Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module K

Young people and psychoactive substance use

This Handout for the module on *Young people and psychoactive substance use* describes the common substances used by young people, the risk factors and protective factors, and the most common problems. The module also considers how health workers can assess young people's substance use and how they can respond to such problems in their clinic and in the community.

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1. Young people and substance use

Rapid increases in global use of alcohol, tobacco and other psychoactive substances are contributing significantly to the global burden of disease. Alcohol and tobacco are major causes of mortality and disability in developing countries, and the impact of tobacco is expected to increase in other parts of the world. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Cigarette smoking is spreading rapidly in developing countries and among women. Among the ten leading risk factors in terms of avoidable disease burden, tobacco was fourth and alcohol was fifth in the year 2000. The burden of ill-health from use of psychoactive substances is substantial and the main global burden is due to legal rather than illegal substances.

Alcohol and tobacco are similar in that both are legal substances, both are widely available in most parts of the world, and both are marketed aggressively by transnational corporations that target young people through advertising and promotional campaigns. Despite increased law enforcement activities, illicit substances are widely available.

Around the world there is increasing concern about the use of psychoactive substances by young people. The onset of such use is occurring at younger ages in many countries and the range of substances is increasing. Substance use is more prevalent among young people than in older age groups. In some countries early tobacco use is the major issue; in others there is an alarming rise in the use of amphetamine-type stimulants among young people.

Health workers come in contact in a number of ways with young people who are having difficulties associated with substance use. A young person may come to the clinic with an issue related to substance use (e.g. a youth with a broken arm from a fight after drinking alcohol, or a young woman with mental health symptoms after taking psycho-stimulants at a party), or with an unrelated issue (e.g. a routine contraception visit, or concerns about their development). Whether related to the presenting problem or not, substance use should be discussed by the health worker routinely during every contact with young persons. Health workers have a role in preventing substance use among young people and to assist them to reduce or stop their use.

This module focuses on substance use by *young people* (rather than adolescents) because many of the issues discussed are also important for people aged 19-24 years. WHO defines “adolescents” as individuals aged 10-19 years and “youth” as aged 15-24 years. These age ranges are combined in the group of “young people”, who are individuals aged 10-24 years.

What are the substances?

Psychoactive substances (or psychoactive drugs), both legal and illegal, are substances which when consumed can affect the way people see, hear, taste, smell, think, feel and behave. In this module, the term *substance* includes all legal and illegal psychoactive substances and psychoactive drugs.

Common substances can be divided into depressants, stimulants, opioids and hallucinogens. Some examples of these are:

- **Depressants**
  - Alcohol (wine, beer, spirits, home-brew)
  - Sedatives/hypnotics (sleeping pills containing benzodiazepines, methaqualone, barbiturates, chloral hydrate)

- Volatile solvents (aerosol sprays, butane gas, petrol/gasoline, glue, paint thinners, hair spray, nitrites, solvents, felt-tip-marker fluid)
- Date rape drugs (flunitrazepam, rohypnol, GHB, ketamines).

- **Stimulants**
  - Nicotine (cigarettes, cigars, pipes, chewing tobacco, snuff)
  - Cocaine (crack, crystal, coca products)
  - Amphetamines (methylenedioxymeth-amphetamine [MDMA or ecstasy], dextroamphetamines, methamphetamines)
  - Caffeine (coffee, tea, soft drinks)
  - Betel nut, kava, buri.

- **Opioids**
  - Heroin, morphine, opium, buprenorphine, methadone, pethidine
  - Cough syrup with codeine.

- **Hallucinogens**
  - Lysergic acid diethylamine (LSD)
  - Mescaline, psilocybin, peyote, tryptamines
  - Cannabis (marijuana, ganja, hashish, bhang, pot, grass).

Substances can be legal or illegal and can be found in the following products:

- Medicines (obtained with a prescription or over the counter)
- Drugs (obtained without a prescription)
- Tobacco products (e.g. cigarettes, chewing tobacco, cigars, bidis)
- Alcohol (e.g. spirits, beer, home brew)
- Chemical products (e.g. caffeine, glue, mouth wash with alcohol, aerosol)
- Other products which may be locally produced (e.g. khat, cocaine leaves, cannabis).

Although it is important to know whether the substances used by young people are legal or illegal, the action that health workers will take with young people may be the same. This is because the action is concerned with changing behaviour in order to reduce substance use, and with reducing the likelihood of harmful health outcomes from such use. The action may be the same regardless of the legality of the substance used; however, the ease by which the action is developed and implemented is often influenced by the legality or illegality of the substance.

Substances can be administered in many ways. They can be chewed, dissolved slowly in the mouth, or swallowed; smoked or inhaled; injected; rubbed into the skin or placed under the eyelid, or inserted in the anus or vagina. Some of the health risks of substance use (e.g. local or general infection, HIV transmission, hepatitis B and C, nasal sepsis, cancer of the airways, etc.) are related directly to the route of administration.

Regular substance use by young people is rarely confined to a single substance. Frequently they practise poly-pharmacy substance use or poly-substance use (i.e. combining several substances simultaneously or serially). One substance may be used to counteract the unpleasant effects of another, and may itself cause adverse health consequences.

Negative consequences of substance use by young people

The effect on the young substance user is shaped by four factors:

- The substance: the pharmacology or properties of the substance.
- The mode of use: the way it is taken (orally, by injection, sniffing etc.).
- The person taking it: the influences, personality, family situation etc. of the individual.
- The environment: the immediate environment in which the person takes the substance and the risk and protective factors of the wider environment in which the person lives.

The substance

Aspects of the substance that can affect the use and consequences of use include:

- Type of substance(s) used
- Pharmacological properties of the substance
- Use of other substances at the same time
- Immediate and longer-term effects of the substance
- Strength and purity of the substance
- Route of administration
- Social influence.

The person

Aspects of the young person that can affect the use and consequences of substance use include:

- His/her health and nutrition
- Other substances used by him/her
- Previous use of this or other substances
- Use of substances by the family, partner, peers
- Support available from the family, school, friends, peers.

The mode of use

Aspects of the mode of use that can affect the use and consequences of use include:

- Common mode of use among peers
- Availability of drugs that can be used in a particular mode
- For injectors, availability of needle-syringe programmes to reduce the risk of blood-borne infections.

The environment

Environmental aspects that can affect the use and consequences of use include:

- Mood of the occasion when the substance is taken
- The physical environment (safety, support, etc.)
- Whether the use is alone or in a group

- The expectations of the group (support, peer pressure, violence, etc.)
- The risk and protective factors of the wider environment in which the person lives.

These factors also directly contribute to the *negative* consequences of use, both physical and psychosocial.

Physical consequences

- Trauma while intoxicated (e.g. falls, road traffic accident, drowning), overdose, blackouts, unsafe sex, damage to organs (e.g. liver, lungs, nerves).
- Blood-borne infections (e.g. HIV, hepatitis) and local infections (e.g. abscesses, phlebitis).

  The harmful consequences can affect the health of others (e.g. from secondhand smoke, injury to passengers in road accidents caused by impaired drivers).

Psychosocial consequences

- Family dysfunction, social withdrawal, learning difficulties in school, loss of job and income, criminal behaviour, violence, crimes committed for money to buy substances.
- Anxiety, memory and concentration problems, psychotic episodes (fixed false ideas, hallucinations), depression, suicide.

The use of substances can lead to a wide range of acute and chronic health and social problems in young people, as with adults. Acute problems are more likely to occur among young persons because of the frequency and quantity of substance use and because:

- Although there may not be a long history of substance use, young people may use levels which put them at high risk of death and morbidity – e.g. from traffic accidents, falls, drowning, injuries, blackouts, or unprotected sexual activity.
- Young people are less experienced with substance use; they are less tolerant and can have an unexpected overdose (e.g. when using cocaine or heroin) or may have a mental crisis or "bad trip" (e.g. when using LSD or cannabis).
- Young people more commonly become involved in fights and aggressive behaviour, which are more likely to occur when they are intoxicated or under the influence of a substance.

These acute consequences are not, in themselves, predictive of dependence in later years. Nor do they necessarily indicate that the young person is already dependent, although the levels of substance use may be high at times. For the majority of young people, dependence does not follow sporadic episodes of heavy use or intoxication.

It is important, therefore, to understand the relationship between hazardous substance use, harmful use and dependence. Simply asking whether a person has used or is using a substance does not give information on how much he/she is using, or if such use has caused or is causing any problems, or whether the person is dependent.

For example, the immediate risks with alcohol intoxication relate to injuries, aggressive behaviour, homicides and traffic accidents. Repeated use of alcohol over several days can lead to gastritis, acute hepatitis and other health problems. Heavy consumption over a period of years is related to many more health problems and dependence is likely to occur.

In general, young people may feel less threatened and will be more responsive to discuss their current problems and concerns if the health worker did not focus too much on the long-term consequences after 20 or more years in the future (such as cancers, liver cirrhosis).

TABLE 1

Physical effects of different substances

Substances	Desired effects	Undesirable/problematic effects
Depressants Alcohol Sedatives/ hypnotics Volatile solvents	Pleasant relaxation, reduced inhibition, reduced anxiety	Drowsiness, slurred speech, headaches, impairment of judgment, memory and coordination. Hangovers, 'blackouts', acute intoxication, respiratory depression, gastritis, pancreatitis, worsening of existing diabetes or epilepsy, unconsciousness, severe dependence, death from intoxication.
Date rape drugs		Sexual assault by a predator with little or no memory of the attack.
Stimulants Nicotine Cocaine Amphetamines Caffeine Betel nut, kava, buri	Exhilaration, reduced tiredness, sedation, stimulation, sexual arousal, loss of appetite, weight loss	Increased pulse and blood pressure, irritability, insomnia, tremor, paranoia, hyperactivity, exhaustion, weight loss, cardiac arrest, impaired judgment. Psychotic experiences, worsening aggressive and violent behaviour, personality changes, irreversible CNS damage, intra-cerebral haemorrhage, muscle breakdown, nasal septum infection/perforation, organ dysfunction (CNS, liver, renal).
Opioids Heroin Morphine Opium, Buprenorphine Methadone Pethidine Cough syrup with codeine	Pain relief, euphoria, relaxation, reduced hunger	Irritability, drowsiness, nausea, impaired judgment, aggressive paranoia, respiratory depression, myocardial infarction, seizures, cardiac irregularities and sudden death.
Hallucinogens Lysergic acid diethylamine (LSD) Mescaline, psilocybin, peyote, tryptamines, phencyclidine Cannabis	Perceptual distortions, other-worldliness Relaxation, reduced anxiety.	Increased blood pressure, tremor, long-term psychiatric effects, panic attacks, paranoia, auditory and visual hallucinations, impaired judgment, increased appetite, memory and cognitive impairment, amenorrhea (stopping of menstrual periods), reduced sperm production, bronchitis.

Some signs of specific substance use

- *Depressants*. Drowsiness, confusion, lack of coordination, tremors, slurred speech, depressed pulse rate, shallow respiration, dilated pupils.
- *Alcohol*. Slurred speech, impaired judgement and motor skills, lack of coordination, confusion, tremors, drowsiness, agitation, nausea and vomiting, respiratory ailments, depression.
- *Volatile solvents*. Slurred speech, lack of coordination, nausea, vomiting, slow breathing.

- *Stimulants*. Excitability, tremors, insomnia, sweating, dry mouth and lips, bad breath, dilated pupils, weight loss, paranoia, hallucinations.
- *Tobacco*. Smell of smoke in hair, clothes and breath; yellowing of teeth; cough; increased asthma attacks; shortness of breath and poorer athletic performance. After only a few weeks, tobacco chewers can develop cracked lips, white spots, sores, and bleeding in the mouth.
- *Cocaine*. Excitability, euphoria, talkativeness, anxiety, increased pulse rate, dilated pupils, paranoia, agitation, hallucinations.
- *Opioids*. Lethargy, drowsiness, euphoria, nausea, constipation, constricted pupils, slow breathing.
- *Hallucinogens*. Trance-like state, excitation, euphoria, increased pulse rate, insomnia, hallucinations.
- *Cannabis*. Mood swings, euphoria, slow thinking and reflexes, dilated pupils, increased appetite, dryness of mouth, increased pulse rate, delusions, hallucinations.

Drug testing of urine or blood should only be undertaken if needed for diagnostic or therapeutic purposes, or in an emergency situation. Testing must never be carried out without the informed consent of the individual. These tests are expensive and are unlikely to be available in the primary healthcare setting.

BOX 1

Pregnancy and substance use

All substances taken by the mother during pregnancy can reach the unborn baby. These substances can cause serious health effects on the mother, the unborn baby and the newborn.

Effects on the mother

- Safe levels of alcohol intake during pregnancy have not been established
- Drinking alcohol during pregnancy can lead to miscarriage
- LSD can increase the chance of miscarriage and complications during pregnancy
- If the mother stops using opioids suddenly, she can experience withdrawal problems.

Effects on the unborn baby and newborn

- There is a possibility of physical deformities
- Drinking alcohol during pregnancy can cause slower development in the fetus and mental disability in the newborn (fetal alcohol syndrome)
- Smoking during pregnancy can reduce the amount of oxygen available to the fetus and may affect growth and development before birth (low birth weight) and after birth
- If a mother who is pregnant or breastfeeding suddenly stops using opioids, the baby may experience withdrawal. Withdrawal in a newborn is a serious problem.

Reasons why young people use substances

Some reasons why young people may use substances are discussed below.

- *Urge for discovery and experimentation*

  Young people have the urge for discovery of themselves and others, which leads them to experiment with adult behaviours and to question social norms. But often they lack knowledge

and understanding of the risks. Behaviour at this stage can be seen by the young person as a rite of passage of puberty, from childhood to adulthood. Substance use can be considered as proof of reaching “maturity”.

Most young people, after experimenting with substance use, will not continue and will not develop any significant problems. However, it is important to remember that the younger a person starts using any substance, it follows that:

- he/she is at greater risk of developing problems later in life;
- dependence, if it occurs, is more severe;
- the toxic consequences are greater;
- there is more resistance to treatment.

- *Young people may copy other people’s use of substances*

  There are several developmental factors that help account for young people’s attraction to substance use. During transition from childhood to adulthood, adolescents adopt many of the behaviours and attitudes of the adults in the world around them. Thus in the process of establishing their own identity, young people often imitate adult behaviours and attitudes. They observe adults using legal and illegal substances, the conditions under which they are used and the effects they bring about. Parents, other adults, peers, TV personalities and sports stars who use substances can all serve as models for young people’s experimentation and regular use.

- *Marketing of substance use*

  People with commercial interests are all too aware of the need, during adolescence and youth, to encourage the use of substances available for adults. Alcohol and tobacco use are supported by mass marketing strategies which target young people through the portrayal of these substances as “cool” to use. In some cultures, drinking to intoxication is portrayed as “macho”.

  Marketing strategies for substance use show images of wealth, glamour, adulthood and independence which attract young people. This is especially evident in the marketing of alcoholic beverages and tobacco, which is increasing in the developing countries. Marketing activities play a critical role by targeting young people, who are increasingly using alcohol and tobacco. Television programmes and films also frequently portray substance use without showing the adverse consequences.

- *Easy access to substances*

  When substances are easily available and affordable to young people, substance use will increase.

- *Other immediate reasons*

  The reasons why young people use substances are many and include:

  - For excitement, enjoyment, or courage.
  - To stay awake or to sleep.
  - To reduce pain (physical and emotional).

However, like anyone else, young people may use substances in certain situations spontaneously, or only when the opportunity arises.

BOX 2

Young girls and substance use

In the past, not many girls used substances. However, this trend is now changing in most parts of the world as more young girls use different types of substance. It is important to pay equal attention to both boys and girls for preventing, assessing and treating substance use. In this way it is possible to reduce and eventually eliminate their vulnerability to substance use. Young girls using substances are more vulnerable to nutritional deficiencies, prostitution and sexual abuse. This can lead to an increase in unplanned and high-risk pregnancies and an increased risk of sexually transmitted diseases, including HIV.

The relationship between young people and substance use is complex, and the pattern and context of use can change rapidly. In different places and at different times, young people may use a variety of substances, often those that are easily accessible and inexpensive. For example, street children frequently use inhalants like glue, which is cheap and easy to get.

Risk factors and protective factors

As discussed above (see 1.2), the effect and impact of any young person's substance use is a result of four interacting factors:

- the substance;
- the person;
- the mode of use;
- the environment.

Any discussion of the effect and impact of substance use needs to consider these factors and also the risk and protective factors.

Risk and protective factors take into account "who you are, where you live, and what you do", which determine many behaviours, including substance use.

- Risk factors include individual and contextual influences that either encourage or are associated with one or more behaviours that might lead to negative health outcomes, or might discourage behaviours that might prevent a negative health outcome.
- Protective factors include individual and contextual influences that discourage one or more behaviours that lead to negative health outcomes or that encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.

Protective factors function by:

- providing personal or social controls against problem behaviour;
- promoting activities which are an alternative and incompatible with problem behaviour;
- strengthening orientation and commitment to conventional social institutions such as the family, religious institutions or school.

For example, if a young woman has parents who smoke, this is a risk factor that may encourage her to smoke. However, if she has peers who disapprove of smoking, this is a protective factor. Their disapproval may not stop her from smoking, but it may make her smoke fewer cigarettes (i.e. lessen the negative effects) or play a role in her stopping to smoke (i.e. work against the effects of the risk factor, smoking by her parents).

Protective factors play an independent role in influencing young people's behaviours, which can enable them to resist or reduce substance use.

Risk and protective factors can occur in five areas. The following is a list of some risk and protective factors for young people and substance use in each of these areas.

The individual

Although there is no indication of specific mental disorders that are predictive of harmful substance use, people with mental health disorders may be more likely to use substances and substance use can often exacerbate any existing mental health difficulties. Emotional feelings of distress and vulnerability, and stressful situations such as death of a parent, serious accidents, war, physical and sexual assaults, abuse and suicide attempts may cause a young person to turn to substance use as a way to ease the pain or to help them adjust to changes.

- *Risk factors*
  - Low personal expectations and low self-esteem;
  - Personal stress, feelings of hopelessness, distress, depression;
  - Abuse as a child;
  - Expected positive outcomes of substance use.

- *Protective factors*
  - No tolerance for unacceptable behaviour;
  - Positive attitude towards health;
  - Practise a religious belief or have a sense of spirituality;
  - Positive orientation to school by attending school and engaging in community activities;
  - Expected negative outcomes of substance use.

The family

A close relationship with the family is a protective factor for the challenges, including substance use, that confront adolescents. The ability of parents to maintain a mutual close relationship with their children may be compromised by the economic and social problems they face. Parenting skills alone will not be sufficient if there is no available support from child care, health care, social services, adult education, employment opportunities, minimum living conditions, housing facilities, etc.

Young people want to establish their independence from the family, to gain a sense of self-determination, to choose an occupation and to develop their own personal values. In an attempt to achieve these, they may separate from and be rebellious towards their family.

- *Risk factors*
  - Models in the family for risk behaviour;
  - Availability of substances in the home;
  - Tension or violence in the family;
  - Poverty.

- *Protective factors*
  - Parents provide models for conventional and healthy behaviour;
  - Parents provide boundaries, controls and rules for behaviour;
  - Parental expectations for academic achievement;
  - Parental presence and support in the home.

Peer group

Adolescents and young people have a developmental need to strengthen social connections (with friends, peer groups, gangs, etc.), which means that role models can have positive or negative consequences, depending on their behaviour and social connections. Most of the risk-related characteristics of young people have to do with identity-seeking. As young people mature, they enter into new social roles and there is pressure to establish a new social identity, to seek new role models and not miss out on opportunities for new experiences. Young people may identify with certain role models or peer groups in their search for their new social identity, models or groups which may lead them directly or indirectly to substance use.

- *Risk factors*
  - Friends and peers as models for problem behaviour;
  - Influence of friends greater than that of parents.

- *Protective factors*
  - Peer models for conventional and healthy behaviour;
  - Peer disapproval of problem behaviour;
  - Peer controls against risk behaviour.

The school

The school environment and educational social policies are important tools in the prevention of substance use and in the early detection of substance use by young people.

- *Risk factors*
  - School provides models for problem behaviour;
  - Harassment by other students;
  - Stress and poor safety at school.

- *Protective factors*
  - Student-peer disapproval of problem behaviour;
  - School regulatory controls;
  - Perceived teacher expectations for school behaviour;
  - Perceived student norms for school behaviour;
  - Perceived availability of and participation in school activities;
  - Perceived parental involvement in school.

The community

The availability of substances in the community is an important factor related to their use among young people. Ease of access to both legal and illegal substances (e.g. prices, laws and law enforcement, and the community's cultural norms) has a direct relationship with the possibility for young people to experiment with and repeat the use of any substance.

Many young people live in instability and uncertainty (e.g. as migrants, refugees, street children). A disorganized community is likely to be less supportive of young people, offers few alternative activities after school, and may either not care about substance use or be too strict, thus marginalizing substance

users as the source of the community's problems. Selling substances may be an important source of income for young people (and their families) struggling for economic viability.

- Risk factors
  - Advertising and promotion of legal substances;
  - Sponsorship of events by the tobacco and alcohol industry;
  - Availability of illegal substances in the community;
  - Community gang activities that normalize or promote substance use;
  - Poverty and poor safety in the community.

- Protective factors
  - Community's disapproval of problem behaviour;
  - Social controls in the community;
  - Community resources for young people (sports, recreation and creative activities, etc.).

Not all risk and protective factors are equal; some are much more influential than others. For example, having friends who use drugs has been shown to be a very significant factor that influences an adolescent to start using drugs. It is a much stronger risk factor than having substances available in the community. The relative importance of each risk and protective factor must be recognized because it helps in prioritizing action by the health worker. This action aims to support the protective factors, decrease the risk factors for young people, and focus on specific actions for those who are most at risk.

2. Patterns of substance use

The patterns of substance use provide a guide to the different ways that individuals use substances, based on the frequency and amount of the substance used. In this module we discuss three patterns of substance use:

- Hazardous use
- Harmful use
- Dependence.

Understanding an individual's pattern of substance use is a critical part of the assessment. However, individuals and especially young people can move back and forth between patterns in their use of different substances over a period of time. For example, a young person might be dependent on tobacco and simultaneously be experimenting with cannabis.

It is important for health workers to understand the patterns of substance use so that in their approach to assessment and management of a young person they will take into account how that individual is using a substance. Simply asking if a young person ever uses a substance does not give any insight into how much is being used, the frequency of use, and whether there are any problems associated with the use.

Hazardous use

Hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. Some definitions limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patters of use that are of public health significance despite the absence of any current disorder in the individual user. The term hazardous use is used currently by WHO but is not a diagnostic term in ICD-I0.

Hazardous (or potentially hazardous use) is the most common pattern of substance use by young people. Substance use usually begins with experimental use, which is when a young person tries a substance out of curiosity or the desire for a new experience. However, experimental use can only describe the first one or two occasions of using a substance. After this, the use becomes potentially hazardous.

Most young people who experiment with legal or illegal substances do not become dependent and do not continue to use them when they become adults. However, there is evidence that the younger the age at first experimentation, the more likely that a problem or serious dependence will develop. The majority of adult smokers of tobacco products start in their teens. Also, even short-term experimental substance use can have a negative effect on progress in school. It can impair judgement and increase the likelihood of engaging in other risky behaviour, such as unprotected sex or driving under the influence of substances. Some young people have serious adverse reactions to a substance or a mix of substances the first time they are used. There is no guarantee of "safe use".

Hazardous use can include functional use, which is where the substance has a specific purpose in an individual's life (e.g. the substance enables them to get to work). Functional use is not common among young people. They may use a substance for certain occasions (e.g. for recreation, or to stay awake, or to assist in sleeping) and other aspects of their life are often still intact (e.g. they are still able to attend school, go to work). They may know their substance well and, in the case of illegal substance use, they may have a regular source.

During hazardous use the young person only sees the benefits of their substance use and not the problems. Often there is no motivation to stop because they do not experience or do not perceive any problems with their use.

Harmful use

Harmful use is defined as a pattern of substance use that causes damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful substance use often causes adverse social consequences (e.g. loss of job), but the social consequences alone are not sufficient to justify a diagnosis of harmful use. Substance use can have an impact on personal relationships (e.g. fights or arguments with others) and on schooling, work or training (e.g. expulsion from school, periods out of work, or interruptions in training).

Harmful use is prevalent among young people. Brief interventions have proved to work, especially for tobacco and alcohol, and may be effective for other substances. Risky behaviours related to such substance use, including sharing of needles and unprotected sexual activity, may be responsive to brief counselling and outreach programmes.

Harm from substance use can result from:

- Intoxication;
- Mode of administration (e.g. blood-borne infection from sharing of injection equipment, local infection);
- Depleted support from friends and family (e.g. due to alienation);
- Exacerbation of other health issues – physical health (e.g. chronic health problems) or mental health (e.g. depression).

Dependence

Dependence is defined as a cluster of behavioural, cognitive (related to thinking or memory), and physiological experiences that may develop after repeated substance use. This occurs when the individual using the substance has a strong desire to take it and cannot control the desire or the use.

Substance dependence, especially with alcohol and tobacco, is prevalent among young people. If there is indication that dependence already exists, an assessment is needed and referral to specialist services is required (when available).

The following are the criteria for substance use dependence in the International Classification of Diseases (ICD-10).

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use had ceased or been reduced;
- Evidence of tolerance (a need for more of the substance to achieve the same effect);
- Progressive neglect of other activities or obligations;
- Persisting with substance use despite clear evidence of harmful consequences.

Diagnosis of a dependence syndrome is made if three or more of the above six phenomena occur within a year. The dependence syndrome may relate to a specific substance (e.g. tobacco, alcohol), a class of substances (e.g. opioids), or a wider range of pharmacologically different substances.

Dependent users are the most visible and controversial group of substance users. They require a more precise diagnosis and they experience a greater range of disabilities and a higher mortality rate. However, the largest group of substance users, many of whom are young people, are not yet dependent users.

All people with a history of injecting should be offered counselling and testing for HIV. They should be assessed, supported and counselled on the risks of hepatitis B and C and other health problems, how to reduce their risk, and how to change to non-injecting practices.

"Dependence" as opposed to "Addiction"

The term "dependence" is better than "addiction". Dependence is less emotive than addiction; it also more appropriately conveys the relationship between the young person and the substance. Like any close relationship, the individual experiences an intense desire to be with the "other" and this involves certain benefits as well as certain costs. In this way the young person's substance may be likened to a "best friend".

A best friend is usually there to celebrate with us when things go well, and to commiserate when things go bad. Similarly, there is great sadness and loss felt when our best friend is no longer around even if we were annoyed and angry with our friend sometimes. It is the same for young people who make a decision to change their substance use, and this needs to be acknowledged with them. They are going to lose something they enjoy and which they will miss. Often instead of acknowledging this, we ask young people who have changed their substance use how much "better" they feel for the change.

3. ASSESSMENT OF YOUNG PEOPLE'S SUBSTANCE USE AND RELATED DIFFICULTIES

Substance use is common among young people and early recognition and appropriate actions can prevent the development of many problems, including dependence. Assessment is an ongoing process and continues during each contact with the young person.

It is important for health workers to consider – when writing the health records - the possible repercussions that a written record of substance use can have on the future of a young person.

The HEADS approach

The HEADS approach can be used as an aid for eliciting a young person's psychosocial history. The purpose of this is to explore the factors that might be influencing substance use.

The initial letters, HEEADSSS (or HEADS), remind the health worker of the steps to take during the interview. Not all the questions need to be asked at the first visit.

At the initial assessment, it may not be possible or appropriate to discuss sensitive issues in depth. As trust develops between the young person and the health worker it should be possible to deal with issues of concern. This can offer an opportunity to prevent young people who are not using substances from beginning to use them, to advise and assist those who are using substances to stop or reduce their use, and to agree on and arrange ways to reduce the harmful effects for young people who do not stop using substances.

BOX 3

The HEADS approach

H Home
E Education
E Eating
A Activities
D Drugs
S Sexuality
S Suicide and depression
S Safety

H – Home

The home environment is an essential part of the young person's life and is a natural and unthreatening place to begin the interview. This can begin with an open-ended question (e.g. "Who lives with you at home?"). This will help the health worker to understand the family situation or if any family members are missing and whether there is extended family support.

E – Education

The school, college and university environment and peer influences are important factors that influence behaviour. The health worker should ask questions that will help them to understand the young person's school performance, attitude to school, involvement in school activities and relationship with teachers. If the young person is working, the questions can focus on their work. A question to begin the discussion could b, "How is school this year compared to last year?" "What do you do on a typical school/work day?"

E – Eating

The health worker should screen the young person regarding unhealthy eating habits. An open-question could be, "What do you think about your weight?" This opening can then lead to questions on the young person's eating habits.

A – Activities

Asking about what the young person enjoys doing for fun can give a picture of their behaviour. They may respond, "Hanging out with my friends". Asking about the friends and what they do together for fun can lead to further questions regarding risky behaviour.

D – Drugs

The health worker should routinely ask all young people some general questions about substance use. This is an opportunity to begin discussions that can prevent young people from beginning to use substances. A closed question, e.g. "Have you ever smoked cigarettes?", can begin the assessment.

S – Sexuality

This is one of the most intimate parts of the interview. Concerns about sexual development, sexuality and sexual abuse are all sensitive topics and need to be approached in a careful and supportive manner.

The discussion could begin with a statement and a question, e.g. "There are many changes that happen in the bodies and minds of young people of your age. Are there any questions that you would like to ask me, any questions about changes that you may have noticed?"

S – Suicide and depression

Asking the young person about their moods, as well as signs and symptoms of depression is important. Signs of irritability and sleep disturbances may be presenting symptoms of depression in young people. When asking about suicide, the questions should be asked in an accepting manner with no blame on the patient who may have thought about it.

This question could be framed as follows: "Sometimes things get very rough for young people and the pain is so unbearable that they wish they could end it all. Have you ever had such thoughts?"

S – Safety

The health worker should ask about safety issues at home, at work and in school, including questions regarding bullying and violence. Discussion on issues of safety can begin with a question such as "What situations make you feel afraid?" When a person comes to the clinic with an acute substance use problem (e.g. overdose), safety issues are the immediate concern.

Effective listening skills

When the health worker is talking with the young person about their substance use there are three goals in assisting them:

- self-exploration: assist them in examining how they are using substances and how their substance use affects their life.
- self-understanding: assist the young person in understanding how they feel about using substances.
- decision-making with consequent action: assist the young person in coming to a decision on the changes they choose to make and how they can take responsibility and action to make the changes happen.

There are counselling techniques that can help the young person to achieve these goals, by talking and exploring his or her feelings, as well as discovering the facts and circumstances of their situation. These techniques include effective listening skills, such as:

Eye contact and body language

The health worker should maintain appropriate eye contact, so that the young person knows you are paying attention. Eye contact should be natural (not staring) and kept within cultural norms. How we communicate with our body is very significant. Ensure your body language shows you are listening. Communication depends on body language in all cultures.

Remain attentive, show empathy

Remain attentive, do not interrupt, and be genuine. By showing empathy the young person will feel you understand his/her situation. Empathy is when you are able to feel the other person's position and understand their point of view. Young people may not expect empathy from an adult.

In the following examples, consider how the young person may feel about each of the two responses.

Young person:	"My father hit me last night."	
Health worker:	"What did you do to make him angry?"	(no empathy)
	"Did he hurt you?"	(showing empathy)
Young person:	"I don't have any money for cigarettes but I really need a smoke."	
Health worker:	"It's better for your health if you don't smoke."	(no empathy)
	"How does that make you feel?"	(showing empathy)

"Encouragers"

Every culture has "encouragers". These are the small signals (nods of the head), noises (mm hm) and small words ("I see" or "Go on"), which indicate to the young person that you are listening and interested.

Use encouragers that are commonly used in your culture.

Reflecting

Reflecting is repeating what the young person has said using your own words, to confirm that you have understood. Reflecting can be about facts (something that happened) or feelings (how a situation made the young person feel). This can be a useful technique to encourage someone to keep talking. It is important that the health worker is accurate in reflecting what the young person has said. Do not change the meaning. Use simple language.

Affirmations

Affirmations are when the health worker recognizes the effort that the young person has already made. This is particularly important with substance use and with helping a young person reduce or stop his/her substance use.

Examples: "Well done, it must have been hard to walk away from the party without having a drink", "I'm impressed that you were able to refuse to smoke cannabis with your friends". Be sure to be genuine and sincere.

Summarizing

Summarizing is similar to reflecting but can cover more of what the young person has said. It is a useful way to close a topic and change the subject in the least disruptive way. It is shorter than what the young person said, but includes all the important points.

Asking questions

Open-ended questions are ones that cannot be answered with "yes" or "no" or briefly. They are useful to explore the opinions and the feelings of the client. These questions are usually more effective in determining what the client needs. They often start with: What? Could? Would? How?

Closed questions are usually answered by a very short response, often one word. They are useful for determining the client's condition and medical history at the start of the interview.

TABLE 2

Examples of closed questions and open-ended questions

Closed question	Open-ended question
Do you play football?	How do you spend your leisure time?
Do you get on well with your family?	Would you like to tell me about your family?
Have you ever drunk so much that you vomited?	Could you tell me about the worst experience you have had with drinking too much?
Do you use cocaine because your friends do?	What do you like about using cocaine?
Do you know that smoking is bad for your health?	What effects do you think smoking has on your body?

Specific question about substance use

There are some specific questions the health worker can ask when discussing substance use with young people. When the assessment indicates that a young person is using a substance, these questions can help the young person to think about changing their substance use behaviour. Change can happen when the client sees a conflict between their current predicament and the situation that the client wishes in their life.

- **Good things/Perceived benefits of substance use**

  Explore the what the young person sees as the "good things"

  "What are the things you like about smoking cigarettes?

  "What are the things that you get out of smoking cigarettes?

- **Less good/Not so good things about substance use**

  Explore the young person's concerns about the "less good things"

  "What are the 'not so good things' about smoking cigarettes?

  "Can you give me some examples of that?"

  Have the young person argue for change by asking such questions as:

  "But aren't you used to having no money because you spend it on cigarettes?"

- **Cost of change**

  Explore what would be different for them if they gave up or reduced their substance use

  "What would be different in your life if you stopped/cut down on your smoking?"

The GATHER approach

BOX 4

The GATHER approach

G Greet
A Assess
T Tell
H Help
E Explain
R Return visit/Refer

The GATHER approach can be used to interview young people.

G – Greet

- Greet the client and offer a seat
- Introduce yourself
- Ensure confidentiality and privacy.

This step appears simple, but it is crucial because this is the step when the health worker starts to establish a rapport with the young person.

Confidentiality is essential to establish a trusting and professional relationship. The health worker needs to tell the young person that they will not reveal to others what is said in this interview. If possible, have a quiet and private space where you can talk with the young person without being disturbed, as discussed in the *Adolescent Friendly Health Services* module.

A – Assess

- Ask the client what you can do for him/her.
- Obtain personal information.
- Assess whether the young person is using substances.
- Assess the pattern of substance use and the feelings/concerns about use.

During the first visit, use open-ended questions and general enquiries to begin talking about substances. The first question can be, "Have you ever used a substance (e.g. alcohol)?" Other questions can be more specific about the timing and the quantity the substance(s) used. Remember that the health worker should not criticize the young person's use of substances, but can assess his/her feelings, opinions, knowledge, concerns and difficulties associated with substance use.

During a follow-up visit with the young substance user, ask about:

- Any changes in situation.
- Any other concerns/difficulties.

T - Tell

- Ask permission to give information.
- Discuss the dangers and problems with substance use.
- Give information on preventing/reducing/stopping substance use.
- Respond to the concerns and questions.

The health worker, having determined in the assessment whether the young person is or is not using substances, the following actions are valuable for both groups - users and non-users. The specifics of the information provided will be different.

- The health worker asks the young person for permission to give him/her information on substance use.
- It is important to discuss the dangers and problems with substance use in general and with the specific substances and modes of use that the young person is using or may use.
- The health worker gives the young person information on preventing, reducing or stopping substance use and responds to his/her concerns and questions. The information needs to be given in a factual and non-judgemental manner, using plain language.

H – Help

- Help the young person decide what to do about substance use.
- Encourage him/her to identify possible options.
- Discuss the possible outcomes of the options.
- Help the young person to make a decision on action.

The health worker helps the young person to find out what he or she wants to do about their substance use. If they are not substance users, the health worker can reinforce and encourage behaviour that will prevent them from starting.

Encourage the young person to identify the available options to reduce or stop substance use. Discuss the possible positive and negative outcomes of each option. It is for him/her to make a decision on what action to take. Young people need to feel ready for change and be willing to take responsibility to make the change happen. Reinforce the fact that whatever action they decide to take, they will have the health worker's support. Young people will not respond well to being lectured or told what to do.

E - Explain

- Identify other possible options.
- Explain the young person's responsibility to make action happen.
- Identify other sources of support.
- Provide supplies or services.

The health worker can identify other options that have not come up. It is important to explain that it is the young person's responsibility to make the action happen. The health worker can encourage them to feel confident that they are able to make the change happen. They may feel afraid of how their life will change if they stop using substances.

It is possible for the health worker and the young substance user, working together, to identify people who can support the young person to make the action happen. The health worker can provide supplies (e.g. condoms, needles and syringes) and services (e.g. STI management, contraception).

R - Return Visit/Refer

- Schedule a return visit.
- Refer for other services.
- End the session with a positive message.

It is important to schedule a return visit and write it down for the young person. If required, refer him/her for other services (e.g. peer support, STI, community outreach services).

End the session by thanking the young person for coming; acknowledge the progress made during the session and review the plan.

4. Stages of change

BOX 5

The Stages of Change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

The Stages of Change model describes the process of change which all people may go through for any behaviour change, not just in giving up substance use.

The idea behind the Stages of Change Model is that behaviour change does not happen in one step. People usually progress, at their own pace, through different stages on their way to successful change. People have to feel ready for change and be willing to take responsibility to make the change happen.

As an example, consider a young man who is overweight and what he may feel or do in the different stages.

- *Pre-contemplation*. He does not yet acknowledge that there is a problem with his weight and he makes excuses.
- *Contemplation*. At this stage he acknowledges that there is a problem with his weight, but he is not yet ready or sure that he wants to make a change.
- *Preparation*. He starts to get ready to change and he may tell some people of his plan.
- *Action*. He begins to carry out his plan: eating less, eating well, exercising.
- *Maintenance*. He stays with his diet for many weeks even though it is sometimes hard.
- *Relapse*. One weekend he attends a family wedding and eats too much rich food. The next morning he feels bad and regrets that he broke his diet. This type of incident can happen at any stage. At this point he may go back to any stage of change; he may be so discouraged that he returns to his former eating habits and abandons his diet (pre-contemplation), or he may spend some days thinking that he really should get back to his diet (contemplation), or he may make plans to return to his diet on Monday (preparation/action), or he may get straight back to his diet (maintenance stage).

The stages of change can be applied to many situations. It is a useful way of determining where an individual is in his/her readiness for change. However, it is only a model and may not always provide an accurate assessment of individuals and their stage of substance use.

The key to understanding the Stages of Change model is that there needs to be a match between the stage of change of the young person and the action proposed by the health worker. For example, if young persons are at the “pre-contemplation” stage, then it may be useless for a health worker to give them a referral to a counselling service, because they do not feel they have a problem or the desire to change their behaviour.

See Annex 3 for an individual exercise on the process of change.

5. Action by health workers with young substance users

Health workers have an important role to play in dealing with the issues of substance use in the communities they serve. However, they cannot work alone and there is a need for the community to help them on substance use by young people. Community action includes:

- Providing information on substance use that specifically targets young people and their families, especially young people most at risk for substance use.
- Strengthening the support given to young people by their families and communities.
- Developing social activities for and with young people to replace their substance use.
- Providing young people with educational opportunities to build intellectual, social and vocational skills which could lead to productive and purposeful activities in society.
- Offering counselling and psychiatric interventions to deal with any psychological problems young people may have.

The aims of health worker action with young substance users are to:

- Prevent young people (who are not substance users) from starting to use them.
- Advise and assist young substance users to stop or reduce their use.
- Arrange ways to reduce the harmful effects for young people who do not stop substance use.

Actions at each stage of change

Health workers are an important source of information and advice about substance use for all people in their community. They should be prepared and willing to discuss substance use with their young clients, parents, families and community members with the aim of motivating them to reduce or help reduce substance use.

The following examples are actions that the health worker can take when assisting young substance users at each of the four stages of change.

Stage 1: Pre-contemplation

Young persons usually feel that what is enjoyed (or "positive") in their substance use far outweighs any perceived costs, so that there is no desire to change their behaviour. A health worker encountering such a person may consider action to:

- Raise his/her awareness of the risks; routine assessment provides an important opportunity to identify substance use in the early stages.
- Provide information (factual, professional and non-judgemental) using plain language.
- Discuss ways of reducing the risks and potential harm of substance use (e.g. by eating something before taking alcohol, or smoking only half a cigarette, and not injecting the drug).

Lectures and sermons do not "raise awareness" and do not assist in the engagement process. If young persons decide to change or to think about changing their substance use behaviour, they are less likely to discuss or act on their decision with someone who lectures to them.

Stage 2: Contemplation

A young person who is starting to think about change is filled with mixed feelings. Contemplation is often induced by someone or something external (parents, school, juvenile justice, etc.). A health worker encountering a young person at this stage may consider the following actions:

- Continue to raise awareness of the risks of substance use.
- Assist the young person in making informed choices.
- Listen to what young persons say about why they like using the substance and what they see as the problem with stopping. This will give important information on how to assist them towards change.
- Avoid too much focus on 'action', e.g. by not telling them too soon what to do. If they make the decision to change by themselves, they will be more likely to succeed.
- Aim to tip the balance in favour of change by recalling the points they made earlier in support of change.

Stage 3: Preparation and action

In this stage, the young person's attitude moves towards change and he/she decides to begin with changing their pattern or level of use. A plan is made and implemented. The health worker may:

- Decide that an assessment is now appropriate, using a national assessment tool for *substance use or the WHO assessment tool (*see *The WHO ASSIST Substance Use Assessment Tool* (www.who.int), even if not yet validated for use with young people***).***
- Advise the young person on the options that have been identified during the GATHER assessment.
- Assist the young person in making a plan and help him/her in developing skills and strategies to support the plan.
- Assist the young person in maintaining motivation.
- Prepare the young person for the possibility of a relapse. If not prepared for this, they may feel very disappointed and discouraged by their return to substance use. The disappointment may cause them to feel all is lost, but if they had been told about a relapse, they can see this as a single lapse and maintain their progress towards behaviour change. It is therefore important for the health worker to prepare young persons for the possibility of a relapse before it occurs.

Stage 4: Maintenance

During this stage the young person maintains his/her changed behaviour and works to avoid a relapse. The health worker's action may be to:

- Provide reinforcement to deal with any difficulties and assist young persons to maintain their new status.
- Teach them to recognize their own strengths and draw on the positive experiences they had in maintaining their behaviour change.
- Monitor relapse prevention by reminding them that a relapse may happen and by not making them feel bad when or if this occurs.
- Teach them self-monitoring skills and help them to take responsibility for their behaviour by raising awareness of early detection of their feelings and of situations which may lead to a relapse. For example, ask them: "What makes you feel you want a drink?" or "How can you plan in advance to avoid such a situation?"

- Link them with other community resources. Self-help groups and peer support may be useful because the experience of peers may reflect their own situation.

Stage 5: Relapse

In this stage, the individual may relapse just once or return to continued substance use. Owing to the tendency for relapses with substance use this is the most likely initial outcome. As it is important for young persons to know about relapses in advance, explain that while this may occur, it does not mean that all they have gained in behaviour change is lost. The health worker can help them to learn from this experience and to overcome any harm from a relapse.

The health worker's actions may include:

- Support for young persons to renew their decision to change.
- Support for them to identify and try different strategies (e.g. strategies to reduce the risk of getting into situations where substances are commonly used, or to help them deal with peer pressure to use substances, or to find peer support for their changed behaviour).

Important issues when working with young substance users

The attitudes and values of the health worker on substance use

It is important for health workers to examine and understand their own values and attitudes to substances so that they could work effectively with the people who come to their clinics with substance-related problems. It is also important for them to examine their personal substance-use behaviour.

Our attitudes and values are formed over a period of time by the circumstances in which we are born and live, by the situations and people we encounter, and by the experiences from which we learn. The attitudes and values that we hold influence our view of other people's behaviour and our ability to provide professional and nonjudgemental care and support. In previous modules, this has been discussed in relation to many important and sensitive issues (adolescence, sexuality, adolescent-friendly health services). Substance use and substance users are another important area where health workers need to assess their own attitudes and values. This will enable them to provide the best possible care and to challenge the stigma and discrimination which substance users frequently have to deal with in society and in healthcare settings. The exercise in Annex 7 can assist the health worker in exploring their attitudes and values.

The health workers own substance use is important both as a basis for their attitude and as a role model in the community. Young people will be aware of the hypocrisy of health workers who give a client information and advice which they do not practise themselves.

Establishing a trusting relationship is important for the effective assessment and treatment of problems with young substance users. Young people are usually honest with their health worker once trust is established. It is very important that the health worker is also honest and respectful of the young person, since young people will sense if the health worker is insincere, disrespectful or judgemental. Most young people do not like to be told what they should do and not do. It is important to give factual information, to be supportive, friendly and non-judgemental, and to act in a professional manner. Health workers need to be themselves and not try to talk or behave like the young people to whom they are providing a professional service. Using street names for drugs or activities may be important to ensure understanding; however, health workers should avoid exaggerating this and

trying to speak and act like a young person. Maintaining a professional, respectful and understanding attitude will help build a relationship of trust.

One way to establish trust is to listen to young people with genuine respect, and to be attentive to their emotional needs. Young substance users may be guarded and suspicious at first – they may have had past experiences with professionals who "preached" to them about their substance use, or who stigmatized them as "addicts" or "delinquents". In order to be effective, the health worker must approach the young person in a frank, open, non-threatening manner. Expressions of shock or disapproval are not helpful. Trust is increased when health workers express sympathy and understanding for the young person's situation and when he/she is allowed to express him or herself openly.

When speaking to young people, health workers should use simple words and plain concepts. Personal responsibility should be encouraged and it should be emphasized that all final decisions are in the young person's hands.

Helping young people to express their feelings

Young people may have a limited vocabulary for identifying and expressing their feelings. For example, they may not be able to distinguish differences between anger, jealousy, or annoyance. For this reason, it can be difficult for them to express their feelings to a health worker during clinical interviews. Frustration can result for both the young person and the health worker.

When working with young people, health workers can help them to label their feelings. For example, if a young person starts crying, the health worker can say, "You look sad." This helps the young person to learn to give words to their feelings, and also to feel understood. Through listening skills and open questions, the health worker can assist young people to explore their feelings about their substance use and their readiness for change.

Health workers can also encourage young people to use other media to express their feelings, such as making drawings of situations related to substance use. These drawings can be reviewed together and the health worker can help the young person to identify the feelings they had when making the drawing.

Coping strategies for young people

Young people can be encouraged to use strategies that can reduce or stop their use of substances, and reduce the negative consequences of substance use. For example:

- plan ahead if they are going to use a substance and decide how much they will use;
- plan how they will negotiate not using or reducing their use of a substance;
- practise what to say if they are pressured by others to use more than they planned;
- eat some food before they use the substance;
- slow down their rate of consumption;
- avoid combining two or more substances.

They can also take precautions against secondary consequences of substance use by, for example, not driving a car while intoxicated and not accepting a ride from someone who is intoxicated. To help avoid substances altogether, young people can get involved with non-substance-related activities, especially activities that may be incompatible with substance use (e.g. smoking and exercise). They

can prepare and practise how to resist social or peer pressures to use substances. Role playing is a useful method for developing confidence to face these encounters: it helps young people to find the right words to say, and increases their ability to challenge the social norm.

Relapse prevention

When reducing substance use, a backward 'slip' into earlier behaviour is common (e.g. a young person who has stopped smoking takes one cigarette at a party). When slips occur, it is important for the substance user to view them as temporary and surmountable, and not to view them as evidence that he or she will never be able to overcome their substance use.

Relapse prevention is a set of skills that the health workers have to counsel young people in advance, so that they will be less likely to 'relapse' into former substance use patterns once a slip occurs. Young people are taught to view slips as temporary and surmountable experiences, and to determine what went wrong and make changes accordingly for the future. Young people are also taught how to avoid situations that could lead them towards relapse (e.g. social events where the consumption of substances is likely), and how to manage their urges and pressures from others to use substances.

This approach focuses on three main areas for relapse:

- *Intra-personal* (e.g. feelings and moods that are likely to lead to relapse);
- *Inter-personal* (e.g. relationships that are likely to lead to relapse);
- *Situations/cues* (e.g. places and times that are likely to lead to relapse).

Some approaches that attempt to address these different areas can include:

- Individual or group work focused on the identification and management of negative or positive affect (emotions) associated with the use of particular substances.
- Individual, group or family interventions focused on inter-personal issues (e.g. family conflict, relationship difficulties).
- Individual and possibly group interventions which target cues and situations (e.g. cue exposure, developing social networks and alternative leisure pursuits).

Developing these approaches assists young people to consider the following statement: I am more likely to use X, when I feel Y*, and/or* when I am with Z*, and/or* when I am at W.

When health workers recognize these triggers, they will be able to look for alternative actions. To develop statements like these and then to effectively address some of the triggers, the following must be offered to the young person:

- accurate and unbiased information;
- attention to personal variables that may be associated with increased vulnerability to negative peer influence for some individuals or groups;
- decision-making skills and skills associated with resistance to negative influences;
- assistance in improving communication between young persons and their parents, teachers, adults and peers;
- harm reduction strategies (e.g. techniques of safer use) when appropriate, and exposure of users to satisfying and acceptable alternatives to substance use;
- long-term support.

Parents and young people: towards a better relationship

National laws govern issues of consent and confidentiality about young people and their parents' rights to give consent and to know about their treatment. It is important for health workers to understand the laws of the community in which they work. In some areas, professionals are required to tell parents if minors are using substances, while in other areas this information can remain confidential. Health workers should take into account the best interests of the young person and their evolving capacities. All health discussions with minors should be kept confidential – unless unlawful.

Regardless of the law, involving the family is usually important, because parents and other family members may be part of the problem and may be able to help the young person to reduce his or her substance use. However, involving the family must be dealt with sensitively, because the young person may not want to involve them at all. Similarly, parents may feel blamed or defensive about substance use and about their family and may not want to participate in treatment with the young person. The health worker should recognize these potential problems, assist everyone to feel less defensive, and encourage the family to work together to solve its problems.

Community action for young substance users

Raise family and community awareness of a young person's substance use by talking with the parents, community members and young people about the situation locally.

Raising awareness of substance use in the community can enhance the protective factors and minimize the risk factors for young people.

In the enhancement of protective factors the involvement of parents is vital. Parents typically have concerns about their children's substance use. It is important to provide them with accurate information about the substances and their effects, as well as additional sources of information on treatment in the community. Parents, teachers, community leaders and peer counsellors can be educated about:

- prevalence of substance use among young people;
- typical reasons why young people use substances;
- effective strategies that can be used to discourage young people from substance use;
- effective strategies that can be used to encourage young people to reduce harmful use.

They also need to be aware of the problems related to more commonly used and legal substances (such as alcohol and tobacco), which often cause more health problems than the illicit ones but are overlooked by parents and the community.

Involve the community in planning and implementing community prevention programmes. This will mean that the target community will have ownership of the programme, which is a key ingredient to the success of any initiative. Programmes should make use of existing links and networks between community organizations, both governmental and nongovernmental.

Contribute to prevention programmes that aim to reduce supply and demand. Health workers can work with the community to examine and promote change in the supply and availability of illegal and legal drugs in the community. Also, contribute to school education campaigns and community action (e.g. no-smoking areas and venues, regulation of availability).

Media promotion of substance use, especially tobacco and alcohol advertising, is often aimed at young people. Health workers can encourage young people to look at how, in such advertising, they are being manipulated by companies that aim to promote their products.

Provide community links which can provide young people with support services within the community. Provide young persons with connections and encourage them to seek support, especially from peer counsellors and peer support groups. If appropriate, encourage them to ask their family, relations and friends for help. Give them information about community resources, peer support groups, referral services, etc.

Encourage community recreational activities as well as vocational and educational pursuits.

Support harm reduction strategies which aim to reduce the negative consequences of drug use rather than to stop or reduce drug use. These strategies focus on the most immediate and achievable changes that can reduce the threat to the health and wellbeing of the user and of society (e.g. a needle-syringe programme for injectors who do not stop injecting can prevent the transmission of HIV and hepatitis C, and providing safe injecting rooms and sterile equipment can prevent abscesses).

There is evidence to prove that harm reduction is a sound public health strategy. Health workers have a role in raising public awareness of the importance and benefits of harm reduction for individuals and communities. Harm reduction strategies are often opposed by community members who think this will encourage substance use.

6. Approaches to acute problems with young substance users

The signs and symptoms of intoxication and withdrawal from various substances often overlap. So when faced with an acute problem from substance use, it is appropriate for the health worker to focus on the individual's presenting symptoms in order to take immediate action. After dealing with any life-threatening situation, the health worker must assess the substance use patterns and problems and identify (if not already known) the main substance which caused the acute problem before proceeding to establish a long-term plan for the patient.

TABLE 3

Immediate cction in ccute substance use problems

Presenting symptom	Immediate action
Anxiety, agitation and/or panic	Approach the patient calmly and confidently, move and speak without hurrying, and keep to a minimum the number of staff attending him/her. Reduce stimulation by keeping the environment quiet, and frequently reassure and calm the patient. Explain the interventions and protect him/her from accidental harm.
Confusion, disorientation	Provide frequent orientation by reminding them where they are and what is happening, remove unnecessary equipment, and use or display object(s) familiar to the patient (e.g. own clothing, personal objects, etc.). Ensure frequent supervision and accompany the patient to/from locations.
Altered perception, hallucinations	Explain errors or misunderstandings they may have, create a simple and uncluttered environment, and provide care in well lit surroundings to avoid perceptual ambiguities and uncertainties about what they think is happening. Protect the patient from harm, use antipsychotic medication if necessary.
Anger, aggression	Keep space to protect yourself and touch the patient with care, keep your own emotions in check, speak calmly and reassuringly, and use his/her name when speaking to them. Let the patient talk about his/her feelings, listen attentively, determine the source of the patient's anger and be reasonably flexible.

Substances affect cognition, emotions and behaviour. Some substance can cause sudden confusion, disorientation, perceptual disturbance, euphoria, agitation, panic, emotional liability, repetitious behaviour and aggression. Withdrawal from these substances also can affect mental functioning, causing hallucinations, paranoia, agitation, or depression. Information on the time of the last dose, as well as the quantity and frequency of regular use, can help in the assessment process.

During an examination of their mental state, it is important to assess the following areas:

- levels of consciousness;
- orientation (to person, time and place);
- memory (recent and remote);
- judgement (e.g. are the patient's responses rational, do his/her ideas make sense?);

- affect (e.g. are the young person's emotion, grooming, posture, and facial expression appropriate?);
- speech (manner of speech, speech pattern, possible disorders, e.g. aphasia, dysphasia);
- language comprehension (understanding verbal instructions), particularly during emergency treatment.

Care must be taken not to overlook conditions that mimic some of the features of intoxication or withdrawal (e.g. metabolic disorders, cerebral disease and endocrine disorders).

Intoxication with depressants

Alcohol

Drinking alcohol is common among young people, but intake to the point of intoxication can lead to death (due to overdose). Alcohol is a central nervous system depressant. In sufficient doses, it can suppress respiration, gag reflex, and cough reflex. It also affects heart function, leading to irregular cardiac rhythms. Young people often 'binge' drink (defined as having 5 or more drinks in a row in males and 3 or more in females), which may result in blacking out.

In gross intoxication, respiration can be depressed and the person may choke on food, fluid or vomit. This can present a major problem in semiconscious or unconscious patients. Care should be taken to maintain a clear airway and prevent aspiration. Although rare, hypoglycaemia can occur and in these cases the administration of glucose is necessary.

Conditions other than alcohol intoxication should be ruled out (e.g. head injury, other drug overdose, psychosis, hypoglycaemia, severe liver disease). The patient should be kept for observation and vital signs should be monitored if the level of intoxication poses a threat to life, health or safety. In addition, you should follow these guidelines:

- orientate the patient;
- introduce yourself;
- provide a quiet place or room for the patient;
- speak slowly, using short sentences and repeating information if necessary;
- avoid emotional topics or discussions;
- maintain eye contact and use the patient's name.

Alcohol dependence takes some years to develop. It can occur with young people who have a history of long and heavy alcohol intake. Several psychological problems, adjustment problems and heavy alcohol use are conditions often found in young people.

Volatile solvents

Although the effects of individual components of compounds can be different, the overall action of most solvents is depression of the central nervous system. If high doses are inhaled, they can cause coma and death. Onset of solvent action is very quick; central nervous system impairment generally clears within a few hours after inhalation. The effects include initial exhilaration and euphoria followed by:

- slurred speech;
- ataxia (involuntary movements);

- drowsiness, dizziness;
- increased salivation, nausea, vomiting;
- confusion, disorientation, perceptual distortions.

In some cases, these symptoms are accompanied by hallucinations and delusions. Very high doses can result in convulsions, solvent-induced respiratory depression and cardiac arrhythmias, which can be fatal. Patients who sniff petrol may also present with lead poisoning.

If the solvent user presents with chest pain, difficulty in breathing or strange behaviour (including violent and aggressive behaviour), stay calm and keep him/her calm. If the user is unconscious, make sure that the airways are free. Lay him/her on the side (not flat on the back or front) so that if vomiting occurs, there is no aspiration of vomit, and observe the vital signs. Solvent intoxication may be suspected from the patient's history or from the odour on the clothing or breath.

Barbiturates

Barbiturates are central nervous system depressants which can be taken in a suicide attempt or in combination with alcohol. They produce cardiopulmonary depression, which can be life-threatening. They are more dangerous in overdose than benzodiazepines. Effects in some individuals may be atypical, with excitement instead of sedation in smaller doses. Intoxication symptoms and signs vary according to dose, ranging from euphoria in small doses to:

- impaired memory and attention;
- inability to walk;
- slurred speech, rapid eye movements;
- drowsiness;
- slow heart beat, hypotension;
- depression of respiratory drive and rhythm;
- coma.

Intoxication with stimulants

The stimulants considered here include amphetamine, dexamphetamine, methylphenidate, cocaine, crack and ecstasy (MDMA). High doses of stimulants can induce chest pain, hypertension and cardiac arrhythmias. Hyperthermia and convulsions also may be present. Following stimulation of the central nervous system, depression of higher nervous centres may occur, which may lead to death due to overdose. Panic can cause irrational behaviour causing harm to themselves and others. People suffering delusions that they are being persecuted may react with hostility and violent behaviour.

It is therefore important to observe the vital signs and to approach the patient calmly and confidently. Move and speak without hurrying, and keep to a minimum the number of staff attending him/her. Reduce stimulation by providing a quiet environment and frequently reassure and calm the patient. Explain the interventions and protect him/her from accidental harm.

Intoxication with opioids

Opiates have a depressant effect on the central nervous system. They are powerful analgesics and suppress cough and diarrhoea. Acute effects include analgesia, euphoria, tranquillity, constipation,

orthostatic hypotension, respiratory depression and decreased level of consciousness. An overdose may lead to respiratory depression without major effects on the cardiovascular system.

Withdrawal

This term is used to describe the physical and psychological symptoms associated with cessation or reduction of a substance.

The severity of the withdrawal depends on a number of factors:

- Type of substance(s) being used;
- Method and levels of use;
- Length of time used;
- Young person's experience of previous withdrawal(s);
- Use of other substances;
- Physical health of the young person;
- Environment of the young person (supportive versus unsupportive).

Most young people, because of their age and limited access to substances, generally do not develop a severe dependency as found in older individuals. Consequently, they may not experience a serious or difficult withdrawal; most will need safety, calm, rest, sleep, good food and to be off the streets or away from substance-using peers. There are few conditions where the use of medication is warranted to assist with withdrawal, but it is important to avoid over-medication.

Acute situations of substance use by a young person, which require medication, include the use of naloxone or naltrexone for opioid overdose and flumazenil for benzodiazepine overdose. In cases where there are hallucinations, care should be taken when administering antipsychotics because they lower the seizure threshold and may increase the risk of a convulsion.

The signs of withdrawal are different for the various categories of substances used. Often withdrawal is the opposite of the effect of intoxication. So, after heroin use, where one generally becomes relaxed, content, quiet, constipated, and pain-free, withdrawal usually results in restlessness, inability to sleep, diarrhoea, and feelings of pain (especially in the back and legs). Use of amphetamines makes one alert and energetic, and withdrawal can result in depression, lethargy and tiredness (often associated with a "crash", a long unsettled sleep).

Withdrawal is not a pleasant experience, no matter what the substance. Ensuring the young person is in a safe, supportive environment can assist them during this difficult time. In the knowledge that this may not be their last withdrawal, it is important to ensure that it is as painless as possible for the young person.

The most severe withdrawal occurs in those dependent on hypno-sedatives and alcohol. Withdrawal from either of these can be serious and, in some cases, life-threatening. For this reason it is important that withdrawal from these substances should be handled under medical supervision. For other substances withdrawal is less hazardous, but it is still good practice to encourage and assist the young person in accessing appropriate medical support as necessary.

Overdose

In dealing with young people who use different substances there is always the chance that they could "overdose". Overdose is the general term applied when a person has taken a substantial amount of a substance and poisoning has occurred. Overdose can occur accidentally or intentionally. Signs to look for with overdose are specific to each substance taken, but generally can include:

- decreased level of consciousness;
- difficulty in breathing;
- abnormal pulse (fast/slow/irregular);
- seizures, fits, convulsions;
- hallucinations, anxiety, depression;
- nausea, vomiting;
- slurred speech, drowsiness.

Some guidelines in managing a young person with an overdose are:

- If you suspect that an overdose has occurred, act immediately.
- If the young person is conscious, ask about the substance (how many, when and how it was taken), and look for signs of use.
- If unconscious, place him/her in the recovery position (side position, with the head on one side), and call for emergency medical assistance.
- If the young person begins to have a fit, do NOT restrain but move the furniture etc. to prevent injury.
- **Never leave the young person alone**.

7. Key messages

- Most substance use begins during adolescence.
- Substance use by young people is common.
- Family relationships and peer associations are important determining factors which can promote or protect young people from substance use.
- Early detection and intervention can prevent harmful use and dependence.
- The three patterns of substance use among young people (hazardous, harmful and dependent) indicate how the young person uses a substance. Understanding an individual's pattern of use is a critical part of the initial assessment for appropriate action.
- Understanding the stages of change can assist the health worker to assess a young person's readiness for change.
- Actions by the health worker aim to prevent young people from starting to use substances, to stop (or reduce) the use of substances by young people, and to reduce the harmful effects of substance use for young people who do not stop.
- Health workers have an important role with young people and substance use, both in the clinic and in the community.

8. Glossary

Abstinence. This refers to refraining from substance use, usually alcoholic beverages or illicit drugs, as a matter of principle or for other reasons.

Alcohol. Refers to a large group of organic compounds derived from hydrocarbons. Ethanol or ethyl alcohol, the main psychoactive ingredient in alcoholic beverages, results from the fermentation of sugar by yeast. The term "alcohol" is used, by extension, for alcoholic beverages. Alcohol is a sedative/hypnotic (a substance that reduces the functioning of the central nervous system with the capacity of relieving anxiety and inducing calmness and sleep).

Amphetamines. A class of synthetic substances which have a powerful stimulant effect on the central nervous system. Commonly used amphetamines include amphetamine, dextroamphetamine (or dexedrine), and methamphetamine (or methedrine). On the street, these substances are all often referred to as "speed". A more potent chemical form of methamphetamine, commonly known as "crystal" methamphetamine (also known as jib, ice, crystal, crank), has become more commonly available on the street in the last ten years.

Antidepressants. These are psychoactive agents which are prescribed for the treatment of depressive disorders. Three common types of antidepressants are 1) monoamine-oxidase inhibitors (MAO-inhibitors), 2) tricyclics, and 3) selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Paxil and Zoloft. These are also used for certain other conditions such as panic disorder.

Barbiturates. A group of central nervous system depressants, they are used to treat epilepsy and as anaesthetics, sedatives, hypnotics, and (less commonly) anti-anxiety medication.

Binge drinking. A pattern of heavy alcohol drinking that occurs in a limited period of time (usually defined as 5 or more standard drinks in a single session for men, 3 or more standard drinks in a single session for women). One standard drink is a can (350 ml) of beer, a glass (150 ml) of wine, or a shot (40 ml) of spirits.

Brief intervention. A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to stop or reduce the use of a psychoactive substance. It is designed for primary healthcare workers and is used mainly to assist in cessation of smoking and harmful use of alcohol.

Cannabis. Refers to all psychoactive substances derived from plants of the cannabis genus, which include marijuana leaf, hashish (dried sticky resin), and hashish oil (made by purifying hashish with a solvent). Cannabis products contain a number of psychoactive compounds known as cannabinoids, the best known of which is THC (delta-9-tetrahydrocannabinol).

Club drugs. Refers to substances associated with use by young people at dance clubs and parties. Although alcohol, tobacco, and cannabis are the most commonly used drugs in these settings, "club drugs" usually mean substances such as ecstasy, amphetamines, GHB, and ketamine.

Cocaine. This is a powerful central nervous system stimulant which is used non-medically to produce euphoria and wakefulness. Cocaine hydrochloride is a white powder which can be sniffed or dissolved in liquid and ingested orally or injected. Cocaine has a long history of use by many indigenous peoples of South America and is produced by processing the leaves of the coca plant (*Erythroxylum coca*). See also "crack".

Crack. This is a form of cocaine, produced by heating cocaine powder with baking soda. "Crack" refers to the crackling sound made when it is heated and smoked. It may also be injected. This form of cocaine produces a quicker and more intense "high", but the effects last only a short time (5-7 minutes).

Date-rape drug. See Rohypnol

Demand reduction. A general term to describe policies or programmes directed at reducing consumer demand for substances. It is applied primarily to illicit drugs, particularly with reference to educational, treatment, and rehabilitation strategies.

Dependence. Defined as a cluster of behavioural, cognitive (i.e. related to thinking or memory) and physiological experiences that may develop after repeated substance use. Dependence occurs when the individual taking the substance has a strong desire to take the substance and cannot control the desire or the use.

Early intervention. A strategy that combines early detection of problematic substance use and (if necessary) treatment of the individual. This pro-active approach is initiated by the health worker rather than the patient. As it aims to engage individuals before they develop physical dependence or major psychosocial problems, the treatment is often offered or provided before they are aware that their substance use may cause a problem. There is evidence that early and brief interventions, especially in primary healthcare settings, are effective in changing harmful alcohol use.

Ecstasy. This is the common street name for methylenedioxymethamphetamine (MDMA). It is a synthetic, psychoactive drug that is popular at raves and all-night dance parties for its mood-boosting and stimulating effect. It can cause feelings of empathy, wellbeing and euphoria along with some stimulatory effects and side-effects similar to amphetamines.

Harm reduction. A public health strategy that makes the reduction of potential harm the highest priority. It supports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence. As it is impossible to keep people from engaging in certain risky behaviours, harm reduction seeks to ensure that individuals are fully informed and provided with the means to make safer choices. Policies and practices are measured according to their actual impact in preventing and reducing harm. Success is not reflected primarily through a change in use rates but rather by a change in the rates of death, disease, crime, and suffering.

Harmful use. This refers to a pattern of substance use that causes damage to health, even with no dependence. The damage may be physical or mental. Social consequences alone are not sufficient to justify a diagnosis of harmful use.

Hazardous use. This refers to a pattern of substance use that increases the risk of harmful consequences for the user. The harm may be to physical and/or mental health. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by WHO but is not a diagnostic term in ICD-10. This is the most common pattern of substance use by young people.

Heroin. This was a brand name given to diacetylmorphine, a semi-synthetic opiate derived from morphine which is a constituent of the dried milk of the opium poppy plant. Heroin depresses the central nervous system, including reflex functions such as coughing, respiration, and heart rate. It also dilates the blood vessels (giving a feeling of warmth) and depresses bowel activity (resulting in constipation). Overdose can lead to coma and possible respiratory failure and is more likely if other depressant drugs, like alcohol, are used at the same time. There is an increased risk of hepatitis and HIV infection when heroin is used with unsterilized needles.

HIV (human immunodeficiency virus). The virus that causes AIDS (acquired immune deficiency syndrome). HIV is a lifelong infection. A positive HIV test does not mean a person has AIDS, but that HIV antibodies have been detected in their blood.

Inhalants. Volatile substances (i.e. they vaporize at room temperatures) which are inhaled for psychoactive effects.

LSD (lysergic acid diethylamide). This is a powerful hallucinogen. Although some psychologists and psychiatrists believe it may have therapeutic value, scientific research has been discontinued.

Methadone. This is a long-acting, synthetic (man-made) opiate which is used in the treatment of dependence on opioids.

Opiates. The group of substances derived from the opium poppy. The term opiate excludes synthetic opioids.

Opioids. A general term that includes all the substances derived from the opium poppy and all synthetically prepared opioid substances. Opiates and opioids are all central nervous system depressants and have the capacity to relieve pain, produce a sense of wellbeing, and (at higher doses) cause stupor, coma, and respiratory depression.

Overdose. The use of any drug in an amount that precipitates a crisis with adverse physical or mental effects. Deliberate overdose is a common means of suicide or attempted suicide, especially among young people. Accidental overdose occurs with injecting drug use, especially with young inexperienced injectors.

Polydrug use. This refers to the use of more than one psychoactive substance by an individual, all at the same time or sequentially, usually with the intention of enhancing the effect or counteracting the undesired effects of another substance.

Prevention. Action aimed at eradicating, eliminating, or minimizing the impact of disease and disability, or if these are not feasible, slowing the progress of disease and disability. There are four levels: 1) Primordial prevention - inhibiting the situations that increase the risk of substance use (e.g. by improving housing conditions, reducing child poverty); 2) Primary prevention - helping individuals and communities to take health-promoting actions and deal with the risks (e.g. training in effective socialization and decision-making skills, programmes to strengthen links to family, school and community); 3) Secondary prevention, which involves early detection and prompt intervention to prevent or minimize the impact of substance use (including early detection by school counsellors or home care workers); and 4) Tertiary prevention, which seeks to eliminate or reduce impairment, disability and harm (e.g. methadone replacement therapy).

Psychoactive substance use. The use of any substance that affects the way people see, hear, taste, smell, think, feel and behave. The use of psychoactive substances is an almost universal human cultural behaviour, and has been practised since the beginning of human history.

Rohypnol. The trade name for flunitrazepam, a benzodiazepine like valium (a central nervous system depressant with sedative-hypnotic effects that can be lethal when mixed with other depressants like alcohol). Much of the concern surrounding this drug is its use in drug-facilitated sexual assault, or “date-rape”. Rohypnol is a tasteless and odourless drug, and can be dissolved in drinks which mask its presence.

Second-hand smoke. This refers to a combination of two types of smoke: "mainstream" smoke which is exhaled by the person who smokes, and "sidestream" smoke which is released from the burning tobacco. Mainstream cigarette smoke is a mixture of over 4000 substances, 40 of which are known or suspected to be cancer-causing agents (carcinogens) in humans. Sidestream smoke contains all these same carcinogens, many of which are more concentrated because the lower temperature of a smouldering cigarette burns up fewer carcinogens. Cannabis, consumed in smoke form, also produces second-hand smoke, although it has not been studied as well.

Stimulants. A class of psychoactive substances that activates, enhances, or increases the activity of the central nervous system. Common stimulants include caffeine, nicotine, cocaine, amphetamines, and synthetic appetite suppressants.

Substitution programmes, replacement or maintenance therapy. The treatment of drug dependence by prescribing a dose of the drug or a substitute drug that suppresses withdrawal symptoms. The goals are to eliminate or reduce the use of a particular substance (especially if it is illegal), to reduce harm from a particular method of administration (such as injecting), or to reduce the health dangers and social consequences of drug use. Substitution programmes often offer other services, such as counselling and long-term follow-up.

Supply reduction. This is a general term to describe policies or programmes that aim to prevent production and intercept distribution of drugs, particularly by law enforcement strategies for reducing the supply of controlled substances.

Tolerance. Refers to a situation where a person requires a higher dose of a substance to get the same effect originally produced by a smaller dose. Different substances have different levels of tolerance attached to them. Tolerance develops for most substances - rapidly for some substances (e.g. heroin and associated substances) and less quickly for others (e.g. alcohol and benzodiazepines).

A complete list of alcohol and drug terms can be found at:
http://www.who.int/substance_abuse/terminology/who_lexicon/en/index.html

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Annex 1

Module schedule

Activities that are marked with * are optional activities which are not included in the 180 minutes planned for this module. The facilitators' decision to include the optional activities depends on the available time and whether these activities are covered in other modules in this workshop.

Sessions and activities	Time
Session 1 **Module introduction** ACTIVITY 1-1 Module objectives ACTIVITY 1-2 Spot checks	10 min
Session 2 **Young people and substance use**	50 min
ACTIVITY 2-1 Mini lecture: Meaning of "substance" ACTIVITY 2-2 Brainstorming: Locally used substances ACTIVITY 2-3	
Mini lecture by guest presenter: Local situation with young people and substance use *	10 min *
ACTIVITY 2-4 Mini lecture and brainstorming: Negative consequences of substance use for young people ACTIVITY 2-5 Group work: Reasons why young people use substances ACTIVITY 2-6 Mini lecture: Risk and protective factors ACTIVITY 2-7	
Group work: Risk and protective factors *	20 min *
ACTIVITY 2-8 Mini lecture: Patterns of substance use	
Session 3 **Assessment of young people for substance use and related difficulties**	30 min
ACTIVITY 3-1 Mini lecture: Assessment of young people for substance use ACTIVITY 3-2	
Group work: Listening skills and the health worker *	10 min *
ACTIVITY 3-3 Mini lecture: Listening skills and asking questions ACTIVITY 3-4 Mini lecture: The GATHER approach ACTIVITY 3-5 Role play: Using effective listening skills and GA(THER)	
Role play demonstration *	10 min *
ACTIVITY 3-6	
Individual exercise: Explore health worker attitudes and values on substance use *	20 min *

Sessions and activities	Time
Session 4 **The Stages of Change model**	30 min
ACTIVITY 4-1 Mini lecture: Stages of change	
ACTIVITY 4-2 Individual exercise: Understanding the process of change *	15 min *
ACTIVITY 4-3 Group work: Stages of change	
Session 5 **Health worker action with young substance users**	50 min
ACTIVITY 5-1 Mini lecture: The aims of health worker action	
ACTIVITY 5-2 Mini lecture: The (GA)THER approach	
ACTIVITY 5-3 Mini lecture: Action matched to each stage of change	
ACTIVITY 5-4 Role play: Action in the clinic using GATHER	
ACTIVITY 5-5 Mini lecture: Action in the community	
ACTIVITY 5-6 Mini lecture by guest presenter: Local substance use programmes for young people *	10 min *
Session 6 **Approaches to acute problems for young substance users** *	25 min *
ACTIVITY 6-1 Brainstorming: Acute problems *	
ACTIVITY 6-2 Individual and group work: Addressing the immediate needs of young people with acute problems *	10 min
Session 7 **Module review**	
ACTIVITY 7-1 Review of objectives	
ACTIVITY 7-2 Review of spot checks and Matters Arising Board	
ACTIVITY 7-3 OPPD	
ACTIVITY 7-4 Key messages from Module and closure	
180 min	**optional 120 min**

Annex 2

Spot checks

Sessions 1 and 7

SPOT CHECK 1

Name three protective and three risk factors for young people and substance use

Protective factors

Risk factors

SPOT CHECK 2

What are the three patterns of substance use for young people?

SPOT CHECK 3

What are the stages of change?

SPOT CHECK 4

What are the aims of health workers' actions with young substance users?

SPOT CHECK 5

Read each statement and tick the box that reflects your point of view

Statement	I agree	I disagree
There is no way of stopping young people from getting drunk - it is part of their growing up	○	○
As a health worker, I should ask all young people about the substances they use	○	○
Scaring young people is a good way to stop them from using substances	○	○
It is acceptable for boys to smoke cigarettes	○	○
It is acceptable for girls to smoke cigarettes	○	○
A drug addict is anyone who has ever injected drugs	○	○
Our health services should not waste money on treating young people who inject drugs	○	○
Girls and boys need to have information on substances so that they can make sensible choices	○	○
If I spend 5 minutes talking with a young person about substance use, I may make a difference	○	○
If a boy of 15 years came to me with an alcohol problem, I would need to tell his parents	○	○
Talking about substance use makes me uncomfortable	○	○
If I thought I had a problem with substance use, I would never discuss this with anyone	○	○

Annex 3

Understanding the process of change

Individual exercise

Session 4: ACTIVITY 4-2

The following exercise is to help you understand the process of change.

Through thinking of personal experiences, you will individually look at the phases of behaviour change and your needs at each stage.

The sequence of the questions can help you to understand the difficulty in changing and maintaining the outcome, and the reasons behind our refusing help at certain stages.

Questions 1 to 5 are about the stages of change and question 6 is about relapse.

Read through the questions individually, consider your feelings about the behaviour and briefly write down your responses. You will have 5 minutes to do this. Then there will be a short plenary discussion. Participants will not be asked to reveal the personal behaviour that they have considered (unless they wish to tell), but only their thoughts, reactions and feelings to the questions.

1) Think of something in your behaviour (e.g. eating, smoking, exercising, etc.) which people around you have asked you to change, but you don't think is important to change.
   a) What do you think of those who asked you to change?
   b) How do you react to them?

2) Think of something in your behaviour that you know you should change or that people are asking you to change, but you have not yet taken any steps towards change.
   a) Have you told anyone that you intend to change? Who?
   b) What do you think of those who ask you to change?
   c) How do you react to them?
   d) Why haven't you changed?

3) Think of something in your behaviour that you have decided to change but have not yet done so, or have not decided when you will do it.
   a) Have you told anyone that you intend to change? Who?
   b) What do you think of those who ask you to change?
   c) How do you react to them?
   d) What would make you move towards the change?

4) Think of something in your behaviour that you are now in the process of changing or have changed just recently.
   a) What is it that primarily made you change?
   b) How do you feel about the change?
   c) How easy is it to maintain the change?
   d) What challenges are there to maintaining the change?

5) Think of something in your behaviour that you have changed some time ago.
   a) How do you feel about the change?
   b) How easy is it to maintain the change?
   c) What are the challenges to maintaining the change?
   d) How do you cope with the change?

6) Think of something in your behaviour that you recently changed, but later something caused you to return to the previous behaviour.
   a) How do you feel about returning to the previous behaviour?
   b) What made you return to the previous behaviour?
   c) Did you try to resist?
   d) What were you thinking about at the moment you were returning to that behaviour?
   e) How did people who have known you before and after the change react? And how did you react to them?

Annex 4

Role play

Session 3: ACTIVITY 3-5

The purpose of this exercise is to use the following scenarios to practise effective listening skills and the G (Greet) and A (Assess) part of the GATHER approach in a role play situation.

You will be separated (counting 1, 2, 3) into groups of three (triads). All the 1s will be the young person, the 2s will be the health worker, and the 3s will be the observer. Each triad will be allocated a scenario.

The young person and the observer (1 and 3) should read the scenario that has been allocated to them.

The health workers (2) should not read the scenario but will find out the situation with their young person as the client, using listening and assessment skills. In this exercise, do not spend time discussing the presenting condition. Focus on Greeting and Assessment of the young person.

Stop the interview when you have completed the Greet and Assess parts.

The observer will watch and make notes. At the end of the exercise the three of you will discuss together what happened during the scenario.

Remember to come out of the roles at the end of the role play.

You have 2 minutes to prepare, 5 minutes for the interview, and 3 minutes to report back in your triad.

ROLE PLAY 1

Benni

You are a young man of 16 years living at home with your family. Your mother asked you to go to the health centre because you often complain of headaches before going to school.

If the health worker asks you, you say that you like to smoke cannabis with your friends and at the weekend you drink alcohol at parties. You were badly scared last weekend when you got drunk and had sex at a party with a girl in your class. You are concerned that you did not feel in control of what you did and are worried about what you may do another time. You also feel embarrassed to see the girl as you do not particularly like her. You did use a condom.

ROLE PLAY 2

Mohamoud

You are a young man of 18 years. You have come to the health centre because you have had a gash on your leg for two weeks that will not heal. Tell the health worker that the orderly has dressed the wound and does not think you need antibiotics. The orderly has sent you to see the health worker to check that this is the correct treatment.

If the health worker asks you, you can say that you ran away from home a year ago; since then, you have been living on the street with a group of friends. You find work as a casual labourer and are able to make enough money to support yourself. You snort (inhale) cocaine daily, you smoke cigarettes and cannabis, and you drink alcohol when you can afford it. Sometimes you cannot work because you are too slow and sleepy. If you don't use cocaine every day you feel bad. You injured your leg when you were high and have noticed that you are falling at work more often. You like sharing the pleasure of drugs with your friends but you dream of owning something one day (e.g. a cycle rickshaw or a motorbike or something else you can choose). At the moment you do not save any money but you would like to save some of the money that you spend on drugs. You did stop using cocaine for a month but it was hard.

ROLE PLAY 3

Chekkie

You are a young person (boy or girl) of 12 years. You have come to the health centre because you have had a cough for the last three weeks and you find it hard to breathe at night.

If the health worker asks you, you say that you have been smoking cigarettes for the last one year. You mostly take them from home where both your parents smoke. You think smoking makes you look cool and feel grown-up. You have friends who smoke. You do not have a boy/girl friend. You used to be good at sports (you choose which one) and wish you had continued. Now you find that you get too breathless.

ROLE PLAY 4

Shasta

You are a 15-year-old girl. You have come to the health centre because you feel that your breasts are too big. You think people are always looking at them and are hoping there is some medicine or operation you can have to make them smaller.

If the health worker asks you, you say that you have a boyfriend, Freddo who belongs to a gang. They all smoke cigarettes and cannabis, drink alcohol and hang out together. Freddo wants you to join in but you are afraid that smoking cannabis or drinking will make you crazy or want to have sex or something.

Your parents and your girl friends do not like Freddo or his gang.

Annex 5

Scenarios

Session 4: ACTIVITY 4-3

Session 5: ACTIVITY 5-4

Session 4: Activity 4-4

Group work: Stages of Change

In your group, look at your scenario and consider the following for presentation in plenary:

- Give a brief summary of the scenario.
- What is the pattern of use for each substance for this young person?
- What stage of change do you believe the young person is at with each substance?

You have 10 minutes to work in your group, and then one of you will give a 3-minute presentation.

Session 5: Activity 5-4

Role play: Action in the clinic

Interview using GATHER.

Sit in your group of three persons. Decide who will be the observer, the young person, and the health worker. If there is a participant who has not taken the role of a health worker, please give them this opportunity now.

You will be allocated a scenario. Go through the interview in your role play using the GATHER approach. Focus less on the G and A components this time, and more on the THER in identifying actions for this young person.

You have 2 minutes to prepare, 5 minutes for the interview, and 3 minutes to report back in your group. Remember to come out of your roles.

SCENARIO 1

Yasmine

Yasmine, an 18-year-old woman, has come to the health facility for a follow-up contraception visit. After discussing and meeting her contraceptive needs, you ask her about her family, her friends and work. She tells you that she has recently lost her job. After some discussion she tells you that she is often drunk or feels too ill to go to work. She also frequently injures herself or has arguments with her boyfriend when she is drunk.

She also complains of gastric pain most mornings, which prevents her from eating regular meals. She has recently realized that her alcohol use is a problem and she has been trying to reduce the amount and frequency of her drinking.

On further discussion, you find that she has been inhaling (snorting) cocaine at parties. In the morning after cocaine use she has often felt very ill and she says she wants to stop using it. She also tells you that she has been smoking about 30 cigarettes a day for about 2 years. She says she needs to smoke this number of cigarettes and does not see smoking as a problem.

SCENARIO 2

Hoang

Hoang, a 17-year-old man, comes to you with a genital ulcer and urethral discharge. As you begin to examine him closely, you realize that his eyes are bloodshot and he smells of cigarette smoke. When you have given him the treatment for his STI, he tells you that he smokes cannabis and tobacco. When you ask him about his cannabis use, he states that he smokes every weekend with his friends and has done so for over a year. However, he is thinking about giving it up because he had a bad fright the last time he was high. He thinks it would be hard to stop because getting high is something he likes to do with his friends.

He used to have a job after leaving school and could afford to smoke a pack of cigarettes a day. At that time he often had a bad cough. Now he cannot afford to buy cigarettes and he only smokes when they are given to him (about 3 a day). He has taken methamphetamine a couple of times with his friends. He liked the feeling and sees no problem with trying new substances occasionally.

SCENARIO 3

Samir

It is late in the evening and you are working in your hospital's casualty department. A young man is brought in with minor cuts on his face and arms. You attend to his cuts.

After a few questions you realize that he seems sleepy and his pupils are dilated. After some discussion, he tells you that he has been using heroin for about three years and smokes it every day. He got hurt earlier that evening when he was in a fight with some men over a drug deal. He says his family are very worried about his substance use and the troubles he gets into, but he says he has no desire to stop using heroin.

He said that a year ago he was drinking alcohol most evenings until he passed out once. After he lost his job, he managed to stop drinking. Now he has another job and wants to keep it. He says that now he only drinks alcohol with his friends at parties about once every few months.

Annex 6

Case studies

Session 6: ACTIVITY 6-2

SCENARIO 1

Tung

Tung, a 19-year old client whom you know well, staggers into your health centre. He smells very strongly of alcohol and is bleeding from a cut above his eye. You know him to be a pleasant young man who has been diagnosed with depression; however, he can become aggressive when intoxicated.

What would your immediate responses be?

SCENARIO 2

Nhat

Nhat, a 15-year old boy, comes running into your health centre. He starts screaming in the waiting room, "You are all out to kill me", "I know that the cameras are in my head taking pictures". He seems to be breathing fast and is very jittery, wide-eyed and staring. Because of this behaviour you believe you believe that he is possibly under the influence of methamphetamines. You have seen him in the centre once or two twice before. There is currently no one else in the room. As you approach him he picks up a chair and holds it above his head threatening you.

How would you respond?

SCENARIO 3

Ravi

The young people from your health centre are participating in a festival at a local park where there are ball games, activities and food. You notice that four of the young people have gone missing. You walk down to the river where you find them inhaling from a plastic bag. Three of the young people seem a little bit intoxicated but manageable; however, the fourth young person, Ravi, is quite unsteady on his feet and yells something about you spying on them and that he is going for a swim.

What would your immediate responses be?

SCENARIO 4

Young woman

You come across a young woman who is lying unconscious in the street near your health centre. There is a syringe beside her.

What would your immediate responses be?

Annex 7

Exploring your own attitudes and values on substance use

Our attitudes and values can be affected by many things - some are professional and some personal. Whatever you can do to clarify your values on substance use issues will help you to work with young substance users.

There are no objective data that can help you to assess your own attitudes and values regarding substance use. It is, however, important to review your thoughts on this topic because of the potential problems a lack of understanding in this area can create.

Our attitudes and values are formed over a period of time by the circumstances in which we are born and live, by the situations and people we encounter, and by the experiences from which we learn. The attitudes and values that we hold influence our view of other people's behaviour and our ability to provide professional and nonjudgemental care and support.

Health workers need to assess their own attitudes and values. This will enable them to provide the best possible care and to challenge the stigma and discrimination that substance users frequently have to deal with in society and in healthcare settings.

The following questions can help you explore your own attitudes and values on substance use. You can periodically ask yourself these questions to help clarify your thoughts on this subject.

Professional

- How important is it to ask your patients about their alcohol, smoking and substance use behaviours during a routine visit to the health centre?
- How much drinking is too much from your point of view?
- Is there really anything wrong with a 25-year-old using a little marijuana from time to time?
- How serious is smoking cigarettes for the health of a 17-year-old woman?
- How serious is smoking cigarettes for a pregnant woman?
- If a female patient drinks more than one drink a day, what health concerns would you have?
- How confident are you that you can help your young patient to change his/her substance use behaviour?
- How important is it for you to know all the street terms and all the characteristics of street drugs used by young people in order to really help a young substance user in your health centre?
- How important to your work with young people is personal contact with referral sources in your community?
- How serious a problem is substance use for young people in your community?

Personal

- What is different about the way you think about alcohol, tobacco, and other drugs compared to your parents?
- What effect do you think your childhood experiences have had on your current substance use patterns?
- How many drinks a day can you consume without creating health or social difficulties?
- How much can you smoke without creating health difficulties?
- Is it possible to use substances without causing harm to yourself, either socially or to your health?
- Do you have any personal alcohol, tobacco, or other substance-related behaviours that you would like to change?
- If the answer to the above question is yes, do you feel you know how to get help in your efforts to change?
- Would the fear of repercussions (professional, social, etc.) keep you from seeking help?
- If you had a colleague who was in trouble with alcohol or other substances, what would you do to help?
- How important an issue is substance use to you and your family?
- What is the worst thing that could happen to you in relation to your alcohol, tobacco or other drug use?
- What is the best thing that could happen to you in relation to your alcohol, tobacco or other substance use?

There are no "correct" answers to the above questions. If answered honestly, the answers reflect what is true for you. When you find that your opinion is out of step with the information presented in this module or with commonly accepted medical or social positions on substance use, it would be worthwhile to review the information and data concerning these issues.

We sometimes hold opinions that come from events in our lives, but these opinions may not be evidence-based and may involve a great deal of generalization. Challenging these opinions can have an enormous influence on our attitudes and values on these issues.

It takes courage to question and change an attitude that we have held for years, but these attitudes can hold us back from providing the best possible professional care and support. Through challenging our beliefs, we can stay open to current, correct and enlightened ideas.