a TI clinic, with the facilitator and co-facilitator seated across each other on chairs, with a table in between.

Scene – The IDU client has been referred by an outreach worker and is visiting the DIC for the first time. He has been asked to meet the counsellor by the outreach worker.

Enactment – The co-facilitator will carry out the assessment in the manner discussed during the presentation, while the IDU client played by the facilitator would try to answer the assessment questions. During role play, the facilitator may try to act disinterested or irritated for having been asked to come to DIC to bring out real life depiction. Emphasis should also be on the techniques used by the counsellor for carrying out assessment, asking questions appropriately, manner of greeting, rephrasing, making the client at ease, and trying to establish rapport with the client.

Duration: 15–20 minutes

Post role-play: Following the role play, the facilitator will seek the participants' feedback. One of the participants should be asked to summarise the findings from the assessment carried out during the role play and other observations with regard to the techniques, attitude of the counsellor, ease of carrying out assessment and what has been missed out in the assessment.

Session Four

BASICS OF COUNSELLING, COUNSELLING SKILLS AND TECHNIQUES

Objectives of the session

- ◆ To make the participants understand what is counselling and why it is required
- ◆ To facilitate awareness of the various skills required in counselling
- ◆ To make the participants well-versed in the specific techniques of counselling
- ◆ To make the participants know what are the characteristics of the counsellor

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

Interactive discussion with the participants using the presentation (**Day 2 Session 4 – Basics of Counselling**) following the notes provided with the slides and group activity and role play.

Notes on power point slides (Day 2 Session 4 – Basics of Counselling)

Slide 5: The facilitator asks the participants about the needs for counselling an IDU and expected outcome of counselling.

Slides 8 & 9: The facilitator elaborates on:

Greeting – Important to greet client like a ‘human being’ and not as a file number. In an Indian setting, it is advisable to use a proper gesture like *namaste*.

Physical Arrangement – Setting should allow for adequate audio-visual privacy (i.e. in a room, there should be only the counsellor and one client); it should be well-lighted and comfortable.

Confidentiality – Important to tell client that the information given by him would be kept strictly confidential.

Slide11: The facilitator asks the group to:

Give examples of open-ended and closed-ended questions
Which type should be used and when

Slide 13: The facilitator asks a participant to volunteer as the counsellor. The facilitator becomes the client to demonstrate the following situations in which the counsellor is asking questions about drug use and how the client procured drugs:

Situation 1: The client looks at the counsellor, maintains a comfortable posture, does look a bit sorry but tells the truth about how he stole money from home or coaxed family members to give him money.

Situation 2: The client looks uncomfortable, not looking at the counsellor, shifts uneasily in the chair; his tone becomes defensive and louder as he declares that his friends always got him the injections.

The facilitator asks the group to discuss both the situations.

Slide 15

Activity 1: The facilitator asks a participant to volunteer as a client. The facilitator asks the client what makes him use injections. And using what the client has said, the counsellor demonstrates what is meant by repeating, paraphrasing and reflecting.

Activity 2: The facilitator divides the participants to form groups of three where one will be the client, another the counsellor, and the third an observer. The client is instructed to discuss a specific issue with their counsellor. The counsellor should practise reflective listening. Be sure to allow time for participants to reflect on their own ability to listen reflectively, and provide a chance for observers to comment as well.

Slide 40: To make participants understand each of the techniques, the facilitator writes the following statements on the flip-chart and for each statement, asks the group to tell which technique would be most useful and why, and also give examples.

- ◆ **Statement 1:** I am trying hard, but it is so difficult to leave injections.
- ◆ **Statement 2:** I know taking injections has ruined me... but it's ok... I have no regrets.
- ◆ **Statement 3:** I do try to leave injections. I am even successful for 2-3 days, but then I start using again.
- ◆ **Statement 4:** I don't like my job as a clerk, so I take injections.
- ◆ **Statement 5:** Why do I take injections? Why did I go to that red light area in an intoxicated state...I love my wife... Why am I like this?
- ◆ **Statement 6:** You know I really don't want to get HIV, but I end up sharing needles with my friend. It saves money.
- ◆ **Statement 7:** No one can understand what I go through... it is so horrible.
- ◆ **Statement 8:** You can never understand what I go through... How can you understand it?

Slide 42: After explaining each characteristic, the facilitator asks participants to discuss the need of each characteristic.

BASICS OF COUNSELLING, COUNSELLING SKILLS AND TECHNIQUES

Basics of Counseling, Counseling Skills and Techniques



OUTLINE

- What is counseling
- Why is counseling required
- Specific counseling skills
- Counseling techniques
- Characteristics of counselor

What counseling is...



- Counseling is:
 - Interactive process between client and counselor

What counseling is not...



- Friendship
- Telling or directing
- An interrogation
- Confession

Need for counseling...

• GROUP DISCUSSION

- Why is counseling required???

Need for counseling...

- Assessment of client's problems
- Explore client's thoughts, emotions and defenses regarding drug use
- Helping client get a perspective about his drug use and its consequences in a protected environment
- Develop individualized treatment plan

Specific Counseling Skills

Opening technique

Structuring the session

Open-ended vs closed-ended questions

Understanding non-verbal language

Listening skills

Specific Counseling Skills

Opening technique

Establishing rapport with the client

- Make the client comfortable
- Address him by name
- Be aware of self's body language when talking to client
- Be sensitive to what client says
- Let the client talk

Specific Counseling Skills

Opening technique



Greeting



Physical Arrangement



Confidentiality

Specific Counseling Skills

Structuring the session

- ❑ Providing client a framework or orientation for counseling
- ❑ Need to set rules, guidelines and expectations from future sessions
 - ✓ Client should not come intoxicated in session
 - ✓ Client should be honest
 - ✓ Counseling is a collaborative process

Specific Counseling Skills

Open-ended vs closed-ended questions

Open-ended Questions

- Advantageous to open interview
- Elicits elaborations

Closed-ended Questions

- Used to interrupt over-talkative clients
- Obtain specific information

Specific Counseling Skills

Understanding non-verbal language

- ❑ Understanding non-verbal language important
- ❑ Can give important clues to what is going on in client's mind
- ❑ Can help in pointing discrepancies

Specific Counseling Skills

Understanding non-verbal language

Types of important non-verbal signs*



Specific Counseling Skills

Listening skills

- ❑ As a counselor, listening is the most important skill
- ❑ The art is listening to what the client “says” and what he “does not say”
- ❑ Comes with practice



Specific Counseling Skills

Listening skills*

→ Different levels of listening include:

REPEATING

- Saying back the message exactly as client has spoken

PARAPHRASING

- Summarizing message using similar words spoken by client

REFLECTING

- Linking emotions and thoughts with what client has said

Specific Counseling Techniques

Clarification

Probing

Silence

Interpretation

Empathic response

Self-disclosure

Identifying alternatives

Confrontation

Specific Counseling Techniques

CLARIFICATION

- Used to clarify meaning of what client has said
- Helps client to see confusing in his thinking

Specific Counseling Techniques

CLARIFICATION

- Commonly used phrases:
 - Would you tell me more about...
 - I did not understand...
 - Would you please elaborate/describe...

Specific Counseling Techniques

PROBING

- Questions encouraging client to express his thoughts/emotions in greater details
- Used to develop self-insight

Specific Counseling Techniques

PROBING

- Probe should not be overwhelming for client
- Important to avoid starting probe with a "WHY"

Specific Counseling Techniques

PROBING

- Commonly used probes:
 - What happened?
 - What made you use ...?
 - What were you thinking?
 - How did you feel...?

Specific Counseling Techniques

SILENCE

- Very powerful technique
- Helps client to continue sharing

Specific Counseling Techniques

SILENCE

- Used when client is
 - indulged in self-analysis
 - Expressing strong emotions- e.g. crying

Specific Counseling Techniques

SILENCE

- Commonly used expressions:
 - Nodding head
 - Saying, "Hmm.."

Specific Counseling Techniques

INTERPRETATION

- Pointing out discrepancy between what client says and does
- Explaining it in a non-confronting manner

Specific Counseling Techniques

INTERPRETATION

- Should not be given as a final verdict
- Should only be done if counselor is sure of what client behavior could be indicating

Specific Counseling Techniques

INTERPRETATION

- Commonly used expressions:
 - Perhaps...
 - Correct me if I am wrong, but I think...
 - Would you agree if I said...?

Specific Counseling Techniques

EMPATHIC RESPONSE

- Indicates understanding and acceptance of client
- Includes verbal/non-verbal communication (e.g. looking encouragingly at client)

Specific Counseling Techniques

EMPATHIC RESPONSE

- Commonly used expression:
 - I understand...
 - I can imagine how you must be feeling...

Specific Counseling Techniques

EMPATHIC RESPONSE

- Is different from sympathy

Specific Counseling Techniques

EMPATHIC RESPONSE

GROUP DISCUSSION

What is difference between sympathy and empathy?

Specific Counseling Techniques

EMPATHY

- Listen to and understand client's experience from his perspective
- May not always be in agreement with client
- Help client find his own solutions
- Not making client's suffering your burden

SYMPATHY

- Always side with the client
- Become emotionally involved
- Sharing the burden with the client
- Reactions of counselor may become similar to other family members

Specific Counseling Techniques

SELF-DISCLOSURE

- Contradictory views about how much counselor should disclose to client

Specific Counseling Techniques

SELF-DISCLOSURE

- May/may not help therapy process
- Needs to be done carefully

Specific Counseling Techniques

IDENTIFYING ALTERNATIVES

- Client may feel helpless/hopeless
- Needs to be made aware of choices he has with respect to drug use, relationships, occupation etc.

Specific Counseling Techniques

IDENTIFYING ALTERNATIVES

- Commonly used expressions:
 - Lets try and see what all options we have...
 - I was just wondering what are the possibilities...
 - Do you think there could be an alternative...

Specific Counseling Techniques

CONFRONTATION

- Involves challenging discrepancies and distortions in client's thinking
- Difficult technique

Specific Counseling Techniques

CONFRONTATION

- Should be used very carefully and only when absolutely necessary
- Should be delivered in a firm, but polite way

Specific Counseling Techniques

CONFRONTATION

- Commonly used expressions:
 - I am not sure you meant that...
 - What I think is...

Specific Counseling Techniques*

Clarification

Probing

Silence

Interpretation

Empathic response

Self-disclosure

Identifying alternatives

Confrontation

Characteristics of an effective counselor



- **GROUP ACTIVITY**
- Ask the group what could be the characteristics that make a good counselor?

Characteristics of an effective counselor*



Characteristics of an effective counselor

Do's

- Ask yourself
 - How do I feel about the client?
- When in doubt, take a deep breath and then respond
- Be patient
- Should be respectful towards client
- Stay neutral towards client

Don't's

- Don't preach
- Don't impose one's own values on clients
- Don't become over-involved with client
- Don't argue
- Don't lie/make false promises
- Don't adopt a business-like attitude

Summary

- Counseling helps the client get a perspective to their problems
- A good counselor can help client with not only dealing with his drug problem but also building healthy relationships



THANK YOU

SESSION DETAILS FOR DAY THREE

Session One

COUNSELLING IDUs – INJECTION-RELATED RISK-REDUCTION

Aim of the session

- ◆ To teach the participants on how to counsel the IDU client on reducing risks related to injections

Objectives of the session

- ◆ To make the participants aware of the various risks faced by an IDU during his injections, and the factors associated therewith
- ◆ To orient the participants on the basic principles of harm-reduction
- ◆ To teach the participants about carrying out counselling for IDU client at various steps of injecting

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

Discussion with the participants during presentation (Day 3 Session 1 – Risk Reduction) on the lines described along with the slides.

Notes on power point slides (Day 3 Session 1– Risk Reduction)

Slide 6: Before presenting this slide, the facilitator will initiate a discussion among the participants on the various risks that they think can occur due to injecting. The responses should be noted down on a white board/chart paper. After enough responses have been provided, the facilitator shall present this slide.

Slide 9: Before beginning this slide, the facilitator should ask the participants to recall the session on various types of approaches to drug abuse treatment, and also the harm-reduction approach. The facilitator should ask some of the participants to summarise what was discussed in the session on harm reduction. They should be allotted 5 minutes for this. If the facilitator at this point feels that the participants have not understood the concept clearly, the facilitator should once again re-orient the participants on various approaches to drug management and the concept of harm-reduction once again. In addition, the above slide may be used to discuss harm-reduction.

RISK REDUCTION COUNSELLING RELATED TO INJECTIONS

Risk reduction counselling related to injections

Risks faced by Drug users

- Risks encountered at many stages
 - Procurement of illicit drug
 - Obtaining money for procurement of drugs
 - Drug intake
 - Intoxications / withdrawals faced by an IDU
- Risks are in multiple domains – physical, legal, occupational, financial, social
- Risk faced by an IDU over and above those faced by non-IDUs because of injecting behaviour/route of drug intake

Why do IDUs face risk?

- Lack of knowledge/wrong knowledge
 - Wrong knowledge from peers
- Lack of adequate time for injecting
 - Due to fear of police arrest or severe withdrawals
- Injecting in hazardous places/settings
 - Unclean places such as near an open drainage, railway tracks, abandoned houses, etc

- Non availability of injectable drugs
 - Injecting impure form of heroin - 'brown sugar'
 - Injecting capsules (S.P.)
- Non availability of materials to clean injecting equipment
 - Cotton swabs, spirits, etc.

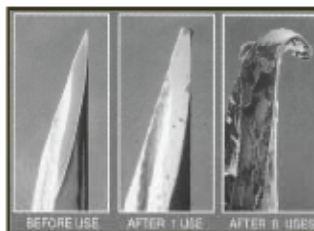


White heroin



Brown sugar

- Non availability of adequate needles/syringes for injecting resulting in
 - Sharing
 - Reuse: reuse leads to blunting of the needle tip



- Using unclean/non-sterile water for cleaning needle/syringe before reusing

Injecting risks

- Blood borne infections: HIV, Hepatitis B, Hepatitis C
- Local Infections: skin infections with bacteria/fungus resulting in swelling, or pus collection → abscess, and a wound → ulcer
- Loss of veins / sclerosis: due to repeated injecting in the same site, scarring leads to blockage of the vein



- Scarring of tissues around the injecting site due to seepage of drug outside the vein
- Septicaemia: local infection spreading through blood stream causing generalised infection
- Injection into artery: resulting in gangrene/necrosis of tissue



- Infection of internal organs: heart, brains, lungs
- Overdose: injecting more amount of opioids than what can be withstood by the body leading to symptoms of overdose

Risk Reduction counselling

- Premise of risk reduction counselling: harm reduction
 - Not every IDU is either ready or able to give up drugs instantly
 - Harms continue to be incurred by IDUs till he/she is ready or able to give up drugs
 - The harms incurred can be reduced in the meantime
- Intervention differs depending on the stage of the IDU in the harm reduction hierarchy

Hierarchy of harm reduction strategy

Drug using status	Strategy to be used
Never start using drugs	Preventive education to general community
Even if using drugs, don't inject	Education to Drug users on harms with IDU
If injecting, assistance to stop injecting drugs	Opioid Substitution Therapy
If not able to stop injecting, don't share	NSEP, educate on safe injecting
If not able to stop sharing, ensure clean equipment before every use	Educate; Provide cleaning materials

Risk reduction counselling...contd.

- IDU client is not able to stop sharing:
 - Reasons may range from group behaviour to non-availability of clean needles /syringes when the client has to inject
 - Best way is to educate the client to be prepared for such an eventuality and carry one set of new needle syringes all the time
 - There is NO FOOLPROOF METHOD OF CLEANING NEEDLE/SYRINGES
 - *Something (cleaning) is better than doing nothing (not cleaning)*

Risk reduction counselling...contd.

- IDU client is not able to stop sharing
 - Recommended method for cleaning N/S:
 - Pour bleach into one cup or bottle and water into another.
 - Draw up freshly prepared bleach solution into dirty needle and syringe.
 - Expel bleach away down the sink (not back into the cup or bottle).
 - Repeat steps 2 and 3.
 - To remove the bleach, draw up cold water into the needle and syringe.
 - Expel water down the sink.
 - Repeat steps 5 and 6 two or three times.



Risk reduction counselling...contd.

- IDU client is not able to stop sharing ...contd
 - Points to remember for cleaning the used needle/syringe
 - The above cleaning method does not guarantee protection
 - Bleach cleaning the previously used equipment should only be a last resort option
 - Clean equipment both before and after use.
 - Boiling plastic syringes melts them.

Risk reduction counselling...contd.

- IDU client is not able to stop sharing ...contd
 - Points to remember for cleaning the used needle/syringe
 - Cold water is recommended as warm water may coagulate blood and hence will be harder to expel through the needle.
 - Thick bleach is impossible to draw up though a needle.
 - Diluted and old bleach may not be effective
 - **Using new/clean injecting equipment (from a needle exchange) is the safest option.**

Risk reduction counselling...contd

- IDU is not able to stop injecting, but is in a position to avoid sharing:
 - Possible reasons:
 - Not motivated to stop injecting
 - Not able to afford non-injectable drugs
 - Dependent on injecting

Risk reduction counselling...contd

- IDU is not able to stop injecting, but is in a position to avoid sharing Contd...
 - Counselling: Educate the clients on the following -
 - Risk with sharing
 - NSEP and link up with concerned outreach team
 - Returning used N/S
 - Risk of reusing used N/S
 - How to inject safely, abscess prevention
 - Overdose prevention and management
 - OST if ready to stop injections and OST available in the city/town

Risk reduction counselling – Safe injecting

- Explore current injecting practices followed by the IDU client
 - Understand the risky and safe practices
 - Reinforce the safe practices followed
 - Point out risky practices for modification
 - Summarise the important practices at the end of assessment as feedback to the client
- Counselling for three stages of injecting
 - Before injecting
 - During injecting
 - After injecting

Risk reduction counselling – Safe injecting

- Counselling for before injecting
 - Choose a safe place where you are not anxious. Relaxation helps in relaxing the muscles
 - Do not inject alone; injecting in presence of someone else will ensure availability of help
 - Keep the immediate surroundings clean – use a clean newspaper or magazine to lay down the injecting equipments
 - Choose the smallest bore needle possible

Risk reduction counselling – Safe injecting

- Counselling for before injecting
 - Use sterile water; if not use cooled freshly boiled water
 - Use an acidifier such as vitamin C tablets or citric acid for dissolving brown sugar → use small doses of acidifier, as large dose will injure the vein
 - Do not heat the drug too much as doing so will cause injury to the tissue where the drug is being injected

Risk reduction counselling – Safe injecting

- Counselling for before injecting
 - Filters are often used to filter out un-dissolved particulate matters
 - Cotton swabs and cigarette butts are often used
 - Cigarette butts are preferable, as cotton swabs have loose fibres which may enter the injection
 - Do not touch the cooker (metal cap, spoon used for mixing and heating) with needle tip, as doing so will make the needle tip blunt



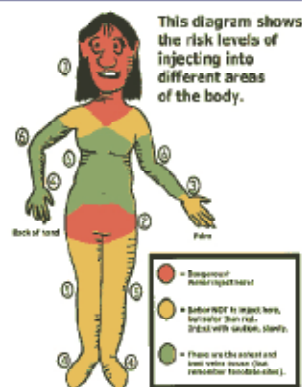
Risk reduction counselling – Safe injecting

- Counselling for 'during injecting'
 - Intravenous route preferable to subcutaneous injection
 - Clean the area where the drug is to be injected
 - Best way is with plenty of soap and water
 - If not possible, use alcohol swabs
 - Ensure that alcohol dries off before injecting, otherwise the site will not be sterile
 - Best area for injecting – cubital fossa (front of elbow)



Risk reduction counselling – Safe injecting

- Counselling for 'during injecting'
 - Dangerous sites for injecting
 - Groin veins
 - Neck veins
 - Veins on the face
 - Veins of the hand and legs
 - Breast veins
 - Penile veins



Risk reduction counselling – differentiating artery from vein

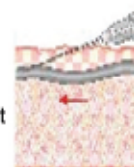
- Counselling for 'during injecting'
 - Differentiating an artery from vein

Artery	Vein
Pulsating blood vessel	Non-pulsating blood vessel
Cannot be easily seen	Seen as a blue vessel
No valves which can be felt	Valves in veins can be felt
Bright Red blood oozes out/drawn into syringe	Dark red blood oozes out/drawn into syringe

- If you hit an artery,
 - there will be excruciating pain;
 - The part of body which the artery supplies blood, will become black and die (gangrene/necrosis)

Risk reduction counselling – Safe injecting

- Counselling for 'during injecting'
 - Use smaller bore needle → larger bore needle will damage the vein
 - Tie a tourniquet which can be easily released; do not tie the tourniquet tightly; release tourniquet soon after the needle enters the vein
 - Hold the needle at 45 degree angle
 - Once you hit a vein, stop further puncture and draw some blood in vein to confirm that it has hit the vein; the blood should be dark red in colour
 - Administer the drug slowly
 - Do not repeatedly push the blood back and forth



Risk reduction counselling – Safe injecting

- Counselling for 'after injecting'
 - Slowly remove the needle from vein
 - Immediately apply pressure on the injected site with a dry cotton swab. DO NOT use alcohol swabs
 - Apply pressure for at least one minute
 - Allow time for injected vein to heal.
 - Use another site to inject → rotate veins

Risk reduction counselling – overdose prevention & management

- Risk factors for overdose
 - Periods of abstinence/staying away from opioids and then resuming the previous dose of opioid
 - Change in purity of the heroin sample available from the streets
 - Poor ill health
 - Recent infections
 - Mixing different type of drugs e.g. heroin and benzodiazepines

Risk reduction counselling – overdose prevention & management

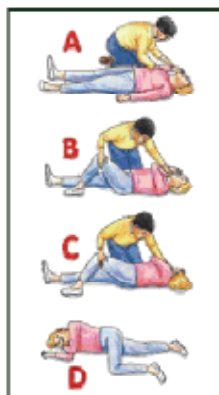
- Symptoms of overdose
 - Occurs over 1 – 2 hours, not instantly
 - Slow and shallow breathing
 - Skin pale in color
 - Body goes limp
 - Slow pulse/no pulse
 - Bluish coloration of fingernails
 - Vomiting
 - Choking noise
 - Seemingly awake, but no response

Risk reduction counselling – overdose prevention & management

- **Counselling for overdose prevention:**
 - Risk factors for overdose
 - Abstinence for more than 3 days and resuming of previous dose will cause overdose
 - Purity is not guaranteed, even if the dealer is same
 - Before a full dose, a small dose should be taken first to test purity
 - Take injections in the presence of someone else, so that help is readily available if something goes wrong
 - Dangers of mixing drugs
 - Myths about treating overdose: inducing vomiting, drinking coffee/tea, drinking water, taking cold showers, etc.

Risk reduction counselling – overdose prevention & management

- Overdose management - Emergency/first aid
 - Stimulate the client: shout name, shake the patient, rub sternum
 - Call emergency helpline and/or ambulance
 - Check for breathing: if no or slow breathing → mouth to mouth resuscitation
 - Put the client in recovery position



Conclusions

- IDU faces many risks during his injecting period
- Not all IDUs are ready to quit drugs, and hence require risk reduction counselling
- The IDU can be helped even during his injecting period
- The benefits of risk reduction counselling goes beyond HIV prevention, and helps to keep the individual healthy and productive

Session Two

COUNSELLING IDUs ON SAFER SEXUAL PRACTICES

Objectives of the session

- ♦ To provide the participants with a basic understanding of sex, sexuality, sexual orientation and their implications in sexual health
- ♦ To sensitise the participants on the importance of not being judgmental about the sexual practices of the clients but rather look at them objectively from the point of related sexual risks
- ♦ To enable the participants to be able to assess the level of risk and provide counselling services for safer sexual practices – including risk reduction, motivation for treatment seeking and behaviour change as needed
- ♦ To help the participants to understand the special problems of the IDUs and enable them to counsel IDUs on safer sexual practices and link them to services that match their needs

Duration of session: Two hours

Materials/Aids required

- ♦ Flip-charts/chart paper/white-board
- ♦ Marker pens
- ♦ Laptop/computer and LCD projector

Methodology of conducting the session

- ♦ Interactive discussion with the participants using the presentation on **Day 3 Session 2 – Safer Sex** following the notes provided on the slides
- ♦ Condom demonstration

Notes on power point slides (Day 3 Session 2 - Safer Sex)

Slide 1: The facilitator opens the session by asking the participants to name the various sexual acts known to them. The responses of the participants are listed on the flip chart/chart paper. Care needs to be taken to list the penetrative sexual acts in one and the non-penetrative ones in another column without putting those headings. This is to continue until responses dry up.

Sample table for sexual acts

Penetrative acts	Non-penetrative acts
Peno-oral	Masturbation
Peno-vaginal	Rubbing
Peno-anal	'Thigh' sex
Insertive sex with toys (like vibrators)	Petting

The facilitator asks the participants the difference between the two sets and probes till they differentiate them as 'penetrative' and 'non-penetrative' acts and the facilitator now puts the names at the top of the columns.

The facilitator further asks about the organs involved in the various penetrative acts and notes down the responses on another flipchart/chart paper in two columns – one for male another for female.

Sex and sexual preferences

- ◆ Sex is a natural reward and fulfils more purposes than just reproduction in human lives
- ◆ Among other purposes sex is also for pleasure
- ◆ There are various sexual acts and people have their own preferences
- ◆ Preferences maybe guided by gender and type of partners selected, which again is based on the sexuality of the individual

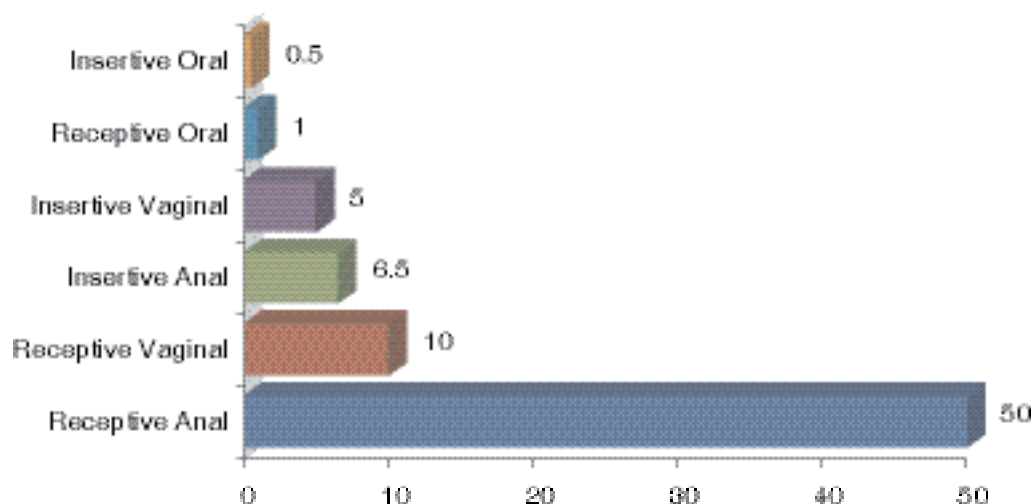
Slides 2 & 3: The facilitator points out the various parts of the male and female sex organs, including the anus and mentions that some people (both male and female) also have penetrative anal sex.

Slide 4: The facilitator then divides the participants into two groups and invites them for a debate on “People who have anal sex are essentially people with bad moral character”. The facilitator ‘tosses’ to choose the teams – ‘for’ and ‘against’ the statement, gives them 2-3 minutes to select the speakers (4 speakers per team) and plan before inviting them to take turns to speak for 1 minute each, giving another 1 minute to each team for making final comments. This should be followed up by the facilitator’s wrap-up where issues related to sex and sexual preferences are highlighted.

The facilitator follows up with power point slides on sexuality, sexual orientation.

Slide 11: Before going to the next slide the facilitator randomly distributes cards with the six different sexual exposure routes (mentioned in the slide) written on them and asks the participants to rate them from the one with the lowest risk of HIV transmission to the highest. Anyone who feels that he/she has the card with the lowest risk of HIV transmission can volunteer to come up to the board and explain why it has the least risk. The facilitator asks the other participants to respond in terms of appropriateness of this claim. The facilitator too responds to the claim and has the final say in case of conflicts. In case the route of sexual exposure is not the one with the lowest risk the facilitator parks it for later discussion. He/she then asks another participant to volunteer. Once all the cards are lined up in proper order, the facilitator wraps up the session with the next slide where he/she explains the hierarchy of sexual risks with reasons.

Figure: Risks per 10000 exposures to an infected source



Slide 20: The facilitator invites one volunteer and conducts a role play where he/she is the counsellor and the participant is the client (a 17 year-old male IDU). The session should be limited to 5 minutes. At the end of the session the facilitator seeks queries from the participants and answers them.

Slide 23: The facilitator invites two volunteers to come and take part in a role play where the client is a 25 year-old female IDU with a male partner who also does injecting drug use.

Slide 24: The facilitator explains the hierarchy of sexual risks and highlights the need to move from the present level of risk towards lower risk.

Slide 26: Before presenting this slide the facilitator asks the participants about the signs and symptoms for STIs and records them on the flip chart/chart paper. He/she shares with the participants the signs and symptoms of STIs and highlights the fact that infection can be transferred to and from any of the organs involved in the sexual acts, i.e. penis, vagina, anus and mouth (lips and tongue). So the signs and symptoms may appear on any of these organs.

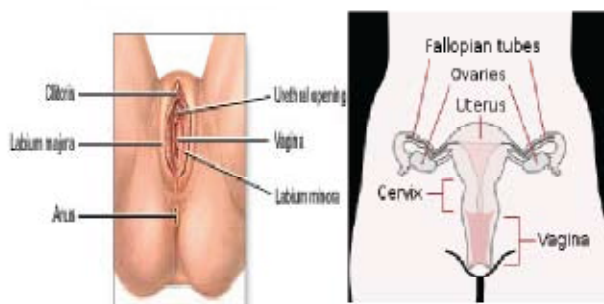
Signs and Symptoms of STIs (the syndromic guideline)

In Males	In Females
<ul style="list-style-type: none"> ◆ Urethral discharge (Discharge or pus from the penis)/Burning or pain during urination/frequent urination ◆ Genital itching ◆ Swelling in groin/scrotal swelling ◆ Blisters or ulcers on the genitals, anus, mouth, lips ◆ Itching or tingling in genital area ◆ Ano-rectal discharge ◆ Warts on genitals, anus or surrounding area 	<ul style="list-style-type: none"> ◆ Unusual/foul smelling vaginal discharge ◆ Genital itching ◆ Abnormal and/or heavy vaginal bleeding ◆ Pain during sexual intercourse ◆ Lower abdominal pain (pain below the belly button, pelvic pain) ◆ Blisters/ulcers on the genitals, anus or surrounding area, mouth, lips

SEX SEXUALITY, SEXUAL ORIENTATION, SEXUAL ACTS AND THEIR RISKS

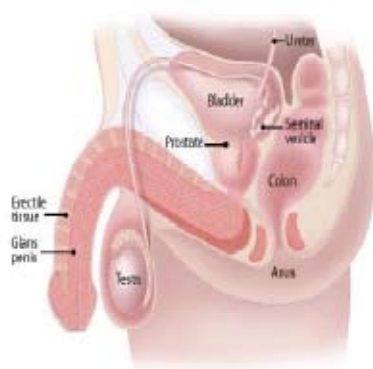
Sex, sexuality, sexual orientation, sexual acts and their risks

By differences in sex organs...



The female sex organs

The Male sex organs



'People who have anal sex are essentially people with bad moral characters'.

Sex and sexual preference

- Sex is a natural reward and fulfils more purposes than just reproduction in human lives
- Among other purposes sex is also for pleasure
- There are various sexual acts and people have their own preferences
- Preferences maybe guided by gender and type of partners selected, which again is based on the sexuality of the individual

Sexuality

- Sexuality is the expression of one's sexual feelings-through words and actions which may or may not be overtly related to sex.
- It is often guided by cultural norms varying from one community to another and changing with gender, age and socio-economic position of the individual.
- The degree of expression is often controlled by the degree of permissiveness allowed by the society.

Sexuality...

- Sexuality is the result of interplay of biological (genetic and hormonal), psychological, socio-economic, cultural, ethical and religious/spiritual factors.
- It encompasses sex, gender, sexual and gender identity, and reproduction and all related aspects of human life.
- Sexuality is expressed through sexual orientation, eroticism, emotional attachment/love and various other behaviours and practices that go beyond the mere sexual acts.

Sexual orientation

- Sexual orientation is individual's personal eroticism and/or emotional attachment with reference to the sex and gender of the partner involved in sexual activity.
- Sexual orientation guides the preference of sex partner (male, female, transgender), type of sexual act (peno-oral, peno-vaginal etc.).

Sexual orientation..

- **Heterosexuals** -prefer opposite sex (male – female),
- **Homosexuals** -attracted to the same sex (male-male or female-female)
- **Bisexuals** have sex with both- same sex as well as from the opposite sex

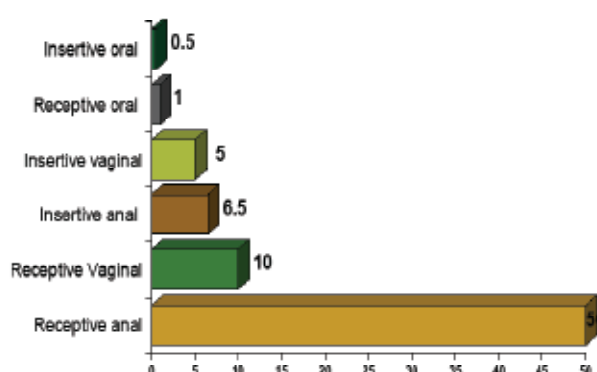
Important for the counsellor

- ✓ For a service provider importance of the act lies in the degree of risk it poses for the people involved rather than the cause of choice
- ✓ Being judgemental will alienate the client and pose barriers to service provision

Sexual exposure routes

- Receptive anal
- Receptive Vaginal
- Insertive anal
- Insertive vaginal
- Receptive oral
- Insertive oral

Risks per 10000 exposures to an infected source



Sexual risks

Sexual risks

Personal high risks	Partner's high risks
Sex, not protected with condom	History of injecting drug use
Anal sex	History of multiple sex partner
Multiple sex partner	History of sex with HRG
Use of alcohol or drugs before sex	Using alcohol or drugs before sex
Sex with HRG	Infected with HIV, Hep-B, C or with history of STI
Situational/positional risk	
Practicing -sex work/MSM/IDU	
Surviving-sexual abuse/rape	
Population in prison	

Sexual risks among IDUs

- Drugs 'cloud' the brain affecting thoughts and actions
- Drugs lower their inhibition leading to 'loss of judgement' resulting in greater risk taking
- Drug use affect power of working with the hand and fingers (effect of drugs on nervous system) – making it difficult for them to wear and take off a condom correctly
- Drug use often leads to disruption of relationship and broken family leading sex with casual and/or commercial partners
- IDU (especially females) may be compromised to sell sex to procure drugs

Sexual risk assessment

Sexual risk assessment must be done at initiation of services and also in case the client:

- Has been diagnosed with STIs/HIV, Hep-B/C
- Reports/complains symptoms of STIs
- Needs to be screened for STIs
- Needs to be referred for Integrated Counselling & Testing Centres (ICTC)

Objectives of sexual risk assessment

- To make an accurate and efficient assessment of the sex related risks faced by the client
- To assess the client's risk of transmitting and contracting STIs
- To help the client recognize the behaviour/s as harmful to self and partner
- To help the client understand that alternatives are available
- To ascertain the course of further action and requisite services
- To help the client seek treatment and allied services needed for changing the high risk behaviour.

Assessment should cover...

- Sexually active or not (in the last one year)?
- Number of sex partners (in the last one year):
- Regular (spouse/girlfriend/boyfriend)
- Non regular (other than spouse/girlfriend)
- Commercial (paid for sex)
- Condom use with:
- Regular (spouse/girlfriend/boyfriend)-how often and last time
- Non- regular (other than spouse/girlfriend)- how often and last time
- Commercial (paid for sex)- how often and last time
- History of STIs-treated, untreated?
- Signs and symptoms of STIs present?

Assessment...

- Drug/alcohol use before sex.
- History of sex with a male. (In case of male client)
- In case of history of male to male sex:
 - Nos. of male partners
 - Type of act
 - Frequency/consistency of condom use.

Role play



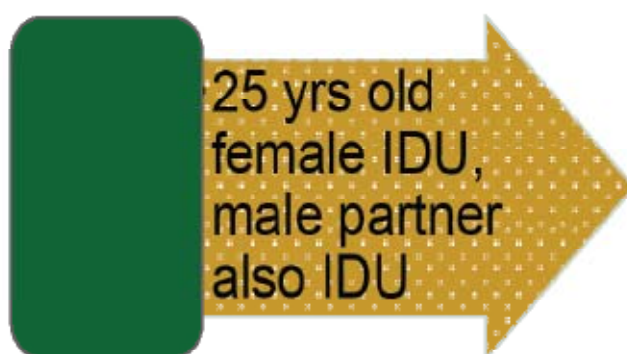
Sexual risk reduction counselling

- Share the level of risk of the client based on his/her current sexual practices
- Educate client on the risks and their complications, both current and future
- Explore client's feelings about the risk/s
- Refer for STI screening, if the client reports/complains signs and symptoms of STIs of self or the partner
- Assess level of risk perception by the client
- Educate the client in case of incorrect perception and/or misconceptions, if any
- Check for the client's level of concern and actions already being taken by him/her, if any

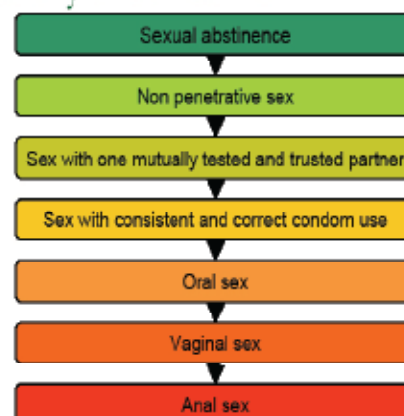
Sexual risk reduction

- Appreciate efforts already in place, if any
- Correct the ideas and practices that will not help in the risk reduction
- Educate the client on alternatives that may help in reducing risks
- Help the client set achievable goals and plan practicable steps towards it
- Educate on importance of condom use, demonstrate correct steps for using and also provide condoms
- Discuss potential barriers to the risk reduction strategy planned by the client and possible support
- Agree on the final strategy and timeline
- Endorse a follow up plan

Role paly



Hierarchy of sexual risk



Follow up visit

- Check for adherence to the strategy/plan
- Appreciate efforts made –highlight achievements
- Explore reasons for failure or inaction, if any
- Explore alternative approaches and other options
- Suggest corrections, if any
- Help redesign the strategy with the client
- Discuss potential barriers and possible supports
- Motivate to seek Voluntary Counselling & Testing
- Agree on the final strategy and timeline
- Endorse a follow up plan

Signs and Symptoms of STIs (the syndromic guideline)

In males	In females
<ul style="list-style-type: none">• Urethral discharge (Discharge or pus from the penis)/Burning or pain during urination/frequent urination• Genital itching• Swelling in groin/scrotal swelling• Blisters or ulcers on the genitals, anus, mouth, lips• Itching or tingling in genital area• Ano-rectal discharge• Warts on genitals, anus or surrounding area	<ul style="list-style-type: none">• Unusual /foul smelling vaginal discharge• Genital itching• Abnormal and /or heavy vaginal bleeding• Pain during sexual intercourse• Lower abdominal pain (pain below the belly button, pelvic pain)• Blisters/ulcers on the genitals, anus or surrounding area, mouth, lips

Objective of STI counselling

To help the client:

- seek and complete treatment, if infected with STIs
- being screened for STIs, if showing signs and symptoms of STIs or with history of unprotected sex or sex with HRG and receive subsequent services as required
- complete the treatment with partner identification and screening/treatment of partner
- reduce high risk sexual practices that may infect/re infect the client.

Motivation for screening

- The client will need to be prepared and motivated for screening before the clinical examination of the genital area and insertion of equipment into the vagina and anus.
- The steps will include:
 - Sharing the level of risk of the client
 - Educate client on STIs their complications
 - Explore client's feelings about the risk/s
 - Educate the client on the need for screening
 - Explain the components of STI treatment
 - Help to evaluate the pros and cons of seeking treatment
 - Refer for STI screening
 - Endorse a follow up plan

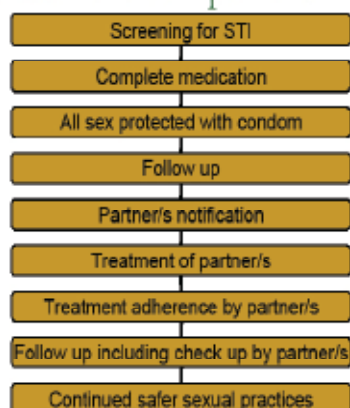
STI counselling

- Educate on the diagnosis based on the syndromic approach, cause of infection and the treatment
- Help the client take the medicines
- Educate on importance of completing the medication
- Explain the need for contacting the doctor, in case of side effects
- Educate the client on impact of not completing treatment
- Explain interaction of the medicines with alcohol.
- Help plan strategies to avoid alcohol use
- Explain the importance of condom use
- Demonstrate proper condom use and provide condoms.

STI counselling..

- Educate on the importance of partner notification and treatment of partner
- Explore alternative sexual practices for risk reductions
- Reinforce importance of treatment completion
- Endorse plan for follow up

STI treatment component



STIs and IDUs

- IDUs equally vulnerable to transmission of STIs as any HRG
- Drugs injected are often have analgesic properties they also reduce pains of STIs
- IDUs often need antibiotics for their abscesses; these may hide ulceration or partially treat STIs
- IDUs often inject in groin or penis; genital ulcers may be misinterpreted as ulcers caused by injections
- Signs/symptoms may be attributed to injections and drugs used missing out STI related symptoms
- Among IDUs, swelling of the lymph nodes in the groins (femoral lymphadenopathy) may be caused due to infections from blisters/abscesses in the foot or un-hygienic living conditions rather than STIs.
- Stigma attached to STIs generally, sometimes may also bar the IDUs from reporting signs and symptoms

Condoms

Condom

- Using condom is the most reliable mode of prevention of STI HIV
- There are both male and female condoms
- Male condom is put on the erect penis
- Female condom is inserted into the vagina
- Both male and female condom should be put on/inserted before any sexual contact is made
- Both male and female condoms act as a barriers, preventing the contact between infective secretions (semen or genital fluids, vaginal fluids) and the mucus membrane of the vagina, anus, glans, penis or urethra

Uses of condom

- Prevents unwanted pregnancy
- Protects self and partner against STI, HIV, Hep-B,C
- Enhance the pleasure (by delaying ejaculation) associated with sex

Reasons for not using condoms

- Condoms may not be easily available or accessible
- Stigma attached to condom use
- Lack of knowledge on the correct use of condoms
- Existing myths and misconceptions related to condoms

Myths about condoms

- Using condoms during sex is irritating
- Condom may tear during intercourse
- Condom is sticky and oily
- Condom reduces sexual pleasure
- Women do not like it
- Loss of erection
- Not 'manly'
- Condoms are reusable
- Two condoms are better protection than one

Counsellor's role in condom promotion

- Explain the need for correct and consistent use of condoms as a part of treatment of STI and protection from STI, HIV, Hep-B & C infections and unwanted pregnancy
- Educate on correct use of condom through demonstration using penis and vagina models
- Make sure condoms are readily available in the clinic and accessible to people who need them
- Keep the condoms in a visible transparent box
- Distribute free condoms to clients visiting clinics
- Ensure those who are involved in sex work have an adequate stock of condoms to protect themselves
- Display and distribute information on STI and HIV/AIDS and on condom use
- Ensure a minimal 3 months supply of condoms

Condom demonstration: The facilitator demonstrates the use of both male and female condoms using demonstrators (models of penis and vagina). He/she first invites volunteers from among the participants to come and demonstrate the correct use of male condom – and asks for feedback from the other participants on whether it was done correctly or wrong. He/she then demonstrates the correct method and again asks one more volunteer to show the method. The facilitator demonstrates the use of female condoms once and asks a volunteer to repeat it while the facilitator provides inputs for correction if any.

Objectives of the session

To familiarise the participants with the special needs of the IDUs related to:

- ◆ Injecting and sexual risks
- ◆ Pre-post counselling
- ◆ Treatment for HIV
- ◆ Living positively

To enable the participants, as counsellors

- ◆ Help the client assess the risks of contracting and transmitting HIV
- ◆ Help the client identify the high risk practices and modify them to safer ones
- ◆ Motivate, prepare and refer the client for HIV testing, if required
- ◆ Provide pre-test counselling to the client

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector
- ◆ Printed copies of the HRBS (**Annexure-2**) and Individual risk assessment (**Annexure-3**) activity worksheets for each participant

Methodology of conducting the session

Interactive discussion with the participants using the presentation on **Day 3 Session 3 – HIV Counselling** following the notes provided on the slides.

Notes on power point slides (Day 3 Session 3 – HIV Counselling)

Slide 2: The facilitator briefly shares with participants the risks of contracting and transmitting HIV among IDUs and their sexual partners explained in the diagram. It should be explained that initial transmissions, if occurring among IDUs sharing needles, syringes and paraphernalia, does not remain confined. These IDUs are also sexually active and the transmission soon takes the sexual route followed by the vertical route of mother to child (MTCT) transmission from the infected female partners.

Slide 4: Before presenting this slide the facilitator asks the participants as to how the risks of individuals can be assessed and directs the discussion towards the need

for assessment of high risk practices. The facilitator asks the participants “What are the objectives of assessment?” and notes down the responses on a flip chart/chart paper. He/she follows this up with a presentation of HIV risk assessment.

Slide 5: Before this slide the facilitator explains how the HRBS can be used and asks for a volunteer to do a role play where he/she acts as the counsellor and interviews the volunteer as the client (**Male IDU being treated for STI or Pregnant Female IDU**) for risk assessment. He/she highlights the following at wrap-up:

- ◆ Build rapport and explain the need for this assessment
- ◆ Prepare the client before asking the sexual risk questions
- ◆ On completion, explain the findings
- ◆ If found at risk, refer for pre-test counselling

Slide 10: The facilitator invites one volunteer for one of the two role plays. The facilitator acts as the counsellor and the volunteer acts as the client. The session should be limited to 5 minutes. After queries from the participants are answered the facilitator requests for two more appropriate volunteers to take up the remaining case – one as counsellor and the other as the client. He/she also requests them to limit the session within 5 minutes. At the end he/she appreciates the volunteers and provides feedback based on the check list of the topics to be covered as mentioned in the two previous slides (i.e. slides 7 & 8).

Slide 18: The facilitator invites four volunteers for role plays on counselling and divides them into two teams with one counsellor and one client in each. The teams are instructed to limit their sessions within a maximum of 10 minutes each. At the end the facilitator appreciates the efforts of the volunteers and provides feedback based on the check list of the topics to be covered as mentioned in the slides on post-test counselling (i.e. slides 10 to 16).

Slide 19: Before presenting this slide the facilitator opens the discussion by asking why partner notification is important in the post HIV testing follow up and gathers the responses on the flip/chart/chart paper.

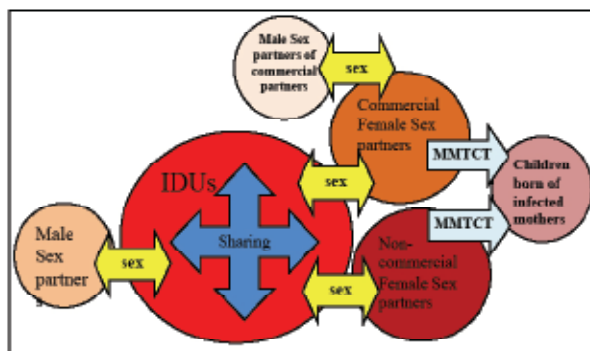
Slide 22: The facilitator invites 2 volunteers to take up one of the role plays – one playing the role of a client and other the counsellor. On completion of role play the facilitator provides feedback based on the issues covered in slides 19, 20 & 21.

Slide 30: For e.g., many service providers are of the view that drug use is a deliberate act by the IDU, and it is a “character problem.” The service providers, including ART providers, should be made to understand that drug addiction is a medical disease with psycho-social problems associated with drug use. In addition, the misconceptions related to ART stated before should be removed.

IDUS WITH HIV

IDUS with HIV

Vulnerability and risks of transmission



Vulnerability of IDUs & their sex partners

- Being sexually active & injecting makes IDUs doubly vulnerable to receive infection both through injecting & the sexual route.
- Non drug using female sex partners and subsequently 'children to be born' always remain vulnerable to infection.
- Sex work and drug use closely linked in many settings.*
- Female drug users are sometimes also involved in sex work.
- IDU- FSW network with strong sexual links with the general community creates a very high risk environment with potential to explode from a concentrated epidemic into a generalised epidemic.

*A study from eastern India shows that over 50% of men who inject drugs visited a commercial sex worker in the previous year.

HIV risk assessment

- Assess client's risk of contracting & transmitting HIV both through injecting and sexual route
- Help client recognize the behaviour /s as harmful to self and partner
- Help client understand the consequences of continued risk taking
- Help the client understand that alternatives are available
- Ascertain course of further action including testing for HIV and requisite services
- Help client seek testing, treatment and allied

Cases for role play –risk assessment

Pregnant
Female IDU

Male IDU
being treated
for STI

Testing -if infected

Advantages

Early identification
Psychosocial support
Regular monitoring
Timely ART
Prevention & treatment of OIs
Prevent transmission
Improved quality of life

Disadvantages

Fear
Denial
Stress

Testing- if not infected

Advantages

Psycho-social support
Reduced risks of infection
Regular check
Lowered stress
Improved quality of life

Disadvantages

False confidence
Continued risky practices

Pre-test counselling

Pre test sessions should include:

- Explaining the Reason for testing
- Educating on the basics of HIV, including routes of HIV transmission
- Exploring personal risk assessment
- Feedback of possible results based on personal risk assessment
- Assessment and discussion regarding capacity to cope with potential positive result
- Assessment of potential support requirements
- Development of a personal risk reduction plan
- Provision of HIV test information
- Informed consent
- Follow-up arrangements for collection of reports and referrals as required

During pre test counselling

Also stress on:

- Test is only voluntary and the client has the right to decline
- Declining test will not affect access to other services
- In case of positive results- disclosure to intimate partners and contacts may be encouraged
- Importance of not engaging in high risk activities before the test

Cases for role play –Pre test

Pregnant
Female IDU

Male IDU
being treated
for STI

Post test counseling

- All clients, tested for HIV should be provided with a post test counseling.
- This is mandatorily held at ICT centres by specialised counselors.

Salient features of Post test counseling

- Results should be provided to the client in person individually
- Strict confidentiality is to be maintained
- The client is within his or her rights in not receiving the results

Breaking the result to IDUs

- IDUs have lower capacity of dealing with stress
- Ensure client not at risk of self harm by overdosing on drugs or suicide
- Negative results may also lead to overdose when trying to celebrate the relief.
- Peer support mechanism is usually helpful.

In case the result is negative

- Explain the result and its significance.
- Educate on window period and a recommendation for retest in case of recent exposure
- Educate on prevention of HIV transmission
- Motivate for drug treatment services especially OST
- Educate on risk reduction (safer injecting and safer sex)
- Provision of condoms and sterile needles and syringes
- Endorse plan for follow up with defined time for re test , if needed
- Assess the need for further services, especially for risk reduction

In case the result is positive

- Inform the client simply and clearly
- Provide time to consider
- Explain significance of the result fully
- Assist in coping with the stress and emotions
- Discuss immediate concerns of the client and their implications
- Discuss available social support that the client may seek
- Educate on services available, their accessibility & advantages
- Educate on need for preventing onward transmission, reinfection
- Educate on prevention of common infections
- Explore disclosure of results, especially to the intimate partners

In case positive

- Motivate for testing and counselling of intimate partners and children
- Advice on other pathological tests (like liver function, hepatitis B and C, pregnancy, TB)
- Advice on referrals to treatment, care, counselling, support and other services (e.g. screening for and treatment of TB, prophylaxis for Ois, STI treatment, contraception, antenatal care, OST, Hepatitis B and C screening, access to condoms and sterile needles/syringes)
- Assess risk of violence, drug overdose or suicide, and discuss possible measures to ensure the physical safety of clients, particularly women diagnosed HIV-positive

Post-test counselling for pregnant women with HIV

- Discuss childbirth plans;
- Use of ARV drugs for client's own health and for PMTCT;
- maternal nutrition, including iron and folic acid supplements;
- infant-feeding options and support infant feeding choice;
- HIV testing for the infant and the follow up
- Partner testing
- Referral to drug treatment centres, particularly those providing OST

Cases for role play –Post test

Pregnant
Female IDU
tested
negative

Male IDU
being treated
for STI tested
positive

Disclosure of positive HIV test results to partners

The need for disclosure to partners- injecting or sexual is important to prevent onward transmission, re infection and infection of newer strain of HIV.

This is a complex process and requires a very sensitive approach.

- Counsellors should support the client's decision-making process by providing a list of potential disclosure mechanisms and facilitating a discussion of the advantages and disadvantages of each.
- Rehearse the act of disclosure to develop the client's skills in managing his or her partner's potential response.

Options for partner notification

- Client himself/herself discloses the status
- Client brings the partner to the clinic for self-disclosure in the presence and with the support of the counsellor.
- Client brings the partner to the clinic and the counsellor discloses in the presence of the client.
- Client authorizes the counsellor to disclose to the partner in the absence of the client.
- Client discloses to a key trusted family member who discloses to the partner.
- Client hands out referral cards for testing and counselling to sexual/ injecting partners.

Protocol for partner notification

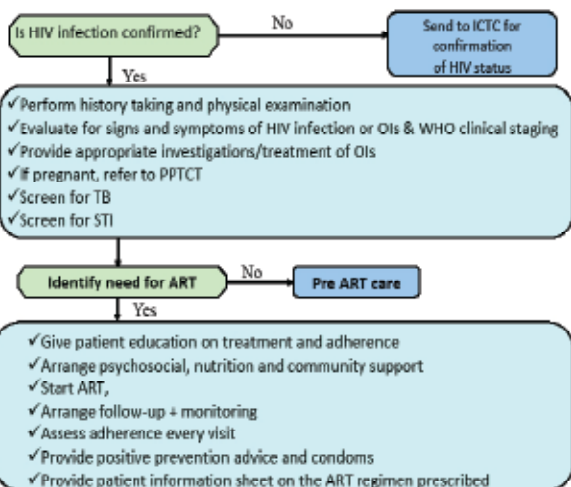
- In case the client does not agree to voluntarily share the HIV status with the spouse or partner the following protocol for partner notification should be adhered to:
- HIV-positive client thoroughly counselled on need for partner notification and encouraged to voluntarily inform partner or bring for joint counselling.
- The HIV-positive person has refused to notify or consent to the notification of partners.
- An imminent risk of transmission to the partner exists.
- The HIV-positive person is given advance notice of the intention to notify.
- The identity of the source of infection is concealed from the partner if that is possible
- Post-notification follow-up counselling, information & support provided to partner & client to prevent violence, family disruption

Cases for role play –partner notification

Married Female
IDU
apprehensive on
disclosure of
result

Male IDU
unwilling to
notify partner /s

Assessment and Management of HIV-infected Person



Anti Retroviral Therapy

Antiretroviral Therapy drugs cannot eradicate HIV infection from the human body but –

- can delay the progress of the disease,
- prolong lifespan, and
- improve the overall quality of life.

Goals of ART:

- **Clinical goals-** Prolongation of life and improvement in quality of life
- **Virological goals-** Greatest possible reduction in viral load for as long as possible
- **Reduction of HIV transmission in individuals-** Reduction of HIV transmission by suppression of viral load

When to start ART?

- The initiation of ART is based on the clinical stage of the disease and the client's CD4 count.
- Optimum time to start ART is before the patient becomes unwell or presents with the first OI.
- The progression of the disease is faster in patients who commence ART when the CD4 count falls below 250 cells/mm³ than in those who start ART before the count drops to this level.
- Lack of a CD4 result should not lead to delay in initiation in case of patients clinically eligible according to the WHO clinical staging.

Adherence to ART

- Adherence simply refers to starting treatment and ability to take medications exactly as directed.
- Adherence to ART is imperative for ART.
- Non-adherence leads to drug resistance requiring the client to be moved from one regimen to another limiting future treatment options.
- TI counsellor in collaboration with the ART/ICTC counsellor plays a crucial role in this matter.
- NACO recommends at least two counselling sessions before the initiation of ART. The primary objective of these sessions are to prepare the client for ART and its adherence.

ART for IDUs

IDUs are often excluded from ART services or are initiated late often caused by some misconceptions among service providers

- IDUs are poor candidates for ART due to poor adherence
- IDUs do not do as well as non-IDUs on ART
- IDUs must be clean of drugs before initiating ART treatment
- IDUs are seen as being non-compliant to the instructions given by the ART team, and hence it is a waste to start ART
- Medical complications associated with IDU such as Hepatitis B and C makes it difficult to initiate ART in IDUs.
- Stigma and discrimination against the IDUs by the service providers are also seen among ART providers

Misconceptions proved false

Studies across the world has proven the misconceptions false.

- Adherence for ART among IDUs is similar to non-IDUs. A large cohort study of more than 6000 patients across Europe in 1999 has found no difference in adherence among IDUs and non-IDUs
- Studies have shown that even without special support or other services such as OST, IDUs have been able to show adherence rates of >65%
- Responses to ART shown by IDUs is similar to non-IDUs in terms of decrease in viral load or increase in CD4 counts after starting ART
- Similar to other treatment strategies for IDUs, satisfaction of the IDU with the treatment provider is a greater predictor of ART adherence;
- Willingness to start ART is associated with patient trust in physician
- HBV and HCV have limited impact on HIV disease progression

Points to remember..

- All IDUs who are medically eligible for ART should receive care and treatment as per the national guidelines.
- The criteria for initiating ART among IDUs patients are same as other patients with HIV.
- Non-availability of OST or active use of illicit drugs should not bar access to ART for those in need of it.
- Provided with adequate support and easy accessibility, IDUs can adhere to ART and have similar outcomes to those of HIV patients not using drugs.

Role of IDU TI counsellor in improving ART adherence

To improve adherence on ART, the following steps can be taken by the counsellor:

- Establish an active liaison with the ART counsellor of the area/city, where the IDU goes to receive ART medications through active referral networking. Meets the counsellor at regular intervals for continued liaison.
- Educate ART counsellor on issues related to IDUs, and remove myths / misconceptions related to IDU. For e.g., many service providers are of the view that drug use is a deliberate act by the IDU, and it is a 'character problem'. The service providers, including ART providers, should be made to understand that drug addiction is a medical disease with psychosocial problems associated with drug use. In addition, the misconceptions related to ART stated before should be removed.
- Understand the rules/requirements of the ART clinic for registration, ART initiation, etc. For e.g., some clinics may charge fees for conducting the laboratory investigations (such as haemogram, liver function tests, etc.). The IDU client must be clearly informed of this and what to expect before going to the ART clinic. This would make the client more comfortable and better prepared before going to the clinic.
- Make sure the IDU is accompanied for the initial phase by a staff of the IDU TI. This will build the motivation of the client, and ensure that the referral is completed

- When conducting one-to-one counselling, address the following issues:
 - specific factors that may affect the timing of initiation and the choice of ART, (sexual intimacy, active use of illicit drugs and the presence of co-morbidities, such as mental problems and co-infection with hepatitis viruses) and refer for appropriate treatment prior to initiation
 - spend adequate time on preparing patients for ART, and helping them understand the treatment goals, need for adherence and lifelong nature of ART will maximize treatment outcomes
 - enquire about the adherence and factors related to adherence/non-adherence to ART medications
 - clarify any myths/misconceptions related to ART treatment
 - encourage the client to involve family members in the treatment process
 - assess the readiness and willingness of the client for drug treatment, e.g. detoxification-cum-rehabilitation, and opioid substitution therapy. Refer the client to these services, if they are available and the client is motivated
- Visit the ART clinic regularly and follow up with the counsellor to enquire about any issues regarding adherence. In addition, ensure that the ART counsellor informs the IDU TI counsellor/other staff on any drop-outs from the treatment, so that the clients can be motivated to re-initiate treatment
- Some IDUs may need special care and services due to morbidities. If identified or recorded in the history of the client, the TI counsellor should refer for specialized care and inform the ART/CTC counsellor

Services needed for HIV positive IDUs

The facilitator then divides the participants into four groups.

Each group is provided with a case and requested to discuss the services needed by their client for 5 minutes and present their findings. Each group seeks feedback from the other groups and highlights the key services required.

Cases for group discussion for ART referral	Key services required
Pregnant Female IDU with CD4 count 1200 > & not on OST	<ul style="list-style-type: none"> ◆ Referral to PPTCT ◆ Services for injecting risk reduction, including OST if available in the area ◆ Motivation for seeking other treatments for drug use, including detoxification ◆ Education on condom use and safer sex
Male IDU drop-out from OST with repeated OIs	<ul style="list-style-type: none"> ◆ Referral to ART centre for CD4 count and follow up services ◆ Explore problems of continuing with OST ◆ Motivation to renew OST services ◆ Counselling for risk reduction and safer sex
Female IDU also in sex work & CD4 <300	<ul style="list-style-type: none"> ◆ Pre ART care ◆ Motivate to seek ART services ◆ Referral to ART centre ◆ Counselling on contraception ◆ Counselling on reduction of injecting risks ◆ Education on condom use and safer sex
Male IDU with poly drug use and TB not on OST	<ul style="list-style-type: none"> ◆ Referral for TB treatment ◆ Referral to ART centre for CD4 count and follow up services ◆ Services for injecting risk reduction, including OST if available in the area ◆ Motivation for seeking other treatments for drug use, including detoxification ◆ Counselling for risk reduction and safer sex

SESSION DETAILS FOR DAY FOUR

Session One

COUNSELLING FOR MOTIVATION ENHANCEMENT

Objectives of the session

- ◆ To familiarise the participants with concept of motivation for behaviour change
- ◆ To develop the skills for Motivation Enhancement Techniques

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

In this session, the discussion and presentation (**Day 4 Session 1 – Motivation Enhancement**) moves forward along with the slides in line with the notes provided on them.

Notes on power point slides (Day 4 Session 1 – Motivation Enhancement)

Slide 2: Facilitator explains that important features of motivation have been presented here.

Slide 6: These features of motivation are applicable to motivation for changing almost any behaviour, from quitting drugs, to adopting healthier lifestyle for losing weight to keeping one's room tidy. The important point to remember is – since motivation is dynamic, it can be changed, and this change can be brought about by interaction between a service provider and a patient.

Slide 7: The facilitator discusses – “How can we change someone's motivation by interacting with them?” These four techniques will be discussed for changing motivation. As may be noticed, these are overlapping strategies.

While these terms may sound technical and heavy, we will see in a short while that these are very practical strategies, which we can use in our day-to-day practice.

Slide 9: The facilitator explains – “As the name indicates, in this technique the therapist just tries to act like a mirror. The key word here is **PERSONALISED**. While everyone must have talked to our patients about the negative consequences of drug use in general, during the feedback process, we must discuss the consequences which the patient has faced himself.”

Slide 10: The facilitator explains – “These are just some of the examples of consequences of drug use, which our patient may have experienced and which could be used for feedback.”

Slide 11: The facilitator elaborates – “Another strategy is decision balancing, – how do we take any decision in general?” The obvious answer would be through comparing pros and cons or positives and negatives of any action.

For any action, doing or not doing it – both are associated with certain likely consequences. Should we take a tea-break now? If we do some of us would feel refreshed and will be better able to participate in training (a positive consequence). However, a tea-break may also delay the proceedings for the entire day. We would end up late (a negative consequence). The reverse is true for not taking a tea-break.

Slide 12: The facilitator adds – “For a drug user too, the decision of quitting drugs will have both positive and negative consequences.” He will discuss with the participants and note down the responses on a Flip chart/chart paper. What will be the positive consequence of quitting? What will be the positive consequence of continued drug use? Similarly, what are the costs involved in quitting? And costs involved in continued drug use?

Slide 13: The facilitator argues – “Thus, if we are able to make the person realise that there is a net benefit in quitting drugs, we may enhance his motivation.”

Slide 14: Another strategy is developing discrepancy – can be called simply as an inconsistency or a mismatch.

Slide 15: The facilitator explains – “Here we help the patients to compare the life of their non-drug using peers/friends/relatives with their own. Similarly making the person realise the difference between what he wanted to achieve and what he could (or could not) due to drug use, also enhances the persons motivation.”

Slide 17: The facilitator sums up – “Many drug users have this myth that quitting is impossible, at least for them. Here the therapist just tries to instil the hope that “change is possible” and the confidence that “you can also make this change.” Examples of others who may have achieved this change, such as currently abstinent peers could be a great motivating factor.

- ◆ After the presentation is over, conduct a role play. In the role play one of the facilitators would become a fictional case, while another would become a counsellor. All four motivation enhancement strategies would be demonstrated.
 1. **Feedback:** While interviewing a client, the counsellor elicits information about all the negative consequences the client has actually suffered. Suppose, during the course of the interview, it was discovered that the client has suffered blocked veins in both hands on many occasions, had an abscess on the left forearm once and had once injected such a large

amount that he fell unconscious. The counsellor then, in her own words, provides feedback about exactly these three negative consequences *“So, you are telling me that because of your injecting drug use, not only have you experienced blocked veins but even abscess and fever too. And once you had experienced an overdose, which was a life-threatening situation.”* While there are obviously many more likely consequences of injecting (like HIV etc.), the counsellor at this moment just focuses on consequences actually experienced by the client.

2. **Decision Balancing:** The counsellor is trying to increase the motivation of an IDU client to get enrolled in the NSEP. The client expresses that enrolling in the NSEP would mean that he has to contact the DIC daily in order to obtain the needles and syringes. This may also mean some inconvenience, spending time and possibly losing some money, through loss of earnings (i.e. cost of change). If he gets enrolled however, he will be able to protect himself from the consequences of injecting with an old needle and will also receive other services (i.e. benefits of change). On the other hand if he decides not to enrol in the NSEP, then he may save himself some inconvenience, time and money (i.e. benefits of staying the same). However, in this situation, he will be at risk of experiencing even more harms due to unsafe injecting (i.e. cost of staying the same). In this way the counsellor can help the client weigh, for himself, both the options and decide upon the best course of action for him.
3. **Developing Discrepancy:** Here the counsellor asks the client about his other friends – those who are either non-drug users or those who have changed their behaviours successfully. Who is doing better in life? The client or them? The counsellor may also ask the client to imagine himself five years down the line. How does the client visualise himself five years from now, if he continues to take drugs in a similar fashion? And how does he appear if he succeeds in changing his behaviour? In this way the client can be helped to see and decide for himself.
4. **Supporting Self-efficacy:** The client expresses pessimism and doubts regarding his ability to be able to change his behaviour. The counsellor attempts to increase his self-efficacy by making statements like, *“I understand that at this moment, you are not sure whether you will be able to do it. However, many others have done this before you and they have achieved success. If others can do it, so can you.”*

MOTIVATION ENHANCEMENT

Motivation Enhancement

Motivation enhancement



Motivation enhancement



Motivation enhancement



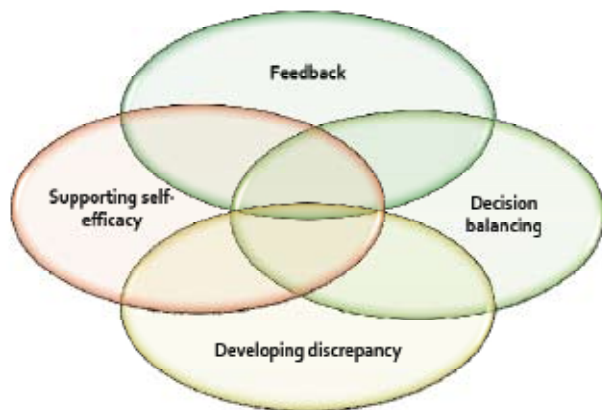
Motivation enhancement



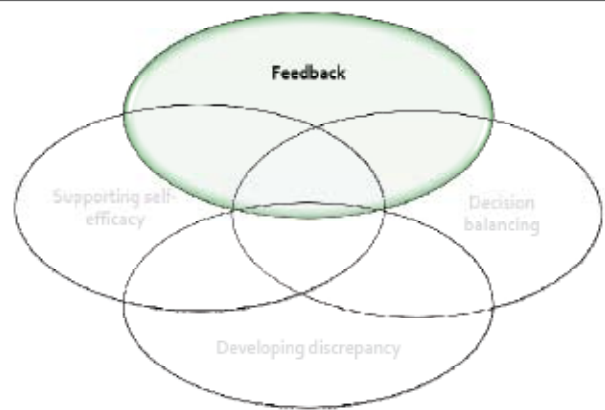
Motivation enhancement



strategies/techniques for enhancing motivation



strategies/techniques for enhancing motivation

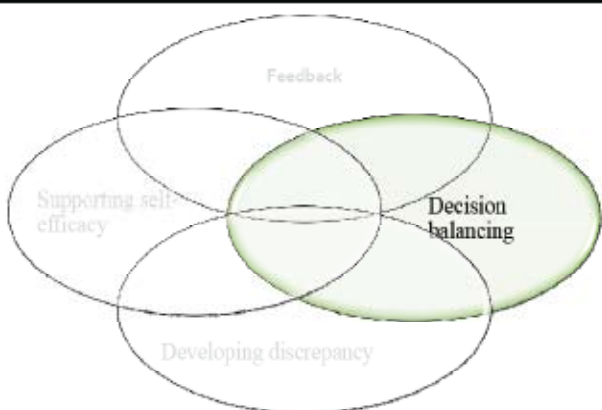


feedback

- Personalised feedback of negative Consequences of substance use
 - Health
 - Socio familial.
 - Occupational.
 - Financial.
 - Legal
- The feedback should be based on the examples of the patient's life.*
 - Eliciting the harms the patient himself had experienced and reflecting it back to the patient*



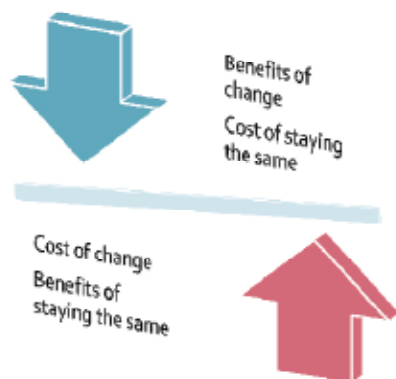
strategies/techniques for enhancing motivation



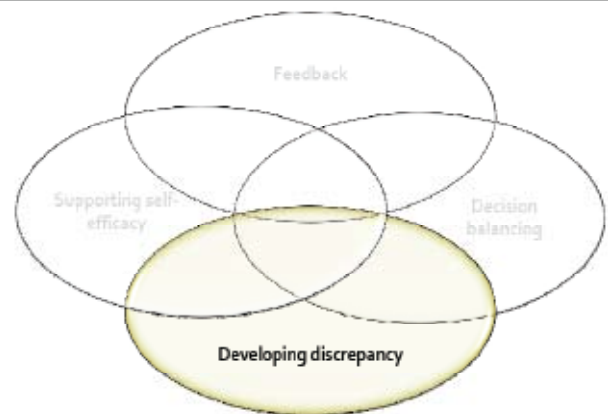
Decision balancing

- The individual is enabled to weigh
 - the benefits of change vis a vis benefits of staying the same
and
 - compare it with cost of staying the same vis a vis cost of change.

Decision balancing



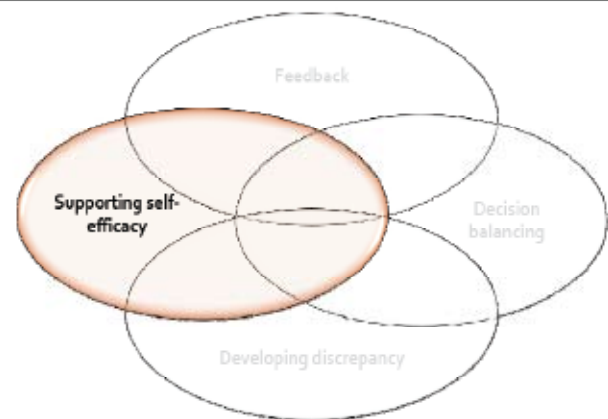
strategies/techniques for enhancing motivation



DEVELOPING DISCREPANCY

- Enable the patient to compare his quality of life with other non users (friends and relatives), and help him to think where he is vis a vis where he wanted to be
- **Discuss Life goals of the patient and how drug use can hamper in achieving these.**

strategies/techniques for enhancing motivation



SUPPORTING SELF EFFICACY

- Instilling hope by telling the patient that
 - "the goal is achievable"
 - "you can do it"
- Some individuals do not attempt behaviour change thinking that the goal is too difficult to achieve*

Session Two

COUNSELLING ON DRUG TREATMENT

Aim of the session

- ◆ To teach the participants on counselling issues related to other interventions associated with drug use

Objectives of the session

- ◆ To train the participants on three specific interventions for drug users: detoxification, opioid substitution therapy, and relapse prevention

Duration of session: Four hours

- ◆ **Detoxification:** 45 min
- ◆ **Opioid substitution therapy:** 45 min
- ◆ **Relapse prevention:** 2 hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Presentation (**Day 4 Session 2 – Drug Counselling**)
- ◆ Discussion with the participants during presentation on the lines described along with the slides
- ◆ Group exercise
- ◆ Role play

Group Exercise 1: How to handle a high-risk situation?

Total time: 25 – 30 minutes

Divide the participants into 4 – 5 groups of 3 – 4 participants for each group.

Give a high-risk situation to each of the groups. The high risk situations which can be given are:

- ◆ Meeting or possibility of meeting drug-using friends
- ◆ Feeling frustrated/bored during abstinence
- ◆ Birthday party at home, celebrating son's birthday
- ◆ Fight with wife; wife accuses the IDU of using drugs today.

Each group, by discussing among themselves, should come out with ways and means of handling the particular high-risk situation given to them. The group should

Day One

Day Two

Day Three

Day Four

Day Five

Day Six

discuss among themselves, and choose a better way of handling the high-risk situation. Time allotted for developing the strategy is 10 minutes.

After the strategy thought out by each group is finalised, one member from each group will give a presentation on what the group thought would be a better way of handling a high-risk situation. Members from the other group should then comment and opine on the presentation. Time allotted for discussions and presentation: 4 minutes each, total of 20 minutes for discussion and presentation.

The facilitator should facilitate the discussions by giving his/her comments and opinions.

Role play: problem- solving technique

Time: 30 minutes

The facilitator asks one of the participants to take part in the role play. The participants play the role of a help seeker, and the facilitator plays the role of a counsellor. The participant is asked to state any genuine problem he/she has faced in the last one month. If there is no genuine problem, ask the participant to make up any problem. The steps outlined in the presentation on problem solving should be followed to solve the particular problem. Time: 15 minutes.

The participants are paired up and asked to practise problem-solving techniques for 15 minutes.

Group Exercise 2: Breathing exercise

Time: 10 minutes

The participants are taught the breathing exercise as outlined in the slide, and asked to practise during the session.

Notes on power point slides (Day 4 Session 2 – Drug Counselling)

Slide 4: Here the facilitator should discuss with the participants about the various features of dependence mentioned in the earlier chapters.

Slide 15: The facilitator asks the participants to recall the hierarchy of harm-reduction discussed in the earlier sessions. The facilitator should ask a participant to volunteer and recall for the entire group about the hierarchies of harm-reduction.

Slide 19: The facilitator uses the diagram to make the participants understand that the daily life of the IDUs or any drug dependent individual revolves around drugs. The IDU spends his entire day in procuring drugs (raising money for his dose by borrowing from friends/family members, or committing illegal activities and travelling distances to buy drugs), using drugs (finding a safe place to inject) and after using, recovering from the effect of drugs (recovering from high or suffering withdrawals).

Slide 34: Before discussing the various types of high-risk situations, the facilitator, after presenting the first bullet and the two sub-bullets, should ask the participants on what could be the high-risk situations that lead to relapse for an IDU/drug user. This should be noted on a chart paper in such a way that the responses should be clustered as described under the heading on types of high-risk situations.

DRUG RELATED COUNSELLING

DRUG RELATED COUNSELLING

Topics covered...

- Detoxification
- Opioid Substitution Therapy
- Relapse prevention therapies

Detoxification



Dependence Criteria:

- Tolerance
- **Withdrawal**
- Loss of control
- Preoccupation with substance use
- Craving
- Continued use despite evidence of harm

What is withdrawal?

- Set of symptoms experienced on stopping or reducing the amount of the substance after prolonged use
- Every class of substance (e.g. alcohol, opioids, etc.) has its own unique set of withdrawal symptoms

Why does withdrawal occur?

- Intake of psychoactive drugs produce changes in the brain receptor level
- With continued use, the brain attempts to maintain balance by producing counter-regulatory mechanisms
- Upon sudden stopping of drugs, the balance between regulatory and counter-regulatory mechanisms is disturbed → withdrawal symptoms



Withdrawal symptoms – General considerations

- Different for different type of substances
 - ▢ Both physical and psychological symptoms seen
 - ▢ Psychological symptoms are similar; difference in physical symptoms
- Onset of withdrawal symptoms is different with different substances
- Severity of withdrawal depends on
 - ▢ Amount of drug consumed in the recent period
 - ▢ Severity of dependence
 - ▢ Individual related factors: physical status, psychological status, presence of other illness
- Withdrawal symptoms of some drugs can lead to death

Withdrawal symptoms – examples

Alcohol withdrawal symptoms

- **Mild-to-moderate psychological symptoms**
 - ▢ Anxiety or nervousness
 - ▢ Depression
 - ▢ Difficulty thinking clearly
 - ▢ Fatigue
 - ▢ Irritability
 - ▢ Nightmares
- **Mild-to-moderate physical symptoms**
 - ▢ Clammy skin
 - ▢ Enlarged (dilated) pupils
 - ▢ Headache
 - ▢ Insomnia (sleeping difficulty)
- **Severe symptoms**
 - ▢ Loss of appetite
 - ▢ Nausea and vomiting
 - ▢ Rapid heart rate
 - ▢ Sweating
 - ▢ Tremor of the hands or other body parts
 - ▢ Agitation
 - ▢ Delirium tremens -- a state of severe confusion and visual hallucinations
 - ▢ Fever
 - ▢ Seizures

Withdrawal symptoms – examples

Opioid withdrawal symptoms

- **Mild – moderate symptoms**
 - ▢ Anxiety
 - ▢ Restlessness
 - ▢ Yawning
 - ▢ Nausea
 - ▢ Sweating
 - ▢ Rhinorrhea (Running nose)
 - ▢ Lacrimation (running eyes, tears)
 - ▢ Dilated pupils
 - ▢ Abdominal cramps
- **Severe symptoms**
 - ▢ Severe Anxiety
 - ▢ Restlessness
 - ▢ Diarrhea (loose motions)
 - ▢ Vomiting
 - ▢ Piloerection (goose bumps)
 - ▢ Muscular pain
 - ▢ Chills
 - ▢ Increased heart rate,
 - ▢ Increased blood pressure
 - ▢ Increased temperature

Withdrawal management

- Withdrawal management – also called as detoxification
 - ▢ Assistance provided to the body to clear itself of the effects of drugs, when drug user decides to stop drug use
- Medical management of detoxification : medically managed withdrawal
 - ▢ Specific medicines
 - ▢ Supportive treatment
- Detoxification can be carried out in both inpatient as well as outpatient setting

Post withdrawal management

- Detoxification alone does not address the psychological, social and behavioural problems associated with addiction
 - ▢ Detoxification alone does not lead to long term behavioural change required
- Detoxification is the first step towards total abstinence
- Detoxification alone leads to 95 – 98% relapse
- Post detoxification: no. of other treatment modalities – periodic counselling, relapse prevention, psychosocial rehabilitation, occupational rehabilitation, etc.

Counselling issues in detoxification



- For those IDUs clients interested in stopping drug use:
 - ▢ Understand the contextual factors
 - ▢ Assess whether the motivation is temporary or pervasive: reinforce motivation/Motivation enhancement
 - ▢ Make the client understand that recovery is a process and detoxification is the first step towards the recovery process
 - ▢ Inform client on what to expect during detoxification
 - ▢ Inform the client on the administrative issues associated with detoxification (user fees, rules/regulations, no. of compulsory days, etc.)

Counselling issues in detoxification



- For those IDUs clients interested in stopping drug use:
 - Explain that if the client relapses after failed detoxification, he should get in touch with the TI staff as soon as possible and practice risk reduction measures
 - Explain that if client relapses after failed detoxification, he should consume very less amount of the first dose of the opioid that he/she would consume to prevent overdose.

Opioid Substitution Therapy



Hierarchy of Harm reduction



Hierarchy of Harm reduction



What is OST

- Defined as
 - Administration of
 - Daily dosage of
 - Opioid medicines with
 - Long lasting effects to
 - Patients with opioid dependence under
 - Medical supervision (prescribed)

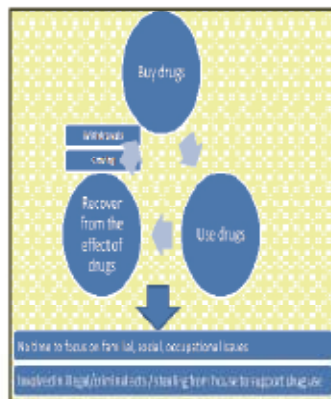
What is OST? Differences

Difference between the illicit opioid and the OST medicines prescribed:

Opioid drugs	OST medicine
• Medically unsafe	• Medically safe and prescribed by a doctor
• Unknown purity	• Purity and strength known
• Used by unsafe route (injection/inhalation)	• Used by oral route, which is safe
• Has short duration of action → has to be administered repeatedly in a day	• Has a long duration of action → can be administered once a day
• Illegal and hence hazards involved in procurement	• Legally prescribed
• Higher chances of overdose, as the potency of the drug is not known and varies	• Lesser chances of overdose, as the potency of the drug is known and constant

OST: Rationale

- Life of an IDU is chaotic
 - Life revolves around drugs – procuring, using & recovering from its effects
 - Hence, not able to focus on other activities, responsibilities
 - Involved in illegal activities to procure drugs



OST: Rationale

- OST medicines have long period of action
 - Help in breaking the chain of opioid use (showed in earlier slide)
- Dose is adjusted → no cravings or withdrawals
→ no high
- Patient able to focus on other areas of life because of stabilisation

OST: basic facts

- Commonly used medicines: Methadone, Buprenorphine
- Methadone used in more than 70 countries in the world
- Buprenorphine is used in more than 50 countries in the world
- India has more than 17 years experience in implementing OST using buprenorphine
 - Found to be safe and useful in Indian settings



OST: basic facts

- OST is given ONLY to those who use opioids and are dependent on them
 - Those who are not dependent on opioids but are dependent on other drugs, do not benefit from OST
- Specific inclusion and exclusion criteria for OST
- Initiated only by a physician, after examination
- Has to visit the centre daily for receiving the dose, in front of the nurse
- OST medicine alone does not suffice: additional psychosocial counselling helps in increasing retention

OST – benefits

- Individual level:
 - Reduced and finally stoppage of use of illicit drugs, including injecting.
 - Reduction in high risk behaviour
 - Improved treatment adherence for co-morbid conditions involving long term treatment such as TB, HIV, Hepatitis B and C.
 - Increased availability for social and psychological support.
 - Reduced overdose mortality.
 - Improved physical and mental health.

OST – benefits

- Community level:
 - Significant reduction in criminal activities in the community, as the client is stabilized on OST
 - Reduced risks of blood borne infections in the community – HIV, Hepatitis B and C
 - Decreased domestic violence and abuses against family members
 - Increased productivity in the society

OST in NACP III

- Recognized as a harm reduction intervention under NACP III
- OST is a medical intervention, initiated by a doctor and administered by a nurse.
- Given on a 'DOT' basis: i.e. daily observed treatment basis
- Both buprenorphine and methadone will be given as OST under NACP III
- About 20% of the total population of IDUs will be provided OST

OST in NACP III contd...

- Currently available through TI settings.
 - ▢ accredited by NACO
 - ▢ implementing OST using buprenorphine.
 - ▢ total of about 50 OST centres in the country
- Also available through some Government district hospitals or medical colleges

OST: Role of TI counsellor

- **Assess** the client and determine the exact reasons for his/her desire of initiating OST. These factors should be used to **build the motivation** of the client.
- **Educate** the clients on the **benefits of OST**
- **Assess** whether the client has **understood the implications** of being in OST programme.
 - ▢ E.g. the client would have to travel to the OST centre daily to receive his/her dose of medicine

OST: Role of TI counsellor contd...

- **Break the myths** surrounding OST among the clients.
 - ▢ For e.g.,
 - Taking OST is enough, psychosocial counselling is not required
 - OST can be used to treat other drug dependence also

Relapse Prevention Therapy



Based on Marlatt and Gordon Model of Relapse prevention

Relapse: basic concepts

- Drug use problem is characterised by relapses and remissions
- Relapse
 - ▢ Defined as 'act or instance of backsliding / worsening / subsiding'
 - ▢ Encountered in many chronic health related conditions, especially involving life style changes:
 - E.g. weight loss, diabetes, hypertension, coronary artery disease
 - ▢ More commonly identified with drug use problem

Relapse – issues

- Multiple factors determine the various phases of drug use (initiation, continuation & termination)
 - Biological – genetic, neurobiology,
 - Psychological – personality, stress,
 - Social – family condition, peers, socio-economic status,
- Addiction is a learned behaviour with involvement of cognitive & behaviour principles in initiation, continuation as well as relapse

Relapse – issues

- An abstinent individual who goes back to drug use, does not restart the previous pattern of drug use immediately
 - Lapse: first episode of drug intake after a period of abstinence
 - Relapse: resumption of previous pattern of drug use
- Both positive and negative factors determine the occurrence of lapse & relapse

Determinants of lapse



- Initial drug use (lapse) determined by three phenomena:
 - Exposure to high risk situations
 - Outcome expectancies
 - Self-efficacy
- Based on the interplay between the three phenomena, an individual may/may not slip into first episode of drug use, after abstinence

Determinants of lapse



- High risk situations:
 - Definition: Situations in which the individual is vulnerable to lapse and relapse
 - The way the individual deals with particular high risk situation determines his coping ability
- Types of high risk situations:
 - Coping with negative emotional states: frustration, anger, fear, anxiety, loneliness, boredom
 - Coping with negative physical states: pain, fatigue, injury, illness

Determinants of lapse

- Types of high risk situations:
 - Enhanced positive emotional states: feeling of pleasure, joy, freedom, celebration
 - Wanting to test one's personal control: testing one's commitment to stay abstinent, wanting to 'try it once'
 - Giving into one's urges/temptation or 'Craving'
 - Coping with interpersonal conflict, e.g. marital relationship, friends, etc.
 - Influence of other person/s: peer pressure

Determinants of lapse

- Outcome expectancy: what the individual expects as an outcome out of a certain event
 - In drug use, because of the effect of drug on the brain, and earlier experience → usually positive outcome (e.g. user feeling high from drug use)
 - Though individual has suffered negative consequence of drug use in the past, positive outcome far outweighs the negative consequence → individual becomes vulnerable to further drug use

Relapse – issues

Self efficacy

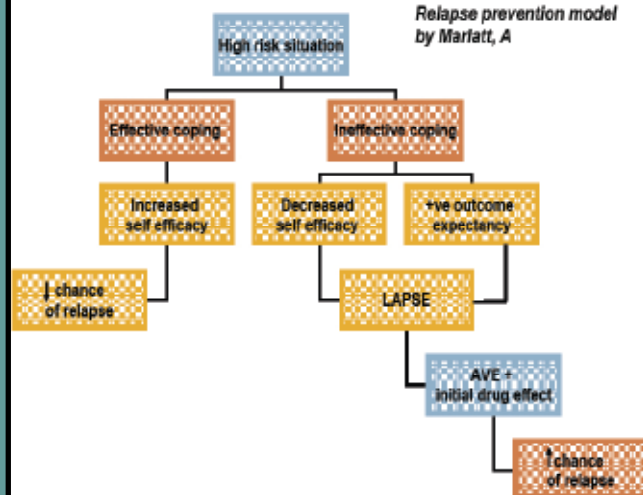
- ▣ Belief of an individual that he is able to handle a given situation and have a positive outcome
- ▣ With every day of abstinence, individual feels able to remain away from drugs
 - Increasing time spent away from drugs
 - Effective coping skills to remain away from drugs



Determinants of relapse

- ▣ After an episode of lapse, the chances of an individual to relapse depends on:
 - ▣ Exposure to high risk situations
 - ▣ Initial experiences with the drug
 - ▣ Abstinence violation effect (AVE)
 - After a lapse, an individual may feel that he is a failure, and not able to control
 - Feelings of guilt, shame, self blame
 - Leads to decreased self-efficacy
- Makes him to continue drug use: RELAPSE

Relapse prevention model by Marlatt, A



Relapse prevention therapy

- ▣ Variety of cognitive – behavioural techniques to modify each of the phenomenon discussed earlier
 - ▣ Handling high risk situations
 - ▣ Coping skills techniques
 - ▣ Stress management techniques
 - ▣ Dealing with AVE
 - ▣ Lifestyle modification
 - ▣ Craving control measures

Relapse prevention therapy

- ▣ Handling high risk situations
 - ▣ List down all the high risk situations a client is going to encounter
 - ▣ Common high risk situations:
 - Meeting old using friends
 - Negative emotional states (feeling frustrated/bored)
 - Occasion for celebration (e.g. birthday, marriage)
 - Relationship problems with family members/spouse



Relapse prevention therapy: high risk situation

- ▣ Work with clients on dealing with each high risk situation
 - ▣ For every situation, ask the client on various ways and means of handling the situation
 - ▣ Avoiding a situation: sometimes the situation may be avoided, e.g. avoiding old drug using friends
 - ▣ 'Behavioural rehearsal' may be used to make the client practice the best way to handle the situation



Group activity 1

How to handle high risk situations?

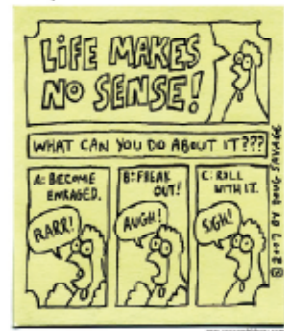
Time: 25-30 minutes

Relapse prevention therapy: coping skills technique

- Enhance coping skills by using 'problem solving' techniques
 - Recognise the problem ("Is there a problem?")
 - Identify the problem ("What is the problem?")
 - Specify the problem
 - Break the problem into small manageable steps

Savage Chickens

by Doug Savage



Relapse prevention therapy: coping skills technique

- Consider various approaches to solving the problem ("What all can I do to solve the problem?")
 - Prepare a list of various options that exist to solve the problem
 - Not doing anything can be a solution also!
- Select the most appropriate approach ("what will happen if..."):
 - Review each approach
 - Consider the positive & negative consequence of each approach
 - Weigh the pros and cons of each of the response
 - Also examine if the solution is feasible/practical
- Choose the best response

Role play

Problem solving

Time: 30 minutes

Relapse prevention therapy: Stress management

- Relaxation training for stress management
 - Breathing techniques
 - Meditation
 - Yoga
 - Exercises



Relapse prevention therapy: Stress management

- Breathing techniques: e.g. Benson's technique:
 - Sit or lie down in a quiet place
 - Pay attention to your breathing
 - Every time you exhale, say the word 'one' quietly to yourself. If any thoughts come, return your concentration to the word 'one'.
 - Do this for 10 – 20 minutes twice a day



Group activity 2

Breathing exercise

Time: 10 minutes

Relapse prevention therapy: Dealing with AVE

- Counsel the clients on
 - Difference between lapse and relapse
 - Make the client aware of AVE, its symptoms & consequence
 - Help the clients in ventilating out their feelings after lapse
 - Catharsis
 - Make the client understand that lapse is a process rather than an event in itself.
 - Make the client understand that working on lapse helps to prevent full blown relapse

Relapse prevention therapy: life style modification

- Lifestyle modification counselling
 - As life of drug user revolves around drug use during using days, the lifestyle needs modification during abstinence:
 - Involve in other pleasurable activities:
 - E.g. sports, exercise,
 - Avoid drug using friends/places
 - Eat healthy foods to regain lost weight and well-being



Relapse prevention therapy: dealing with urge/craving

- Dealing with urges/craving:
 - Two types of craving: cue-induced (external); automatic (internal)
 - External craving:
 - Stimulus control
 - Behavioural rehearsal
 - Internal craving
 - Craving comes in waves with gradual build up of pressure
 - Visual imagery: clients asked to view craving as a wave, and then asked to surf over it.
 - Other techniques: remembering the reason for being abstinent; sharing with family/friends; distraction measures (e.g. watching TV, listening to music, breathing exercises), etc.



THANK YOU

SESSION DETAILS FOR DAY FIVE

Session One

COUNSELLING FOR COMORBID CONDITIONS

Aim of the session

- ◆ To teach the participants on counselling issues related to co-morbidity with injecting drug use

Objectives of the session

- ◆ To make the participants understand what is co-morbidity
- ◆ To teach the participants on carrying out counselling for IDU clients for the common co-morbid conditions

Duration of session: Two hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Interactive discussion with the participants using the Presentation (**Day 5 Session 1 – Co-morbidity**) following the notes provided on the slides

Notes on power point slides (Day 5 Session 1 – Co-morbidity)

Slide 3: Before presenting the slide, the facilitator draws the attention of the participants towards the complications associated with drug use as discussed in the previous presentations. The facilitator should, through discussions with the participants, ask them to name the various complications that may arise. The complications include – physical, mental (psychological), familial, social, occupational, and legal complications.

The facilitator should then ask the participants to name the physical illnesses associated with drug use. The responses given by the participants should be noted on a chart paper. After enough responses have been generated, the facilitator should proceed with the presentation.

Slide 16: The facilitator should ask the participants to recall here the session on risk reduction counselling related to injections. The methods of safe injecting, including steps and processes should be elicited from the participants through discussion, and the same noted on a chart paper. The missed-out points should then be recollected.

Slide 28: The facilitator should inform the participants that only three main groups of mental illnesses will be discussed here, as these are relatively easier to identify and understand. These three groups of illnesses are – depression, anxiety disorders, psychosis.

Slide 29: The facilitator should discuss here that while everyone feels sad at some point of time in their life, depression is a morbid state of sadness. Everyday sadness should not be equated to depression, which is a specific mental illness with a collection of different signs and symptoms which are described in the coming slides.

CO-MORBIDITY AMONG IDUs

Co-morbidity among IDUs

What is co-morbidity?

- Presence of two or more conditions together in an individual (co-occurrence)
 - The conditions can occur simultaneously
 - One condition can precede another one
- Co-occurrence of mental illness along with drug use problem is called as dual diagnosis

Co-morbidity among drug users

■ Physical illness

- Tuberculosis
- HIV
- Hepatitis B & C
- Abscesses
- COPD and other respiratory illness
- Systemic infections

■ Mental Illness

- Depression
- Anxiety disorders
- Schizophrenia and other psychotic disorders
- Personality disorders

Physical illnesses

Physical illness

- Physical illness among IDUs is more common as compared to the general population

- A Study from Chennai conducted in 2005 – 06 showed increased rates of physical illness

(Solomon et al, 2008)

- The same group also showed that mortality is more in comparison with the following causes: Overdose, AIDS, tuberculosis, accident

(Solomon et al, 2009)

Illness	Prevalence / rate (%)
Tuberculosis	33.9
Lower respiratory tract infections	16.1
Anaemia	22.9
Hepatitis B	11.9
Hepatitis C	94.1
Cellulitis	6.8
Herpes simplex	9.3
Herpes zoster	9.3
Oral candidiasis	43.2

Physical illness – reasons

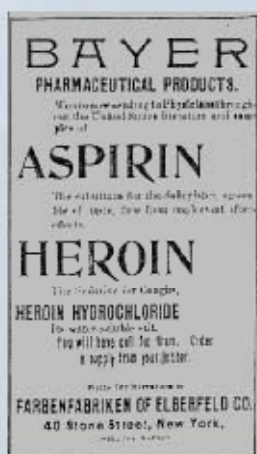
- Three main factors for increased rates of physical illness
 - Drug use itself may lead to increased rates
 - E.g. smoking may lead to respiratory problems; nicotine and alcohol may lead to cancer; injecting may lead to abscesses, HIV, hepatitis
 - Individual may use drugs due to existing physical illness
 - E.g. person with pain condition may initiate drug use and then become 'addicted' to the drug
 - Some addictive drugs banned today were used earlier to treat physical illness



Cocaine used in coca-cola as energy drink



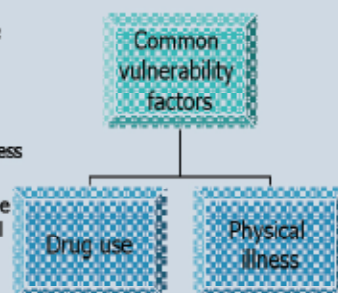
Cocaine used to relieve toothache



Heroin used for relief of cough

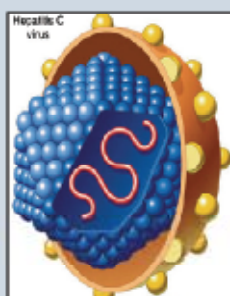
Physical illness – reasons

- Both drug use and physical illness may be caused by overlapping factors leading to both illnesses
 - E.g. genetic factors, stress related factors
 - Drug use and TB may be caused by the individual living in poor socio-economic conditions



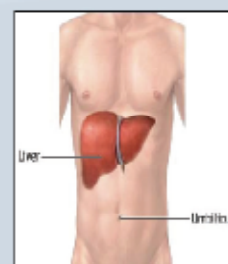
Physical illness – Hepatitis C

- Hepatitis C infection is a major concern among IDUs
 - 80 – 90% IDUs infected with Hepatitis C in some parts of India
- Hepatitis is inflammation of liver
 - Liver can be inflamed by toxins, infection, alcohol, etc.



Physical illness – Hepatitis

- Liver is a vital organ of the body. Functions include:
 - Processing food for energy conversion
 - Neutralise toxins and other drugs
 - Store iron and important vitamins
 - Process hormones
 - Fight infections
 - Produce important proteins in the body
- Liver can re-grow, if injured



Physical illness – Hepatitis

- When liver is inflamed chronically, it causes scarring, called as fibrosis
 - Extensive scarring and re-growth of liver leads to cirrhosis
 - The end-stage of cirrhosis is liver failure, which leads to symptoms such as jaundice, collection of fluid in abdomen, easy bleeding, toxins entering into blood stream and also brain (encephalopathy) which can make the individual comatose



Physical illness – Hepatitis

- Viral hepatitis
 - 5 types of viral hepatitis: A, B, C, D, E
 - Reaction in liver is same
 - Degree of damage and persistence of infection depends on the type (summarised in table)

Type of virus	Route of transmission	prognosis
A	Eating unhygienic food	Transient; very good prognosis
B	Injection, sexual	Chronic infection
C	Injection, sexual	Chronic infection
D	Occurs along with hepatitis B	Worsens prognosis of hepatitis B
E	Unhygienic food	Poorer than Hepatitis A

Physical illness – Hepatitis C

- Transmission of Hepatitis C
 - Sharing of contaminated injecting equipments in majority of cases
 - Other injecting equipments such as spoons, tourniquet, swabs, water in addition to N/S
 - Contamination of hands during mixing of drug
 - Transfusion of infected blood and blood products
 - Mother to baby (5% chances)
 - Very low risk through sexual route, (but still chances exist)

Physical illness – Hepatitis C

- Stages of infection
 - Acute: some infected individuals have symptoms during this stage:
 - Nausea, vomiting, jaundice – 'Acute hepatitis'
 - 25% of individuals clear the virus from their body by 2 years of infection

Physical illness – Hepatitis C

- Chronic: 75% of infected individuals will have chronic hepatitis with presence of virus in body and ability to transmit it to others
 - About 45% do not develop liver damage
 - About 30 – 40% develop mild liver damage
 - About 10 – 20% develop liver cirrhosis
 - About 1 – 5% develop liver failure or liver cancer
- Treatment of Hepatitis C
 - Not everybody requires treatment
 - Success rate is only 30 – 40%
 - Treatment is currently very costly in India

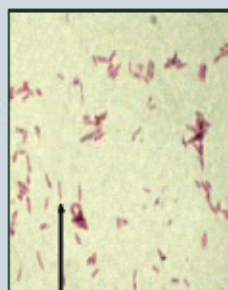
Hepatitis C – counselling issues



- For every IDU, the TI counsellor should:
 - Educate about the transmission dynamics of Hepatitis C
 - Stress on using safe injecting equipment (not only N/S, but also others)
 - Teach the clients on how to inject safely
- For Hepatitis C infected IDU clients
 - Instill hope in the client that not every case is fatal
 - No special diet is required, but if the client is obese, fat foods should be avoided
 - Alcohol IS STRICTLY prohibited: this message should be strongly delivered to the client
 - If the client has problem alcohol use, he should be counselled accordingly, and if required, should be sent to a de-addiction centre

Physical illness – Tuberculosis

- Tuberculosis (TB) is caused by a microscopic organism – bacteria – mycobacterium tuberculosis
- Can affect any body part
 - Usually affect lungs
 - Other sites: lymph nodes, bone, brain, spinal cord, genital-urinary system, etc.

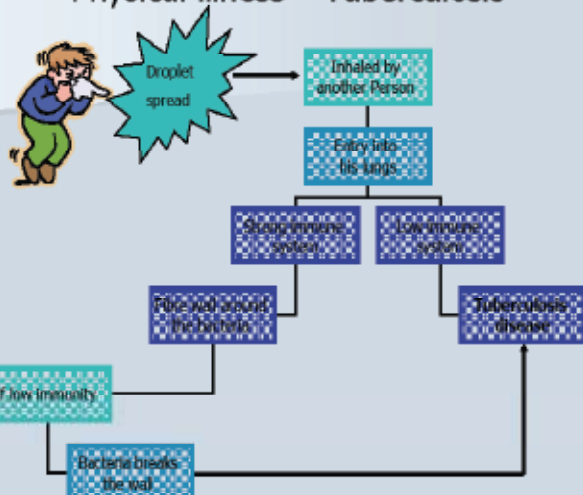


TB causing bacteria

Physical illness – Tuberculosis

- TB is contagious and spreads through air
 - Transmitted from one person to another through droplets
 - When an infected person sneezes, coughs or talks, tiny droplets of saliva/mucus spread to another person, who can get infected
- If not treated, each infected person with active TB will infect 10 – 15 person every year
- TB is not transmitted by touching clothes or shaking hands of an infected person

Physical illness – Tuberculosis



Physical illness – Tuberculosis

Risk factors for tuberculosis

- Living with a person who has an active TB
- Poverty
- Homelessness
- Nursing home residents
- Prison inmates
- Alcoholics
- Injecting Drug Users
- Diabetes
- Certain cancers
- HIV infection
- Health care workers, including doctors and nurses

Physical illness – Tuberculosis

Symptoms of active tuberculosis

- Generalised tiredness/weakness
- Weight loss
- Fever
- Night sweats
- Cough
- Chest pain
- Coughing up of sputum
- Coughing blood
- Shortness of breath
- If other systems involved, symptoms according to the function of the organ
 - E.g. Brain: fits, unconsciousness

Physical illness – Tuberculosis

- Diagnosis based on
 - Symptom profile
 - Chest X ray
 - Sputum examination
 - Skin test (Monteux test)
- Treatment
 - Nearest TB centre under RNTCP
 - Directly Observed treatment (DOT)
 - Duration 9 – 12 months for complete cure
 - Person becomes non-infectious within 3 weeks of initiating treatment

Physical illness – Tuberculosis

- Other important considerations
 - TB is the leading killer of people with HIV
 - HIV infected people are 20 – 40 times more likely to develop active TB
 - TB has resurfaced in the global epidemic because of the onset of HIV infection
 - Multi drug resistant TB (MDR-TB): form of TB that is difficult and expensive to treat which fails to respond to standard treatment
 - Extensively drug resistant TB (XDR-TB): form of TB which is resistant to drugs used in MDR-TB

Physical illness – Tuberculosis



- IDU related issues for TB
 - IDUs have a very high rate of TB
 - Reasons are many – poverty, homelessness, poor living conditions, low immunity, poor nutrition, high HIV rates
- Early symptoms of TB may be mistaken for other conditions. For e.g.
 - Weight loss, weakness or tiredness → general debility
 - Cough, chest pain → chronic bronchitis associated with co-morbid smoking

Physical illness – Tuberculosis



- During every follow up, symptoms of TB must be positively ruled out
- Baseline screening must be ensured by the counsellor by referral to the physician
- Clients should be educated on signs/symptoms of TB
- Clients with symptoms resembling TB must be referred to nearby DOTS centre
- For those on treatment for TB: counselling for adherence, physically verify whether the client is taking TB medicines or not

Mental illnesses

Mental illness

- Mental illness rates more common in Drug using population – dual diagnosis

Mental Illness	Rates (%)
Anti-social personality disorder	15.5
Mania	14.5
Schizophrenia	10.1
Depression	4.1
Obsessive compulsive disorder	3.4
Phobia	2.1

National Co-morbidity Study, USA

Mental illness

- Reasons for increased rates of mental illness:
 - Drug use itself may cause mental illness
 - E.g. cannabis use for a long time seen to cause psychosis in some
 - Individuals suffering from mental illness may initiate drug use – self medication hypothesis
 - E.g. individuals suffering from schizophrenia increase tobacco/cigarette consumption to reverse the slowness in thinking due to their illness or due to the medicines used to treat schizophrenia
 - Both drug use and mental illness may be caused by the same underlying factors
 - E.g. genetic vulnerability, stress related factors, etc.

Mental illness – Depression

- Depression is a very commonly occurring mental illness, with great morbidity
- Everyone feels sad at some point of time
- Depression is morbid state of sadness
 - Affects the productivity and normal functioning of an individual



Depression – symptoms

Symptoms in an individual for at least two weeks period leading to difficulty in work OR personal suffering

- | | |
|--|--|
| <ul style="list-style-type: none"> ■ Low mood /sadness <ul style="list-style-type: none"> – Varies little from day to day – Unresponsive to external situations ■ Reduced energy <ul style="list-style-type: none"> – Marked tiredness even after minimal effort ■ Decreased activity <ul style="list-style-type: none"> – Psychic (thought level) – Motor (physical level) | <ul style="list-style-type: none"> ■ Reduced capacity to enjoy ■ Reduced interest in work and pleasure ■ Reduced concentration ■ Thinking becomes muddled and hazy ■ Sleep disturbed <ul style="list-style-type: none"> – Early morning awakening – Frequent awakening from sleep – Does not feel refreshed |
|--|--|

Depression – symptoms

- Loss of appetite
- Reduced self esteem and confidence
- Ideas of guilt
 - feeling that he has committed wrong
- Ideas of worthlessness
 - Feeling that he does not have any worth, which he deserves
- Ideas of hopelessness
 - Feeling that there is no hope for him in this world
- Ideas of helplessness
 - Feeling that no body can help him from his present condition
- Wishes to die
- Suicidal acts/attempts
 - Feeling that life is not worth living and attempt to end life

Mental illness – anxiety disorders

■ Anxiety as a symptom

- Anxiety is irrational fear, or fear out of proportion to what is expected in the given situation
- Almost everyone experiences fear or nervousness one time or the other
- The fear is usually in anticipation or presence of a stimulus (e.g. darkness, animals, exams, etc.)
 - Fear helps the person in responding to the situation: either fight the situation or prepare to run away (flight)



Anxiety disorders

- The fear is labeled as disorder if it:
 - occurs without any stimulus
 - is out of proportion to what is expected in the given situation by majority of individuals
 - Hampers or hinders the individual's performance
- Anxiety disorder: group of disorders in which the predominant symptom is anxiety

Anxiety disorders – type

■ Common types:

1. Specific phobia
 - Irrational fear of a specific object, animal or situation
 - E.g. phobia for heights, spiders, water, exams,
2. Social phobia
 - Irrational fear of being judged negatively or publically embarrassed in society
3. Panic disorder
 - Characterised by repeated panic attacks
 - Panic attack: state of extreme anxiety and fear with sense of dying without any external stimulus (spontaneous attack)



Anxiety disorders – type

■ Common types:

4. Obsessive compulsive disorder
 - Characterised by obsessions and compulsions
 - Obsessions: anxiety provoking thoughts which intrude into the mind repeatedly, and are irrational
 - Compulsions: irrational actions which the patient is compelled to perform repeatedly

E.g. repeated thoughts of being dirty/unclean: though the patient knows that he is not unclean, he is not able to resist these thoughts and resisting them provokes anxiety → obsessions; as a result of these obsessions, the person repeatedly washes his hands → compulsions

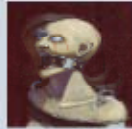


Anxiety disorders – symptoms

Apart from Anxiety as the main symptom, one or more of the following:

- | | |
|----------------------------------|---|
| ■ Excessive unrealistic worrying | ■ Numbness/pins and needle sensation in arms, hands or legs |
| ■ Trembling/shakiness | ■ Restlessness |
| ■ Churning stomach | ■ Easily tired |
| ■ Nausea | ■ Poor concentration |
| ■ Diarrhea | ■ Easy irritability |
| ■ Headache | ■ Muscle tension |
| ■ Backache | ■ Frequent urination |
| ■ Heart palpitations | ■ Sleep difficulties |
| ■ Sweating/flushing | ■ Easy startle |

Mental illness – Psychosis



- Group of mental illness characterised by a loss of reality
- Disorganisation in thoughts, perception and behaviour
- Psychotic Disorders :
 - Schizophrenia
 - Delusional disorder
 - Bipolar disorder
 - Acute Psychosis

Psychosis – symptoms



- Delusions
 - False beliefs which are not part of the person's culture; these beliefs are not amenable to reasoning, and are held tightly by the person despite evidence to contrary
 - Examples:
 - Belief of being persecuted → persecutory delusions
 - Belief of being talked about → referential delusions
 - Belief of having powers → grandiose delusions
 - Bizarre Delusions seen in schizophrenia
 - E.g. patient may feel that neighbours are controlling his mind and compelling him to perform actions by magnetic waves

Psychosis – symptoms



- Hallucination
 - Sensory perception without any stimulus
 - Any sense organ can be involved
 - Most common is hearing – auditory hallucinations
 - E.g. a person may hear voices talking bad about him/ swearing at him when in reality nobody is talking, and others around the patient are not able to hear it

Psychosis – symptoms



- Thought disorders
 - Break in logical connection between one thought chain to another
 - Results in not understanding what the patient is saying
- Negative symptoms
 - Found in chronic psychotic disorders, e.g. schizophrenia
 - Disruption of normal emotions and behaviour, what is expected in a normal person
 - E.g. loss of emotions when a person speaks (loss of affect), not speaking when required, loss of will power to initiate, loss of goals in life, etc.

Mental illness – counselling issues



- If the IDU presents with one of the symptoms of mental illness, explore other symptoms of mental illness
 - If suspicion of mental illness, refer to a psychiatrist
- Educate the client that
 - Mental illness are treatable
 - Having a mental illness does not mean that the person has some defect of will power
 - Instill hope that outcome of mental illness such as depression and anxiety is good, if treated for adequate duration

Mental illness – counselling issues



- Reinforce risk reduction message, as the chances of sharing are increased due to despair
- Emphasize on chances of overdose
 - Due to suicidal ideation
 - To relieve symptoms of mental illness
- Seek support of family during this crisis of the IDU
- Regularly follow up with IDU and counsel him during the follow up phase

Session Two

CRISIS MANAGEMENT COUNSELLING

Aim of the session

- ◆ To help the participants get oriented with counselling related to crisis situations

Objectives of the session

- ◆ To help participants understand what is crisis
- ◆ To list out various situations that can precipitate a crisis in the client's life
- ◆ To make the participants understand the role of the counsellor in crisis situations
- ◆ To facilitate understanding and practice of counselling techniques in crisis situations

Duration of session: One and half hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Interactive discussion with the participants using the Presentation (**Day 5 Session 2 – Crisis Management**) following the notes provided on the slides.
- ◆ Group activities
- ◆ Role-plays

Notes on power point slides (Day 5 Session 2 – Crisis Management)

Slide 2: The facilitator asks the group to discuss the day-to-day problems (related to health, family, friends, work, money) usually reported by the IDU and lists out the responses on the chart.

Slide 4: The facilitator divides the group into smaller groups and asks each group to appoint a leader who would note down the group's responses and later present the same to the larger group. The groups are given 10 minutes to brainstorm various situations (under the headings given in the slide) that can precipitate a crisis in the client's life. On the flip-chart, separate columns are made by the facilitator for each heading. The group leaders are called one by one to present the responses of the group.

After all the situations are noted down, all those situations which are not crisis situations are crossed out while stating reasons for the same.

Slide 5: The facilitator discusses the situations which may have been missed by the group.

Slide 6: After presentation of various stages of crisis the facilitator asks one of the participants to volunteer. The participant plays the role of a client. The participant is given a hypothetical situation. He is then asked to close his eyes for 2-5 minutes, and imagine the situation in as much detail as possible. Then the counsellor asks him the following questions one by one.

Can you please elaborate to the group as to what would be your first reaction to the situation.

After that what thoughts would be running through your mind:

- ◆ What emotions would you be feeling?
- ◆ What would your behaviour be like?

Situation: *The client is an IDU who has been taking injections for the past 2 years. He was aware of the dangers of injections yet he was unable to cut down his use. He also knew about the dangers of sharing needles/syringes. However, on one occasion, he was broke and did not have money to buy a new needle. His friend whom he had known for many months had a needle. He decided to share it with him thinking that it was safe as he was sharing with someone he knew well enough and sharing once won't kill him. After that, he never shared anything with anyone. When he came to the centre, he was asked to get a HIV test done. He was confident that nothing like that could have happened to him and anyway, he felt fit and fine. However, today morning, he got the report in which he had tested positive. He called his friend with whom he had shared and came to know that he was very sick and hospitalised...*

Slide 7: The facilitator asks the group regarding their opinion of the role a counsellor can play during crisis and notes down the responses on the flip-chart.

Slides 8 & 9: The facilitator asks a participant to volunteer to play the role of the client. He is given a hypothetical crisis situation- *"The client has just been thrown out of his job and now he has no source of income. He is very distressed and agitated and has come to the counsellor."* The facilitator playing the role of the counsellor enacts two situations.

Situation 1: The counsellor keeps on interrupting the client and completes his sentences. She tells the client that it is his fault as his employer had given him many opportunities to come to work in a sober state. She also tells him, *"See, I had already warned you that this would happen."* She also reminds him of all the possible problems he is going to face now.

Situation 2: The counsellor just listens to the client as the client ventilates all kinds of negative emotions. She asks open-ended questions like, *"Tell me how do you feel?"* and provides empathic responses – *"You must be feeling so angry?"* She also reassures the client that help is available and all is not lost.

Now ask the participants to discuss both the situations.

Slide 10: The facilitator emphasises here that though what the client says should be kept confidential, but it can be breached if there are any indications that client may want to harm himself or others in frustration or anger.

Slides 12 & 13: The facilitator requests two people to volunteer. One becomes the counsellor and other becomes the client. They are given a hypothetical situation:-

The client returned home in an intoxicated state and was beaten by family members and thrown out of the house. The facilitator asks the volunteer counsellor to ask the client using WHY statements and then ask similar questions without using WHY and using terms such as “I understand...”; “Tell me more about it...” “I would like to understand more about...”

After both situations have been enacted, the group is asked to comment on both situations.

Slide 15: The facilitator asks a participant to volunteer as a client. The hypothetical crisis situation that the client has to face is- *“the client has been diagnosed as HIV-positive and has come to the counsellor. The counsellor has managed to somewhat calm the client and now he is now ready to look at other alternatives to the problem.”*

It is explained to the group that the problem has to be defined as clearly as possible. The facilitator writes down the problem in clear and specific terms on the flip chart.

Slide 16: The facilitator explains to the group that while brain-storming, the client has to come up with as many solutions as possible without thinking of whether the solutions make sense or not. They should be not be evaluated at this stage.

The facilitator asks the volunteer client to list out all the solutions that come to mind even if they sound absurd or bad. Once the volunteer client has exhausted all options, the group is asked to contribute. All solutions are written down on the flip-chart.

Slide 17: The facilitator says to the group that at the third stage all solutions are evaluated for their advantages or disadvantages and their feasibility for implementation. The wrong ones should be cut out at this stage and the remaining ones should be prioritised as per their beneficial value.

The facilitator encourages the volunteer client to discuss each and every solution, giving reasons to keep or reject the same. Erase the solutions which are rejected by the volunteer client. Out of the remaining, prioritise them by numbering them 1, 2, 3 etc. The facilitator explains that the solution getting 1st priority is implemented.

Slide 18: The facilitator says to the *group*- “After some time (days or months), the solution is re-assessed to see if it worked or not. If it did not, then the option which was second in priority in the list is put in to action...”

CRISIS MANAGEMENT AND COUNSELLING RELATING TO COUNSELLING

• Crisis Management Counselling

Need to understand crisis and its management??

- The IDU faces number of problems in day-to-day life- most solved by himself or with help of family members*
- Certain situations are intense and unexpected and
 - Can precipitate crisis
 - Are out of client's capacity to deal with
 - Require professional help

What is Crisis

- A temporary state of
 - emotional turmoil and disorganization
 - following a very sudden and significant stressful situation
- Cannot be resolved by client alone

Crisis Situations

- *What situations precipitate crisis in client's life?



Crisis Situations*

SITUATIONS	EXAMPLES OF TYPES OF CRISIS
Personal Situation	Spouse leaving home; divorce notice; being thrown out of the house; violence at home; sudden death in family; death of a friend with whom injections were used/shared
Financial	Loss of significant amount of money/assets; accumulated debts leading to a crisis
Occupational Situation	Being thrown out of the job; violence at work-place
Health-related	Becoming aware of HIV+ status; developing a physical illness
Legal	Facing legal action
Drug-related	Sudden decrease in availability of usual dose of drugs; overdose; injection-related injury/infection

Stages of Crisis*



Role of counsellor*



- Be available and supportive
- Actively listen to client's story
- Do NOT blame the client
- Express empathy
- Generate resources
- Address unrealistic expectations of client from counsellor (if any)

counselling Techniques

Providing support to client



- Being empathic
- Listen
- Talk in calm and reassuring way
- Instill hope

Counselling Techniques

Facilitating emotional expression*



- Client is facing many negative emotions
- Encourage clients to share their feelings

Counselling Techniques

Ensure safety of client



- Client vulnerable to cause harm to self/others
- Assess for thoughts related to
 - Self-harm
 - Harming others

counselling Techniques

Defining the problem



- Conceptualize problem from client's point of view
- Reflect back to the client

Counselling Techniques

Defining the problem (cont...)



- REMEMBER:
 - Ask open-ended questions
 - Don't ask too many questions together
 - Avoid using "WHY"*
 - Avoid embarrassing questions

Counselling Techniques

Defining the problem (cont...)



- Areas to be explored:
 - What is the problem?
 - Who all are contributing to it?
 - When did it happen?
 - What made it happen?
 - How can it be handled?

Counselling Techniques

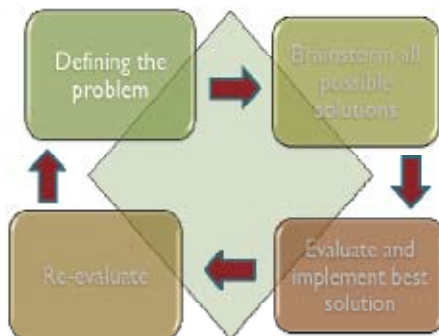
Facilitating problem-solving behavior



- Teach problem-solving strategy

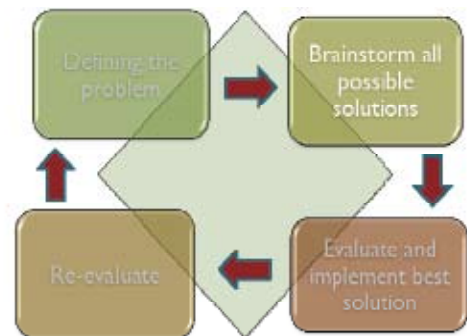
Counselling Techniques

Facilitating problem-solving behavior*



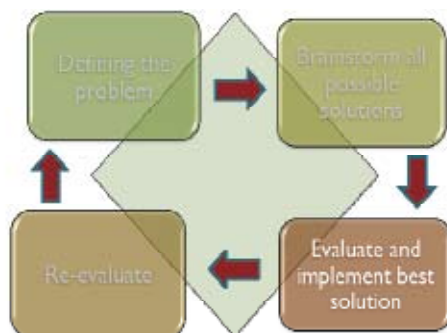
Counselling Techniques

Facilitating problem-solving behavior*



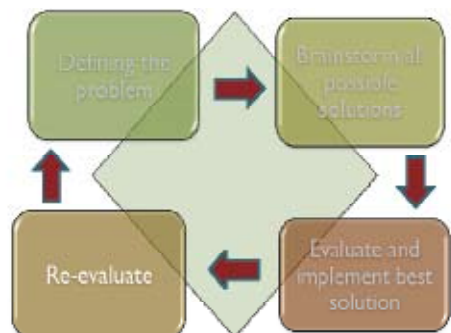
Counselling Techniques

Facilitating problem-solving behavior*



Counselling Techniques

Facilitating problem-solving behavior*



Other services...

- Keep a directory of referral services (e.g. legal aid, intensive medical care)
- Talk to family members, employers... if need be
- Facilitate generation of possible resources

Summary

- IDU is vulnerable to crisis at any point
- Crisis is a temporary phase and timely intervention is important
- Primary task of counsellor is to provide psychosocial support
- Providing actual logistics in any/every crisis may not be possible

Aim of the session

- ◆ To orient the participants how to conduct family counselling sessions

Objectives of the session

- ◆ To help the participants understand basic dimensions of family
- ◆ To elucidate the impact of drugs on a family
- ◆ To enable understanding of some important concepts inherent in family counselling
- ◆ To help participants understand basic components of family counselling

Duration of session: Two and half hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Interactive discussion with the participants aided by the Presentation (**Day 5 Session 3 – Family Counselling**) and the notes on the slides provided.
- ◆ Role-plays

Notes on power point slides (Day 5 Session 3 – Family Counselling)

Slide 3: The facilitator explains alongwith others –“Elected, self-identified and with choice. For example, staying with other IDUs.”

Slide 4: The facilitator explains how behaviours of family members are inter-related.

Slide 7: The facilitator discusses in terms of emotional reactions of family members due to IDUs behaviour – helplessness, stigma, anger, isolation

Also talks about the spouse taking up the role of the client as a father, son or primary caregiver

Slide 8: The facilitator discusses health-related problems in terms of:

- ◆ Violence inflicted by IDU under state of intoxication
- ◆ Neglect of health-needs of family due to money spent in procuring drugs or preoccupation with IDU's drug use
- ◆ Risk of HIV transmission

Slide 9: The facilitator discusses economic losses in terms of:

- ◆ Direct cost – amount spent on procuring drugs
- ◆ Indirect cost – loss of productive days

Slide 10: The facilitator discusses the impact on minor children in terms of:

- ◆ Poor emotional and physical development of children
- ◆ Children feeling guilty or angry due to father's drug use
- ◆ Children at the risk of developing behavioral problems, like, aggression
- ◆ Children at risk of developing substance use

Slide 14: Usually found in wives of the clients. *For example, the wife of the IDU is all the time concerned about the well-being of her husband. Whether he has eaten or not, whether he is safe or not. Even if he beats her, she tries to justify it later by saying that he is a good husband, he is acting like that only because of his drug habit.*

Slide 15: *For example, the client threatens to run away from the house or break things, so family members give him money to buy drugs. Or when other people ask the family about the client, they lie to them saying that everything is alright. Or when the client misses work because of injection use, the family may call the employer and lie that patient is not well.*

Slide 16: It is to be explained to the client, that boundaries between two family members regulates the communication flow between them. For example, in a healthy family, everyone communicates with each other and decisions are made jointly. However, each member has his/her own space and independence. However, in the families of IDUs, these patterns are not healthy. The family members may be too interfering in the matters of each other, or may be completely unconcerned about what other family members are doing.

Slide 17: In families of IDUs, there may be unhealthy sub-systems – like, mother-son. The mother who is having an extra-marital affair hides the son's drug use from the father so that the son can keep her secret from the father.

Slide 18: Explain to the participants that sometimes, the drug use becomes so important in families that other issues, like the lack of intimacy between partners or poor disciplining of children go into the background. Once the drug use ceases to be a problem, such issues start coming to the forefront – giving rise to increasing conflicts within the family. For example, *The client never paid attention to his kids and as his drug use increased and the focus of the family shifted to the client, the children would do anything they desired. With help, when the client decreased his drug use and the focus shifted to the children, they started behaving in a defiant way as they were not used to the attention or disciplining that they were getting from the family.*

Slide 19: *For example, suppose the parents of the IDU never got along well and had difficulty communicating with each other. When the son started using injections, they forgot their conflicts and became one unit to put the blame for everything on the IDU who became the scapegoat.*

Slide 24: Ask a participant to volunteer and become a family member of the client. Explain to them the situation, *"Your family member (son/brother/husband) has been using injections for the past 2 years. Despite repeated efforts, coaxing and begging by all of you, he does not seek help. He does not work and does not*

contribute to family in any way. If he wants money, he either threatens you or sells away household items. At times, he does not come home for 2-3 days and you have no clue about his well-being. Other relatives don't want to come to your house because he humiliates them for no reason. The neighbours express sympathy in front but talk badly about your family behind your back. The children in the house do not listen and for everything they tell you to control the IDU first. The IDU lies to you at the drop of a hat and has even hit other family members in anger. On one or two occasions, he even slashed his wrists to make you give him money." Tell the volunteer that this situation would be role-played in two different ways:

- ◆ Way 1 – The facilitator would not let the volunteer speak at all and would keep on talking in a mechanical fashion. She would also interrupt the family member in an impatient way if they start talking about their feelings and emotions.
- ◆ Way 2 – The facilitator would greet the volunteer appropriately and ask for the relationship with the patient and his/her name. She would thereafter address the volunteer by name. She would ask open-ended question and would let the volunteer talk. The volunteer would be asked to talk about how he/she feels about the whole situations, how she manages etc.

Once the situations are over, first the volunteer would be asked to discuss both the situations with respect to how she felt and then the group would be asked to discuss the same.

Slide 29: Craving – Intense pre-occupation and desire to take drugs that gets intensified in the presence of cues like peers, seeing injections, stress etc.

Withdrawal – Symptoms experienced by an IDU in the absence of the required quantity of drug. E.g. pains/aches, vomiting, diarrhea, increased pulse/BP.

Slide 34: Explain to the participants that similar to the client, family members also need to be told the "stages of change". The wheel analogy can be used here.

Slide 35: Explain to the participants that it is important here to address some myths that family members may have regarding the treatment process. For example, many family members come with the belief that treatment has "magical" properties and just by coming to the centre, the client would change. A useful analogy can be made with chronic medical conditions, such as hypertension – which not only requires medication compliance but also life-style modifications (changing of eating habits, exercise).

Slide 36: Please refer to the chapter on Harm- reduction for explaining this slide.

Slide 39: Make the table on the flip-chart. Now, give the following situation to the group and ask them to conceptualise the situation in terms of the A-B-C chart and give the feedback to the family member.

The spouse told the counsellor that it was yesterday that the client used injections. When asked what had happened yesterday, she told the counsellor that he had gone to work as usual. At home, she and her mother-in-law had a terrible argument and some physical altercation also. She (the spouse) was very upset. As soon as the client entered the house, she started shouting at him that she has had enough and does not want to stay in that house. She even told him that it was all his fault that she got no respect in the house and he was a "good for nothing" fellow. She was very upset and feeling humiliated. At the same time, his mother also started abusing his wife and another argument followed. The client became very irritated, he slapped the wife, shouted at the mother and told them that the house was like

living in hell and he was sick of their constant arguments and it's better for him to be outside than in the house. And he walked out of the house and came back late at night in an intoxicated state.

Slide 41: Finances – clearing debts, budgeting current expenses and future investments.

Time – looking for meaningful activities for the client, engaging him in mutually interesting activities (e.g. playing ludo).

Roles/responsibilities – Family needs to gradually give him roles and responsibilities. Giving too little can make him feel rejected and giving too much can make him feel overwhelmed.

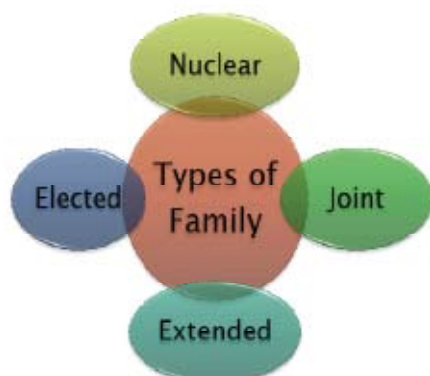
FAMILY COUNSELLING

FAMILY COUNSELING

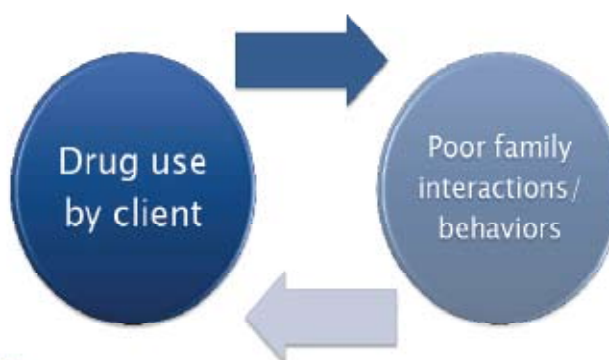
WHAT IS FAMILY

- ▶ No single definition
- ▶ Usually defined as- "A group of people with common ties of affection and responsibility who live in proximity to one another"

Types of Family



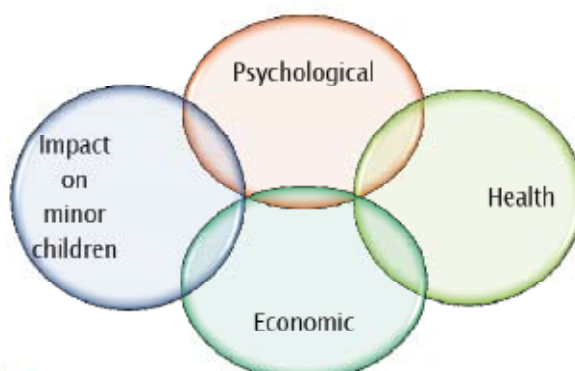
Characteristics of Family



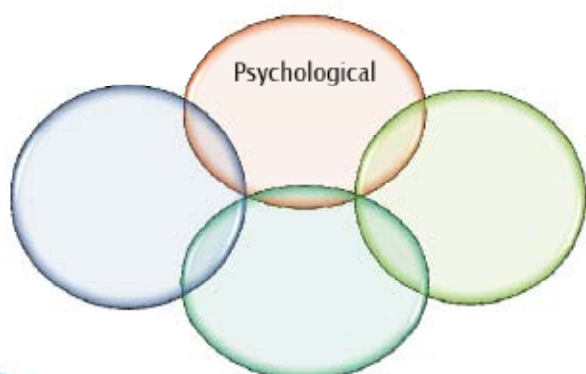
Characteristics of Family

- ▶ Each family has its own pattern on communication (verbal as well as non-verbal)
 - IDU threatens to run away from home- family members get him injections or
 - Family members beat up client for using injections
- ▶ Each family tries to reach a balance
 - Family covers up drug use and act normally

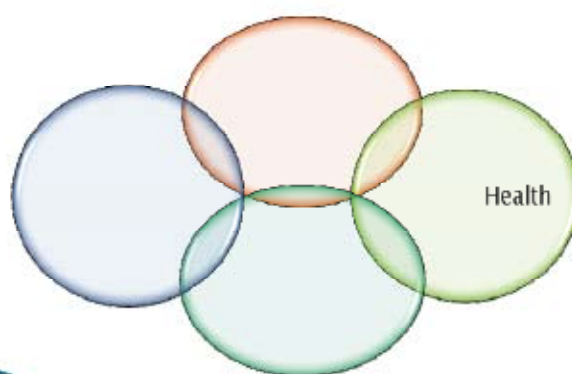
Impact of drug use on Family



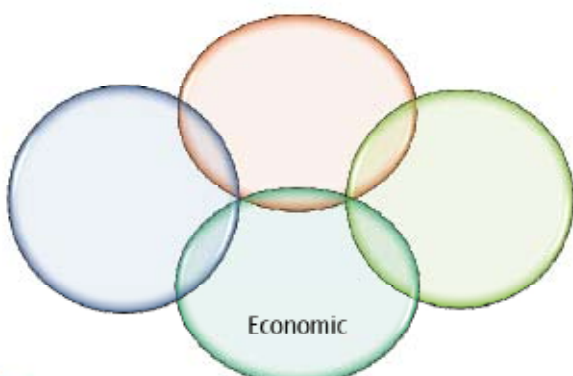
Impact of drug use on Family



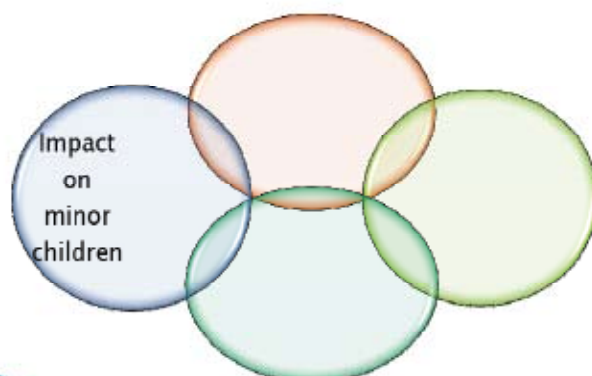
Impact of drug use on Family



Impact of drug use on Family



Impact of drug use on Family



GROUP DISCUSSION

- ▶ Why is it important to include family in treatment process?

What is Family Counseling



- ▶ Approaches that include assessment and intervention at the family's level
- ▶ Important to consider "family" from client's point of view

Important Issues in Family Counseling



Important Issues in Family Counseling

Co-dependency

- Being overly concerned with problems of IDU while neglecting one's own needs

Important Issues in Family Counseling

Enabling

- Process of encouraging drug use by un-intentional behaviors
- It diffuses impact of drug-use and does not allow the client to realize his problem

Important Issues in Family Counseling

Boundaries

- Separates one family member from another
- Dysfunctional patterns in families of IDUs:
 - Over-involved and interfering
 - Completely aloof

Important Issues in Family Counseling

Sub-system

- Clusters of family members separated by clear boundaries. E.g. parental sub-system or sibling sub-system

Important Issues in Family Counseling

Adjustment to abstinence

- Families may show negative reactions to abstinence as hidden conflicts come to surface

Important Issues in Family Counseling

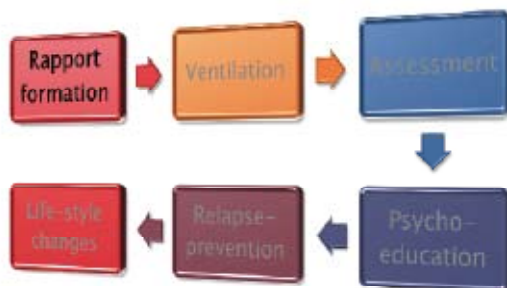
Triangulation

- Occurs when the IDU becomes the scapegoat for two family members who do not want to discuss their conflictual issues

Steps in Family Counseling



Steps in Family Counseling



Rapport- formation

- ▶ Important to address needs, expectations and wants of family members
- ▶ Make the family feel comfortable
- ▶ Identify each family member by name
- ▶ Assure them of confidentiality

Steps in Family Counseling



Ventilation*

- ▶ Very important to facilitate the "un-burdening of family's emotions
- ▶ Use active listening skills
- ▶ Let family members decide what they want to discuss

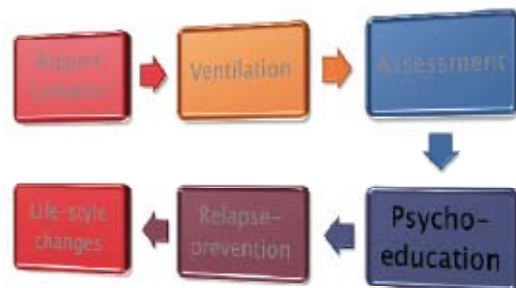
Steps in Family Counseling



Assessment

- Includes following areas:
 - Family member's knowledge about drugs
 - Impact of drug use on financial status
 - Available social support to the family
 - Maintaining factors for drug use (eg. Peer pressure, withdrawal etc.)
 - Health status (e.g. screening spouse for HIV)
 - Quality of relationship of IDU with his family members
 - Communication patterns in the family

Steps in Family Counseling



Psycho-education



Psycho-education: Craving & Withdrawal

- Lack of will-power not sole determinant of relapse
- Elaborate phenomenon of craving and withdrawal- as predictors of relapse

Psycho-education-Risk associated with injection use

- Family member need to be told about various health risks associated with injection use
- Also should be told where to get medical/legal aid as and when required

Psycho-education– Safe sexual practices

- › IDUs is a high risk group for getting sexually transmitted infections/diseases
- › Wife needs to be taught:
 - Importance of regular condom use
 - Condom negotiation skills
 - Taking care of personal hygiene
 - Common symptoms of infections (e.g. itching in vaginal area, excessive/smelly white discharge)
 - Getting regular check-ups done

Psycho-education– Reproductive Health

- › Wife should also be counseled regarding:
 - Maintaining reproductive health
 - Spacing between children

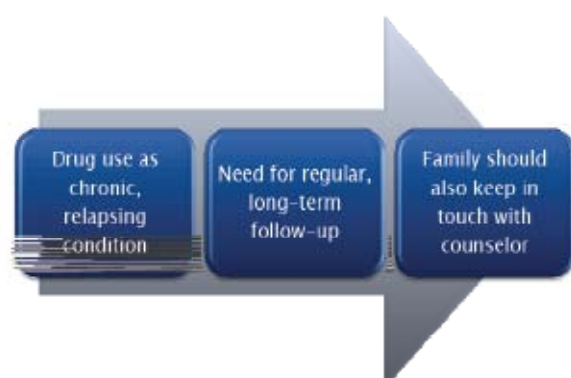
Psycho-education– Process of Change

- › Family goes through cycle of hope (when patient abstains/reduces drug use) → despair (when previous patterns of use are resumed)
- › Family needs to be made aware of “process of change” in addiction

Psycho-education– Process of Change



Psycho-education– Treatment Process



Psycho-education– Harm-reduction Paradigm

- › Family may often blame counselor– *“You are supposed to make him quit, why are you giving him needles?”*
- › Important to make family aware of *Harm reduction* concept

Steps in Family Counseling



Relapse- Prevention

- Triggers (internal/external) can lead to relapse



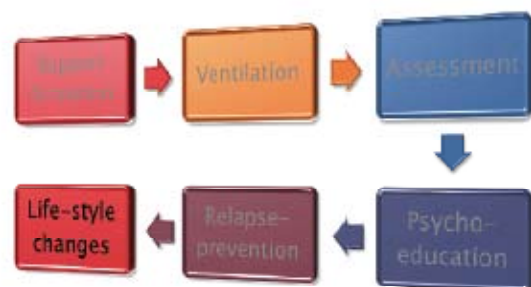
Relapse- Prevention

- Family's role as a trigger should be identified using A-B-C charting*

Date	Antecedent (What was the situation at that time? What were you thinking/feeling?)	Behavior (What did you do?)	Consequence (What happened after that?)

Family should be taught appropriate coping method

Steps in Family Counseling



Life-style Modification



Important points in Family Counseling

- Family to be considered from client's point of view
- Families may resist treatment process as they have become hopeless- the counselor should not give up
- Be non-judgmental.
- Remember the issue of confidentiality
- When in doubt, remember, the IDU is the index client, not family members

Summary

- › Family has important role in IDUs life
- › Can be a protective factor or a risk factor
- › Important to address family's needs, myths and expectations- from client and treatment process
- › Involving family in treatment→ positive outcome

THANK YOU

SESSION DETAILS FOR DAY SIX

Session One ADDRESSING BURNOUT ISSUES

Aim of the session

- ◆ To orient the participants regarding the various dimensions of counselling as a profession

Objectives of the session

- ◆ To help the participants understand what is stress and burnout
- ◆ To facilitate identification of various signs of burnout
- ◆ To orient the participants about the various reasons leading to burnout
- ◆ To help participants develop strategies to prevent and manage burnout

Duration of session: One and half hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

- ◆ Interactive discussion with the participants using the presentation (**Day 6 Session1 – Burnout**) and the notes provided on the slides
- ◆ Group activities

Notes on power point slides (Day 6 Session 1 – Burnout)

Slide 3: Start a 5 minute discussion with participants. Ask them to elucidate on the various stressors they face in their day-to-day lives. List out the answers in the chart under two columns – professional and personal.

Slide 12: Start the session by dividing the participants into small equal groups. Give them 10 minutes and ask them to discuss the question on the slide. Ask

one participant in each group to list out the group's responses. Meanwhile, on the chart-paper, make three columns – Work-related, Personality and Lifestyle. After 10 minutes, ask each group to discuss their responses one by one and note down their responses on the chart-paper.

In the next 3 slides of causes, point out only those issues which have not been pointed out by the participants.

Slide 15: After naming each factor, ask the group to elaborate upon it with examples from their daily lives.

Slide 16: Start the session by dividing the participants into small equal groups. Give them 10 minutes and ask them to discuss the question on the slide. Ask one participant in each group to list out the group's responses. After 10 minutes, ask each group to discuss their responses one by one and note down their responses on the chart-paper.

Slide 17: Ask the group what are the self-statements they use to calm themselves down when they are feeling stressed out or angry.

ADDRESSING BURNOUT ISSUES

Addressing burnout issues



- Stress
- Burnout

What is Stress

- A subjective state of mental or emotional strain
- Caused by an external event termed as *stressor**
- What one person finds stressful, the other person may not

What is Burnout



- State of emotional, mental and physical exhaustion caused by excessive and prolonged stress
- Occurs when negative emotions do not get proper outlet

What is Burnout

- Road to burnout, if...
 - Everyday is a BAD day
 - Caring about anything seems like a waste of energy
 - Feel numb, dull and exhausted all the time
 - Feel that there is no appreciation or worth of what you do
 - Get irritated at anything and everything

Types of burnout



EMOTIONAL EXHAUSTION:
Emotional over-strain and low energy levels



DEPERSONALIZATION: Social isolation or aggression towards others



LOW SELF-ESTEEM

What are the signs of burnout

- Can be: Physical, Emotional or Behavioral
- Physical signs include:
 - Having various aches and pains
 - Getting frequent stomach upsets/diarrhea
 - Feeling tired all the time
 - Not being able to sleep/nightmares
 - Loss of weight
 - Not feeling hungry

What are the signs of burnout

- At psychological level, symptoms include:
 - Feeling irritable and angry all the time
 - Not being able to carry out day-to-day responsibilities
 - Feeling anxious, apprehensive or nervous
 - Frequent changes in mood
 - Feeling like a failure
 - All the time, worried about the future
 - Not being able to concentrate
 - Forgetfulness

What are the signs of burnout

- Behavioral signs include:
 - Anger outbursts (shouting, screaming)
 - Wanting to stay alone
 - Not taking care of any responsibility
 - Start or increase alcohol/ drug use
 - Not working as much and as fast as before
 - Not being able to communicate properly with others
 - Losing interest in patient care

Stages of Burnout



- Initial passion to help others
- Boundless energy
- Positive outlook



- All needs are not satisfied
- Efforts are more and recognition is less
- Starts feeling disappointed

Stages of Burnout



- Experiencing anger, stress and unsure of what to do
- Behavioral signs of burnout



- Pessimistic attitude
- Emotional and physical signs of burnout

Causes of burnout*

- What could be the various sources of burnout?
 - Work-related???
 - Life-style???
 - Personality factors???
- How they might lead to burnout?

Work-related

- Too much work-load
- Not getting enough recognition for work done
- Slow behavioral change in the client
- Less opportunity for promotion

Life-style related

- Being a “workaholic”- not giving time for relaxation
- Too many roles and responsibilities- as mother, daughter, counselor, employee, friend etc.
- Poor social support at work-place or personal life

Personality- factors*

- Need to do everything perfectly
- Need to control situations
- Holding oneself responsible for every situation
- Difficulty asking for help
- Not being able to say NO
- Not being able to delegate responsibility to others

Reducing Stress and preventing Burnout*

- What are some of the current strategies you use to reduce stress?
- What are the other strategies that can be used?

Reducing Stress and preventing Burnout



- **PERSONAL DIARY:** To note down...
 - Early signs of stress and burnout
 - Stressful situations
 - Some remedies to calm down- “Take a deep breath”... “Take a small break and then talk to client” *
 - Contact information of people you can go to if you feel stressed

Reducing Stress and preventing Burnout



- **PHYSICAL HEALTH MANAGEMENT:**
 - Eating right... at the right time
 - Taking adequate rest
 - Exercise daily
 - Maintaining a good posture especially during the session

Reducing Stress and preventing Burnout



- **PSYCHOLOGICAL HEALTH MANAGEMENT:**
 - Positive thinking
 - Relaxation and meditation
 - Using lot of humor
 - Establishing clear boundaries between work and personal life
 - Maintain good social support

Reducing Stress and preventing Burnout



- **WORK-RELATED SUPPORT:**
 - Bond with other colleagues at work-place
 - Take help and support from senior counselors
 - Attending workshops regularly to enhance knowledge, clear doubts and share experiences
 - Obtaining clear feedback and guidance

Coping with Burnout

- Slow down
 - Cut down commitments
 - Take a break
- Get support
 - Don't hesitate in asking for help
- Re-evaluate goals and priorities
 - Ask yourself, "Am I neglecting something that is really important to me?"
 - In answer is YES, find out what is it and do it

Summary

- Stress and burnout can affect any counselor... anytime
- Causes may be related to work, life-style, personality
- Following some simple steps can prevent stress and burnout
- Help is always available

Session Two

IDU TI COUNSELLOR

ROLES AND RESPONSIBILITIES

Aim of the session

- ◆ To make the participants understand the roles that they would play in an IDU Targeted Intervention

Objectives of the session

- ◆ To make the participants understand the various tasks required to be fulfilled by them as a counsellor in an IDU TI.
- ◆ To describe in brief each of the tasks that the counsellor is supposed to undertake

Duration of session: One and half hours

Materials/Aids required

- ◆ Flip-charts/chart paper/white-board
- ◆ Marker pens
- ◆ Laptop/computer and LCD projector

Methodology of conducting the session

Interactive discussion with the participants using the presentation (**Day 6 Session 2 – Roles and Responsibilities**) and the notes provided on the slides.

Notes on power point slides (Day 6 Session 2 -Roles and Responsibilities)

Slide 2: Before initiating the session, the facilitator will ask the counsellors to enumerate the major services and activities required to be provided by the IDU TI. A two-column table will be drawn on a chart paper, and the responses on services/activities will be noted down in the left column. The facilitator will then ask the participants as to who can be the appropriate staff to conduct each of the activities, and note down the responses against each of the activity/services. Please note that a given activity will be carried out by more than one staff member. After this is noted down, the facilitator will proceed to present the slide, by stating that as discussed now, an IDU TI has multiple responsibilities as well as different cadres of staff. One cadre of staff will perform multiple activities, and hence a co-ordinated response is required for smooth functioning. Thus the roles and responsibilities should be clearly delineated from the beginning to avoid any confusion/conflict.

Slide 7: The facilitator should generate a discussion on how outreach is conducted in case of IDU TI. After eliciting responses from a couple of participants, the facilitator should proceed to the next slide.

Day One

Day Two

Day Three

Day Four

Day Five

Day Six

Session: Valediction

The facilitator/s at the valedictory session will conduct a feedback session for the entire training programme. The participants should also be encouraged to share their feelings about the training programme. Certificate of training completion needs to be provided to all the participants who complete the training programme.

IDU TI COUNSELLOR

IDU TI Counsellor - Roles and Responsibilities

1

Introduction

- Working in an IDU TI is a multi-disciplinary approach
 - Different cadre of staff
 - Multiple functions are required to be fulfilled
 - A given staff has to perform multiple roles
- The role of each cadre of staff should be clearly delineated and discussed to prevent confusion/conflict in execution of work

2

Who can be a counsellor? - NACO guideline

- *The counsellor should preferably be a post graduate in Psychology, MSW or Graduate with minimum two years experience in counselling or working with HRG*
(Revised TI costing guidelines, NACO, 2009)
- *The counsellor should have a Bachelor's degree in psychology/social science/humanities. If the counsellor is from drug using background, he / she should have completed higher secondary education with training in counselling. Those who have received training in counselling and prior experience of working with drug users are preferred*
(Standard Operating Procedure for OST Implementation, NACO, 2008)

3

Counsellor – Roles & Responsibilities

- Broad areas of activities
 1. Counselling both in DIC & in outreach setting
 2. Referrals and networking
 3. Advocacy
 4. Manage DIC
 5. Conduct training & capacity building
 6. Record maintenance

4

Roles/Responsibilities – Counselling in DIC

- Baseline assessment of an individual client
 - Emphasis on psychosocial functioning
- Ensure that the client is screened for STIs & general medical conditions by medical staff
- Provide different forms of counselling:
 - Motivational counselling,
 - Risk reduction counselling – injecting & sexual
 - HIV related counselling
 - Drug related counselling – detoxification, OST, Relapse prevention, etc.

5

Roles/Responsibilities – Counselling in DIC

- Counsel spouse/family members of IDU clients & provide family counselling
- Rule out co-morbidity among IDUs and counsel for co-morbidity, including appropriate referrals

6

Roles/Responsibilities – Counselling in outreach setting

- Accompany the outreach staff in the field and provide counselling as required
- Carry out home visits, as and when required
- Link the spouses and family members of the IDU clients to the IDU TI programme

3

Roles/Responsibilities – Counselling in outreach setting

- Conducting outreach: steps
 - Involves outreach planning by the TI team
 - Mapping of places/spots where IDUs are likely to be found – **social mapping**



- Visiting the spots and contacting the IDUs
- Analyse the hotspots to know the injecting/sexual practices of IDUs – spot analysis

3

Roles/Responsibilities – Counselling in outreach setting

- Determining the number of IDUs known to the project staff – **contact mapping**
- Deploying outreach staff in accordance with the number of IDUs and hotspots – **work plan**
- Service delivery by outreach team
 - Needle/syringe exchange
 - Risk reduction materials, including condoms
 - Referrals
 - Counselling

9

Roles/Responsibilities – Counselling in outreach setting

- Outreach by counsellor
 - Plan outreach services along with the outreach team and PM
 - Aim to cover all hotspots in a given time frame (e.g. one month period)
 - Prioritise those hotspots which are more 'hot' i.e. more risky practices are encountered
 - Convey the dates and timings to the outreach team which covers the particular hotspot

1

Roles/Responsibilities – Counselling in outreach setting

- Outreach by counsellor
 - Provide services in outreach
 - Conduct group counselling
 - Build motivation of those IDUs who are not ready to avail services
 - Motivate to seek services in DIC
 - Motivate for other services, e.g. testing, ART services, etc.

11

Roles/Responsibilities –
Referrals and networking

- Referrals for STI check up, ICTC, ART and other relevant services
- Link up with the services/service providers in the vicinity for vocational training, night shelter, detoxification and rehabilitation centres, etc.

12

Roles/Responsibilities – Entities for networking

■ **Health care providers**

- ICTC
- ART
- STI
- DOTS for TB
- CCC
- Detoxification/rehabilitation centres
- Diagnostic labs
- Hospitals

■ **Other services**

- Agencies implementing income generation programmes
- Agencies providing nutrition, educational and vocational support
- Agencies/charities providing food, shelter, clothing, etc.

13

Roles/Responsibilities – Steps in Referrals/networking

- Map service agencies
- Prepare a simple database
- Meet the key person in each agency
 - Inform about the TI work, advocate for humane services for IDUs
- Display the service map & directory in the DIC
- Establish a system of referrals

14

Roles/Responsibilities – Referrals/networking

■ **Role of counsellor**

- Accompany the PM in meeting the key person
- Assist in preparing database of referral agency
- Regular meeting with the referral agency
- Personally F/U with the counsellors of the following agencies
 - ICTC, ART, Detoxification/rehabilitation centres, TB centre, OST centre, etc.

15

Roles & Responsibilities

- Manage DIC – usually managed by counsellor / programme manager
 - Ensure systems are established in DIC functioning, e.g. where will the IDU be registered, who will the IDU interact with first, cleaning of the DIC, etc.
 - Ensure enough commodities are available for the IDUs
 - Ensure rules and regulations are established in DIC prepared in consultation with the clients
 - Ensure staff are oriented on their roles
 - Ensure help is available in case of emergency, e.g. emergency health problem among IDU clients, unruly behaviour of an IDU, etc.

16

Roles & Responsibilities

- **Advocacy**
 - Assist the programme manager in conducting advocacy programmes
- **Conduct training & capacity building**
 - Train the outreach staff on basic issues related to counselling of IDUs in the field
- **Record maintenance**
 - Maintain records as required by the SACS and NACO

17

Thank you

18

MULTIPLE CHOICE QUESTIONS FOR PRE/POST TEST ASSESSMENT

(NB: The right answers are underlined and figures within brackets are marks for relevant answers)

Targeted Intervention for IDUs – an overview

1. What is the prevalence of HIV among Injecting Drug users in India?
 - ☐ 0 – 5%
 - ☐ 5 – 10%
 - ☐ 10 – 15%
 - ☐ >20%
2. Which of the following statements are TRUE about the third phase of National AIDS Control Programme (NACP III) in India?
 - ☐ The goal of NACP III is to contain the epidemic of HIV in India
 - ☐ NACP III has commenced from the year 2005
 - ☐ The emphasis of the NACP III is on prevention
 - ☐ About 50% of all the high risk groups will be covered in NACP III to halt the HIV epidemic in India
3. All of the following services are generally provided in an IDU TI, except:
 - ☐ Counselling services
 - ☐ Treatment of abscesses
 - ☐ Detoxification and rehabilitation
 - ☐ Needle syringe exchange programme
4. Which of the following statements are FALSE about the NACP III programme for drug-using population?
 - ☐ NACP III recognises injecting drug-using population as one of the high risk groups for HIV
 - ☐ Both needle syringe exchange programme as well as opioid substitution therapy are articulated in NACP III for service provision
 - ☐ A targeted intervention for drug-using population aims to reach out to all the drug users, including alcohol users
 - ☐ Referral to detoxification services are provided for in the IDU TI programme

5. Which of the following statements are FALSE about the Targeted Intervention programme for IDUs under NACP III?

- ☐ An IDU TI uses current injecting drug users as peer educators to reach out to the target groups
- ☐ For any case of abscesses or wounds, an IDU is referred to the nearest health clinic/hospital
- ☐ Drop-in-centres act as a resting place for IDUs
- ☐ The approach used in the TI programme for IDUs is that of harm-reduction

Understanding drug use

6. The most common illicit substance used in India is

- ☐ Heroin (brown sugar/smack)
- ☐ Alcohol
- ☐ Cannabis
- ☐ Cocaine

7. Which of the following is NOT a criterion for diagnosing drug dependence?

- ☐ Evidence of tolerance (i.e. need to take a higher amount of drug)
- ☐ Withdrawal symptoms in the absence of drug
- ☐ Poor social and occupational performance due to indulging in substance use
- ☐ Use of an illegal substance

8. Which of the following is NOT illegal in India?

- ☐ Ganja
- ☐ Smack
- ☐ Bhang
- ☐ Cocaine

9. Which of the following has highest concentration of alcohol?

- ☐ Beer
- ☐ Wine
- ☐ Desi (country liquor)
- ☐ Gin

10. Which of the following statements is TRUE?

- ☐ Inhalants ('fluids') are relatively safe because user is not drinking or injecting them
- ☐ In the dependent users, sudden cessation of heroin use causes severe withdrawals that can be dangerous and even fatal
- ☐ In the dependent users, sudden cessation of alcohol use causes severe withdrawals that can be dangerous and even fatal
- ☐ Drug dependence is determined only by the person's own will power

Understanding injecting drug use

11. Which of the following statements is TRUE?

- ☐ Almost all drugs can be consumed orally
- ☐ The smoking route of taking drugs is quite safe, because the user is not drinking or eating the drug
- ☐ Through the injecting route, drugs act very slowly and hence are perceived as more pleasurable
- ☐ The injecting route is one of the most efficient routes of drug intake

12. Which of the following statements is TRUE about IDU in India?

- ☐ In India a large majority of the IDUs inject one or the other opioid
- ☐ Pure heroin is the most commonly injected opioid in India
- ☐ Majority of opioid users in India, inject the drug
- ☐ Mixing other drugs like diazepam or chlorpheniramine reduce the effects of opioids while injecting

13. Which of the following is the most likely figure for the number of IDUs in India?

- ☐ Twenty thousand
- ☐ Two lakh
- ☐ Twenty lakh
- ☐ Two crore

14. Which of the following statements is NOT true?

- ☐ There are more men than women who inject drugs in India
- ☐ Many IDUs are also vulnerable because of risks associated with the sexual route of transmission
- ☐ IDUs are usually people belonging to the very rich class
- ☐ It is difficult for IDUs to observe all appropriate precautions while injecting drugs

15. Out of the following the most risky behaviour would be

- ☐ Sharing the common container in which drugs have been prepared
- ☐ Sharing needles
- ☐ Having oral sex with a sex worker without using condom
- ☐ All are equally risky

Basics of HIV and STIs

16. Which of the following is NOT true about viruses?

- ☐ Most viruses cannot be seen with the naked eye or ordinary laboratory instruments
- ☐ Viruses are considered to be a connecting link between living and non-living matter
- ☐ Most viruses are very strong and can stay alive even outside a living tissue for a long time
- ☐ Viruses cannot multiply and increase their numbers, on their own

17. HIV and AIDS are

- ☐ One and the same thing
- ☐ Two different diseases which affect only the sex workers, IDUs or men-who-have-sex-with-men
- ☐ HIV is the person, who is affected by AIDS
- ☐ HIV is a micro-organism which results in the disease called AIDS

18. In which of the following situations, the spread of HIV is least likely:

- ☐ Vaginal sex with an HIV-infected woman
- ☐ A HIV-infected mother breast feeding her baby
- ☐ Mouth to mouth kissing with a HIV-infected person
- ☐ Anal sex with an HIV-infected man

19. Which of the following body fluids is least infectious?

- ☐ Semen
- ☐ Menstrual blood
- ☐ Mother's milk
- ☐ Urine

20. Sharing which of the following items may result in transmission of HIV?

- ☐ Undergarment
- ☐ Towel
- ☐ Toilet
- ☐ None of the Above

21. Which of the following statements is TRUE about commonly performed HIV tests?

- ☐ As soon as the HIV virus enters the body, the person can be detected as HIV positive
- ☐ If a person is HIV-negative, it means that there is no HIV virus in the body of that person
- ☐ Commonly performed HIV tests detect the presence of not HIV but antibodies against HIV
- ☐ Only known HIV positive persons are at risk of transmitting HIV to others

22. The body part which STIs can affect

- ☐ Penis
- ☐ Mouth
- ☐ Tongue
- ☐ All of the above

23. Which of the following is TRUE?

- ☐ Once a person is HIV-positive, there is no risk of other sexually transmitted infections
- ☐ STIs only affect the genital (sexual) organs of the body
- ☐ Men are more at risk of STIs than women
- ☐ Appropriate treatment of STIs is a type of HIV prevention

Assessment and diagnosis

24. Following are the characteristics of a successful assessment, except:

- ☐ Establishment of a good rapport
- ☐ Judgemental attitude
- ☐ Responses of the client are kept confidential
- ☐ Client is neither intoxicated nor in withdrawals

25. Following are the features of dependence syndrome, except:

- ☐ Tolerance
- ☐ Withdrawals
- ☐ Craving
- ☐ Consuming the drug once a week

26. The following statements about assessment are TRUE, except:

- ☐ Assessment is only useful for making a diagnosis
- ☐ Assessment can be carried out by more than one method
- ☐ Assessment has to be conducted periodically, and not just once
- ☐ Assessment should be modified depending on the client's physical and mental status

Basics of counselling, counselling techniques and skills

27. Which of the following statements is FALSE?

- ☐ Counselling is a collaborative process of change
- ☐ Counselling involves giving factual knowledge to the client
- ☐ Counselling is about talking to the client – telling him what to do and what not to do
- ☐ Counselling is tailor-made to each individual client's needs

28. Which of the following is not an example of an open-ended question?

- ☐ "Would you like to quit drugs?"
- ☐ "What problems have you faced because of your drug use?"
- ☐ "How do you feel when your wife does not trust you?"
- ☐ "What were the reasons for switching to injections?"

29. Non-verbal/body language does not include

- ☐ Tone of voice
- ☐ Pauses
- ☐ Words/sentences
- ☐ Postures

30. All of the following are important counselling techniques, except

- ☐ Confrontation
- ☐ Clarification
- ☐ Silence
- ☐ Suggestion

- 31. If the client is very upset and angry, which of the following steps is the correct one to follow:**
- ☐ The counsellor should be silent and encourage expression of emotions
 - ☐ The counsellor should stop the client and tell him to calm down
 - ☐ The counsellor should start suggesting some alternatives to the problems
 - ☐ The counsellor should change the topic
- 32. While listening to the client, the counsellor should primarily pay attention to:**
- ☐ Her thoughts and attitudes towards the client
 - ☐ Her thoughts regarding what she should say to the client
 - ☐ What the client is saying and his non-verbal behaviour
 - ☐ What is going on in her environment
- 33. Client: “I think you told my father to be more strict, he is not letting me out of the house. Counsellor: “You seem to be irritated that your father is curbing your independence and you feel angry towards me because of that?” This dialogue is an example of**
- ☐ Reflection
 - ☐ Paraphrasing
 - ☐ Clarification
 - ☐ Probing

Injection-related risk reduction counselling

- 34. All of the following are the risks of injecting, except**
- ☐ Infection with blood borne viruses such as HIV
 - ☐ Delayed high/intoxication
 - ☐ Abscesses/local wounds
 - ☐ Overdose
- 35. One of the following is TRUE with regard to injecting drugs:**
- ☐ Reusing the needle syringe is not associated with any physical risk
 - ☐ The risk for an injecting drug user is only with sharing of needles or syringes
 - ☐ Non-availability of cleaning materials before injecting poses a risk for an IDU
 - ☐ An IDU always finds a clean neighbourhood and enough time for injecting
- 36. All of the following are false with regard to risk reduction related to injecting, except:**
- ☐ Cleaning the used or shared needle with bleach offers 100% protection against HIV
 - ☐ A client cannot be helped at all unless he stops injecting
 - ☐ It is not required for the drug user to be abstinent before offering help
 - ☐ Taking the first dose after a period of stopping drug use is not a risk factor for overdose

37. One of the following is not a dangerous site for injecting

- ☐ Veins on the elbow joint (cubital veins)
- ☐ Groin veins (femoral veins)
- ☐ Neck veins (jugular veins)
- ☐ Veins on the penis

38. All of the following are the differences between an artery and vein, except:

- ☐ A pulsating blood vessel is an artery
- ☐ Veins have valves, which can be felt
- ☐ Blood from an artery is dark in colour, while blood from veins is bright red in colour
- ☐ Artery carries blood away from the heart

39. All of the following are the symptoms of opioid overdose, except

- ☐ Difficulty in awaking
- ☐ Slow pulse
- ☐ Bluish discoloration of finger nails
- ☐ Fast breathing

Sexual Health and HIV counselling

40. Which of the following is most appropriate?

- ☐ Degree of risk of STI/HIV transmission depends on the sexual orientation of the partner
- ☐ Degree of risk of STI/HIV transmission depends on sexual organs involved in the act
- ☐ Degree of risk of STI/HIV transmission depends on the sex of the partner
- ☐ Degree of risk of STI/HIV transmission depends on the age of the partner

41. Which of the following is TRUE?

- ☐ Receptive oral sex is riskier than receptive vaginal sex
- ☐ Insertive vaginal sex is riskier than insertive anal sex
- ☐ Insertive vaginal sex is riskier than receptive vaginal sex
- ☐ Receptive anal sex is riskier than insertive anal sex

42. Which of the following is FALSE?

- ☐ Injecting drug use clouds the brain
- ☐ Injecting drug use lowers inhibitions
- ☐ Injecting drug use leads to sexual abstinence
- ☐ Injecting drug use makes condom use difficult

43. Which one is not part of sexual risk reduction counselling?

- ☐ Sharing the level of risk of the client based on his/her current sexual practices
- ☐ Educating the client on HIV testing

- ☐ Referring for STI screening, if the client reports/complains of signs and symptoms of STIs
 - ☐ Informing the client on the effects of drug and alcohol on sexual risk
- 44. Which one of the following is not a sign of STI?**
- ☐ Blisters or ulcers on the genitals, anus, mouth, lips
 - ☐ Burning or pain during urination/frequent urination
 - ☐ Swelling in groin/scrotal swelling
 - ☐ Discolouration of the skin in the genital area
- 45. Which one of the following is TRUE for condoms?**
- ☐ Condoms enhance sexual pleasure
 - ☐ Condoms are reusable
 - ☐ Condoms may tear during intercourse
 - ☐ Two condoms are better protection than one
- 46. Which one is TRUE for Anti Retro Viral treatment?**
- ☐ One should start ART before the CD4 count goes below 200
 - ☐ One should start ART after the CD4 count goes below 200
 - ☐ One should start ART before HIV testing if one has an STI
 - ☐ One should start ART as soon as possible after being tested positive for HIV
- 47. Which of the following is not a part of the pre-test counselling for HIV?**
- ☐ Exploring personal risk assessment
 - ☐ Assessment of capacity to cope with potential positive result
 - ☐ Informed consent
 - ☐ Partner notification
- 48. During the post-test counselling, where the test result is negative which of the following need not be provided by the counsellor?**
- ☐ Explanation of the result and its significance.
 - ☐ Education on window period
 - ☐ Education on ART
 - ☐ Education on risk reduction
- 49. Which of the following is TRUE?**
- ☐ HIV positive IDUs are not fit candidates for ART
 - ☐ IDUs on oral substitution therapy find it difficult to adhere to ART
 - ☐ IDUs on oral substitution therapy are best suited for ART
 - ☐ IDUs on oral substitution are more prone to Opportunistic infections

Motivation Enhancement

- 50. Which of the following is NOT true?**
- ☐ Motivation is an important aspect of behaviour change
 - ☐ Motivation is influenced by interactions and discussions

- ☐ A person can be helped only if he is well-motivated
 - ☐ Motivation is dynamic and keeps changing
- 51. Which of the following is NOT an example of correct motivation enhancement technique?**
- ☐ A counsellor asking a drug-user client to compare his quality of life with his non-drug-using cousin
 - ☐ A counsellor asking a client about what are the perceived advantages of taking drugs
 - ☐ A counsellor telling the client that stopping drug use is very difficult and only people with very strong will-power can do it
 - ☐ All of the above are correct
- 52. A client expresses difficulty in coming daily to the DIC for exchanging needles and syringes, since it is inconvenient for him. What should be the next step taken by the counsellor?**
- ☐ Counsellor should ask client to borrow used needles and syringes from his friends and clean them well with water before injecting
 - ☐ Counsellor should ask the client to take a months' supply of needles and syringes from DIC, so that client does not have to come daily
 - ☐ Counsellor should discuss the advantages and disadvantages of coming daily for needle syringe exchange
 - ☐ All the above options are correct. Depending on the situation, the counsellor can choose any one of these options
- 53. The motivation enhancement strategy "feedback" involves:**
- ☐ Explaining to the client about the rules and regulations of TI
 - ☐ Explaining to the client about all possible harms and risks of drug use
 - ☐ Talking about the harms the client himself has experienced
 - ☐ Showing the records of needles and syringes exchanged in the TI to the client

Drug-related counselling

- 54. All of the following are the symptoms of opioid withdrawals, except**
- ☐ Diarrhoea
 - ☐ Muscle relaxation
 - ☐ Vomiting
 - ☐ Dilated pupils
- 55. All of the following statements regarding opioid substitution therapy (OST) are true, except:**
- ☐ OST can be used in the treatment of all kinds of drugs, including alcohol
 - ☐ OST is substitution of one opioid with another opioid of known purity and potency
 - ☐ The benefits of OST goes beyond mere stopping of injecting/drug use
 - ☐ OST should generally be given for a longer period of time

56. One of the following statements about detoxification is FALSE:

- ☐ Detoxification is the management of withdrawals produced by stopping of drug use
- ☐ Drug withdrawal symptoms depends on individual-related factors, apart from drug-related factors
- ☐ Withdrawal from drugs never produces death
- ☐ Medications are recommended during detoxification to manage the withdrawals

57. All of the following statements related to relapse are true, except:

- ☐ Relapse is not unique to drug use problems alone
- ☐ It is easy to quit drugs completely
- ☐ There are other stages before a person slips into full blown relapse, in which the person can be helped
- ☐ Multiple factors – individual, situational and interpersonal play a role in relapse

58. All of the following statements related to relapse are true, except:

- ☐ Positive emotional states do not make a person prone to relapse
- ☐ Coping abilities, self efficacy and outcome expectancy determine relapse proneness
- ☐ Lifestyle modification is often required in relapse prevention
- ☐ Cravings can be managed with psychological and behaviour techniques

Co-morbidity among IDUs

59. All of the following statements related to co-morbidity are true, except:

- ☐ The rates of co-morbidity among IDUs are same as with the general population
- ☐ IDUs are more prone for Hepatitis C as compared to non-IDU
- ☐ Presence of two or more conditions together is known as co-morbidity
- ☐ Individuals suffering from physical or mental conditions may use drugs to relieve their symptoms

60. One of the following statements related to Hepatitis C is true:

- ☐ Hepatitis can be caused only by the Hepatitis C virus
- ☐ Liver is a non-essential organ of the body
- ☐ All Hepatitis virus infections are fatal in nature
- ☐ Sharing of contaminated needles and syringes is the cause of Hepatitis C virus

61. All of the following statements related to tuberculosis are true, except:

- ☐ Tuberculosis can affect any organ of the body
- ☐ Tuberculosis spreads by eating contaminated food
- ☐ The rates of tuberculosis is more among IDUs as compared to non-IDUs
- ☐ Multidrug-resistant tuberculosis occurs when a person is resistant to usual drugs used for treating tuberculosis

62. The following are the predominant symptoms of depression, except:

- ☐ Sadness of mood
- ☐ Feeling that one has God-like powers
- ☐ Feelings of guilt
- ☐ Sleep decrease/disturbance

63. One of the following is not an anxiety disorder:

- ☐ Phobias
- ☐ Panic disorder
- ☐ Mania
- ☐ Obsessive compulsive disorder

64. One of the following statements related to mental illness is true:

- ☐ Drug use is more commonly associated with mental illness
- ☐ One cannot be cured of mental illness, prevention is the only option
- ☐ Only people with character defects/weak personalities can get mental illness
- ☐ Psychosis is not associated with person talking to himself without any reason

Crisis management and counselling related to crisis

65. Identify which of the following is not a crisis situation for the client.

- ☐ Fight with the wife
- ☐ Getting HIV report and being tested positive
- ☐ Sudden homelessness
- ☐ Death of a peer with whom drugs were used

66. During crisis, the counsellor should not:

- ☐ Provide timely help
- ☐ Express empathy
- ☐ Focus on why the crisis happened
- ☐ Actively listen to what the client has to say

67. Crisis counselling does not include:

- ☐ Expression of emotions by the client
- ☐ Preaching to the client about what is to be done
- ☐ Providing support to the client
- ☐ Gathering resources for the client

68. Problem-solving strategy includes all the following steps except:

- ☐ Defining and conceptualising the problem
- ☐ Thinking of one possible solution
- ☐ Assessing pros and cons of all possible solutions
- ☐ Evaluating whether the chosen solution has effectively worked or not

Family counselling in the context of IDU

69. Who all should be included in family counselling

- ☐ Spouse of the client
- ☐ Parents of the client
- ☐ Friends of the client
- ☐ Self identified family of patient

70. Mark the following statements true or false-

- ☐ During family counselling, the counsellor should make the family members comfortable (T)
- ☐ During family counselling, the counsellor should facilitate the “un-burdening” of family’s emotions and feelings (T)
- ☐ The primary aim of family counselling is to determine the aspects in which client may be lying (F)
- ☐ In family counselling, the counsellor acts like a communication channel between the client and his family members (F)

71. What are the points on which the family of IDUs need to be educated?

- ☐ Risks associated with drug use
- ☐ Safe and high-risk sexual practices
- ☐ Contraception
- ☐ Process of change
- ☐ Relapse prevention
- ☐ All of the above

72. Family assessment does not include:

- ☐ Information about client’s drug use, reasons for relapse and maintaining factors
- ☐ Health status of spouse
- ☐ Family history of drug and alcohol use
- ☐ Impact of client’s drug use on family’s financial status
- ☐ Client’s relationship with others in the neighbourhood

73. Which of the following statement is TRUE:

- ☐ Family may be directly or indirectly responsible for maintenance of client’s drug use
- ☐ Families only become dysfunctional when one of their family member starts taking drugs
- ☐ Family does not have much role in preventing relapse, it is the client’s responsibility
- ☐ The spouse of IDU client is not vulnerable to HIV/AIDS

Addressing burnout issues in counsellors

74. Which of the following are examples of day-to-day events that commonly cause stress among counsellors?

- ☐ Managing personal as well as professional life
- ☐ Travelling to workplace
- ☐ Too many sessions in one day
- ☐ Not getting salary on time
- ☐ All of the above

75. Which of the following are physical symptoms of burnouts?

- ☐ Aches and pains
- ☐ Frequent stomach upsets/diarrhoea
- ☐ Sleep disturbances
- ☐ Disturbances in appetite
- ☐ All of the above

76. Which of the following statements is true?

- ☐ Burnout is not a gradual process and happens overnight
- ☐ Early identification of burnout can help in slowing down or stopping the development of full blown burnout syndrome
- ☐ In case, the counsellor has reached the stage of burnout, adjusting her own attitudes of taking care of physical/psychological health will help the counsellor

77. Which personality characteristic does not act as a risk factor for burnout

- ☐ Need to do everything perfectly
- ☐ Ability to express emotions
- ☐ Difficulty in asking for help
- ☐ Taking personal responsibility for each task and its outcome

78. All statements are false, except

- ☐ Regularly exercising can help in prevention of burnout
- ☐ Showing of negative emotions by the counsellor is a sign of weakness
- ☐ Counsellors always have the ability to multi-task and take care of various roles and responsibilities
- ☐ Counsellor has to always take responsibility for what happens in client's life

Attitude-related questions

Read the following statements and rate your views on the statements provided below

79. “Counselling for risk reduction is just about providing information to the client what not to do to save one self from HIV ”

- ☐ Strongly agree (–2)
- ☐ Agree (–1)

- ☐ Neither agree nor disagree (–0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

80. Drug dependence is a chronic non-communicable disease similar to hypertension or diabetes.

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (–1)
- ☐ Strongly disagree (–2)

81. “Providing treatment to drug users does not help as drug users anyway are going to relapse”.

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (–1)
- ☐ Strongly disagree (–2)

82. Providing services to drug users can reduce drug-related problems in society

- ☐ Strongly agree (–2)
- ☐ Agree (–1)
- ☐ Neither agree nor disagree (–0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

83. Providing safe needles and syringes to injecting drug users is like encouraging drug users to continue using drugs

- ☐ Strongly agree (–2)
- ☐ Agree (–1)
- ☐ Neither agree nor disagree (–0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)
- ☐ Strongly disagree

84. Women who inject drugs are immoral

- ☐ Strongly agree (–2)
- ☐ Agree (–1)
- ☐ Neither agree nor disagree (–0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

85. People use drugs because of weak character and hence should not be cared for, if they are infected with HIV

- ☐ Strongly agree (-2)
- ☐ Agree (-1)
- ☐ Neither agree nor disagree (-0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

86. Every IDU should be tested for HIV, whether the IDU consents to the test or not

- ☐ Strongly agree (-2)
- ☐ Agree (-1)
- ☐ Neither agree nor disagree (-0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

87. Injecting drug users are not good candidates for ART, as they will stop ART medicines due to their drug use.

- ☐ Strongly agree (-2)
- ☐ Agree (-1)
- ☐ Neither agree nor disagree (-0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

88. One has to be totally drug-free to be initiated into ART

- ☐ Strongly agree (-2)
- ☐ Agree (-1)
- ☐ Neither agree nor disagree (-0)
- ☐ Disagree (+1)
- ☐ Strongly disagree (+2)

Skills-related questions

The following statements are on your comfort level in dealing with IDU clients in a TI setting. Please rate on how comfortable you feel in performing each of the tasks mentioned below:

89. I am comfortable counselling people using drugs through injections

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

90. I can handle clients who use drugs when they are upset

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

91. I know the tools to be used for motivation enhancement

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

92. I can easily handle family counselling sessions

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

93. I know exactly what to do when counselling a drug user on injection-related risk reduction

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

94. I am skilled enough to counsel on sexual risk health matters

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

95. I am pretty clear about the steps for partner notification

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (-1)
- ☐ Strongly disagree (-2)

96. I know how to manage my own burn out as a counsellor

- ☐ Strongly agree (+2)

- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (−1)
- ☐ Strongly disagree (−2)

97. I am confident of helping a client in relapse prevention

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (−1)
- ☐ Strongly disagree (−2)

98. I have enough knowledge to deal with co-morbidities associated with drug use

- ☐ Strongly agree (+2)
- ☐ Agree (+1)
- ☐ Neither agree nor disagree (0)
- ☐ Disagree (−1)
- ☐ Strongly disagree (−2)

HIGH RISK BEHAVIOUR SCALE

The HIV Risk Behaviour Scale (HRBS)

a) Drug Use Section	Score
Question 1. <i>How many times have you hit up (injected any drugs) in the last month?</i>	0-1-2-3-4-5
Question 2. <i>How many times in the last month have you used a needle after someone else had already used it?</i>	0-1-2-3-4-5
Question 3. <i>How many people have used a needle before you in the last month?</i>	0-1-2-3-4-5
Question 4. <i>How many times in the last month has someone used a needle after you have used it?</i>	0-1-2-3-4-5
Question 5. <i>How often, in the last month, have you cleaned needles before re-using them?</i>	0-1-2-3-4-5
Question 6. <i>Before using needles again, how often in the last month did you use bleach to clean them?</i>	0-1-2-3-4-5
b) Sexual Behaviour Section	Score
Question 7. <i>How many people, including clients, have you had sex with in the last month?</i>	0-1-2-3-4-5
Question 8. <i>How often have you used condoms when having sex with your regular partner(s) in the last month?</i>	0-1-2-3-4-5
Question 9. <i>How often did you use condoms when you had sex with casual partners in the last month?</i>	0-1-2-3-4-5
Question 10. <i>How often have you used a condom when you have been paid for sex in the last month?</i>	0-1-2-3-4-5
Question 11. <i>How many times did you have anal sex in the last month?</i>	0-1-2-3-4-5

Scoring the HRBS-The HRBS is easy to score. Each of the questions are scored on 0-5 scale, with a higher score indicating a higher degree of risk-taking. These scores are added up to provide measures of drug use risk taking behaviour, sexual risk-taking behaviour, and a global HIV risk-taking behaviour score. Scores on the whole test range then from 0-55, with higher scores indicating a greater degree of risk-taking behaviour. The HRBS provides three scores: a total score indicating level of HIV risk-taking behaviour; a Drug Use Sub-total indicating level of risk due to drug taking practices; and a Sexual Behaviour Sub-total indicating level of risk associated with unsafe sex. In all cases the higher the score, the greater the risk the subject has of contracting and passing on HIV.

(Adapted from -The HIV Risk Taking Behaviour Scale (HRBS) Manual - Jeff Ward, Shane Darke & Wayne Hall, National Drug and Alcohol Research Centre, 1990, Technical Report Number 10)

INDIVIDUAL RISK ASSESSMENT ACTIVITY WORKSHEET

Individual risk assessment activity worksheet

(This should be completed by the counsellor in consultation with the client)

	Client code: _____	
Client has regular partner:	YES/NO	
Regular partner's status:	HIV positive / Unknown / HIV negative	
Date of last test: _____		
Client/partner 1 indicates history of STI infection:	YES/NO	
Treatment referral required:	YES/NO	
Client/partner 2 reports symptoms of TB:	YES/NO	
Treatment referral required:	YES/NO	
Occupational exposure:	YES/NO	Date :
Date: Window period:	Yes/No	
Tattoo, scarification:	YES/NO	Date :
Window period:	Yes/No	
Blood products:	YES/NO	Date :
Window period:	Yes/No	
Vaginal intercourse:	YES/NO	Date :
Window period:	Yes/No	
Oral sex:	YES/NO	Date :
Window period:	Yes/No	
Anal intercourse:	YES/NO	Date :
Window period:	Yes/No	
Sharing injecting equipment:	YES/NO	
Window period:	Yes/No	
Client risk was with a known HIV-positive person:	YES/NO	
Client is pregnant:	YES/NO	
Stage of pregnancy:	1st trimester/2nd trimester/3rd trimester	
Client/partner is using contraception regularly:	YES/NO	
Client requires repeat HIV test due to window period exposure:	YES/NO	
Date for repeat re-test:		

Name of the counsellor

Date of interview

Signature

(Adapted from HIV Counselling for ICTC, PPTCT and ART Counsellors Training Modules- Facilitator's Guide–National AIDS Control Organization (NACO), Ministry of Health and Family Welfare Government of India)



UNODC

United Nations Office on Drugs and Crime



EP-16/17, Chandragupta Marg, Chanakyapuri

New Delhi - 110 021

Phone : + 91 11 42225000

Fax : + 91 11 24104962

E-mail : fo.india@unodc.org

Saksham

Global Fund for AIDS

Tuberculosis and Malaria (GFM-ATM)

Tata Institute of Social Sciences

Sion-Trombay Road, Deonar, Mumbai-400 088