Guidelines for CSOs on working with youth and children who use drugs in the Western Balkans

This publication has been created through the project ``Youth at Risk from Social Exclusion`` funded by European Union. European Union does not necessarily share the views presented in the publication.

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Content

EXECUTIVE SUMMARY

Drug use among children[1] and young people on the Balkans is becoming an increasingly visible problem calling for a serious approach and urgent response, on the part of professionals working on this issue as well as decision makers, towards introducing changes in the health and social protection system. Such changes, historically speaking, involve political will and funding. Therefore, the Guideline aims to serve as an initial point for realization of these changes. At present, it is of crucial importance for civil society organizations to train their teams well and create programs for children and youth who use drugs as soon as possible.

The Guide is primarily intended for civil society organizations working with people who use drugs, as well as professionals involved in the treatment and care of children who use drugs. It is designed to help your organisation and staff to feel safe in commencing this work, and to support you in thinking through the challenging situations and decisions that you face. In some cases, it may lead you to decide that you are not yet ready to go ahead with this work. However, it also offers guidelines for policy creation regarding treatment, harm reduction and care of children and young people who use drugs, and can be utilized by decision makers as well.

Legal and ethical aspects:

1. A successful help, care and treatment of children imply the involvement of parents and family. However, in certain cases family/guardian involvement or their consent would be impossible. According to experts from the National Treatment Agency for Substance Misuse, a child's decision not to inform the parent/guardian for asking assistance and help, when this is in the child's best interest, should be considered and treatment and care should be anonymous and confidential[2] National protocols should regulate this issue more thoroughly. With this tool we provide template which help you to develop your organizational policy regarding the issue of parental consent.
2. In cases when the child seeking treatment and care comes from a dysfunctional family, the team has to report the case to the Centre for Social Work, which then further assess whether the parents should lose custody and another guardian be appointed.
3. The children in need of hospitalization have to be provided with safe residential conditions. Hospitalization is 24-hour intensive medical, psychiatric and psychosocial care in residential environment. The duration of such treatments is usually from 6 to 14 days, i.e. as less as possible [3].
4. In children under 18 years, substitution treatment can be introduced only by a psychiatrist.
5. Children's programs should be separated from adult programs and should ensure that children have no contact with adult users

Civil society organizations can implement the following programs for children and youth who use drugs: harm reduction programs, treatment programs, programs for socialization and care. Of course, civil society organization can also implement other smaller programs, including counselling and educational activities, however, since such activities have the same objectives with the above mentioned programs, they won't be elaborated separately in the Guide but as part of the other programs.

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1 In accordance with Article 1 from the Convention on the Rights of the Child, in this text a child means every person below the age of eighteen years.

2 National Treatment Agency for Substance Misuse. Assessing young people for substance misuse. February 2007:8-20

3 Nesrin Diblas, Vincent Hendriks.Scrining and assessment. In: Young people and drugs Care and treatment. Pompidou Group 2006:103-131

FIRST CONTACT – ASSESMENT

Assessment should determine the severity of the addiction, risk factors, comorbidity mental disorders and related issues. Children and young people who use drugs should be refer to most appropriate program as soon as possible after assessment is finished.

INTEGRATED TREATMENT AND CARE PLAN

During admission, whether for a medical, psychosocial or combined treatment, the entire team develops a treatment and care plan, engaging the child, as well as the parents or carers if possible. The plan also includes whether and how the child would like the parents/carers/other family member to be involved in the treatment and care services.

The plan clearly defines which team member mentors the child and ensures the treatment and care is coordinated across the programs and organizations/institutions. The child and the individuals involved in the program are aware of the mentor's competences.

FUNCTIONAL SYSTEM FOR COOPERATION AND REFERRAL

For support of the treatment benefits, children and their parents/carers are referred to appropriate institution programs as well as local voluntary organizations, civil society organizations, peer groups, self-help groups, including culturally specific groups and organizations. A network of organizations and institutions working with children has to be created to this end.

TRANSFER FROM CHILD TO ADULT PROGRAM

Programs for children should be independent from those for adults and ensure no contact with adult users.

For children approaching the age limit of the program (for instance they are turning 18 and are transferring to an adult program) it is necessary to make a joint transfer plan to an adult program that will cover a six-month overlap. However, the transfer does not have to occur in those six months. Depending on the assessment, the team can decide that the person remains in the current program despite the age if this is to the person's best interest.

CLIENT ASSESSMENT OF THE PROGRAM

Children and their parents/carers are encouraged to give feedback on the program and their answers are reported back to them.

Client assessment of the program is systematically included in the work with children and their parents/carers.

ABBREVIATIONS

ADAD - Adolescent drug abuses diagnosis
ADHD - Attention deficit hyperactivity disorder
ADI - Adolescent diagnostic interview
AIDS - Acquired immunodeficiency syndrome
BBI - Blood born infections
CRC - Convention on the Rights of the Child
EMCDDA – European Monitoring Center for Drugs and Drug Abuse
GAIN - Global Aparisal of Individual Needs
HIV – Human immunodeficiency virus
LSFS - Law on Social and Family Services
MOH – Ministry of Health
PEI - Personal Experience Inventory
STI - Sexually transmitted infections
TEEN ASI - Teen Addiction Severity Index
UN – United Nation

GLOSSARY

Accountable - Accountability is to be responsible for the decisions you make and answerable for your actions.

Addictions - General term referring to the concept of tolerance and dependency. According to World Health Organisation addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use and exhibits determination to obtain the substance by almost any means.

Child safeguarding - An overall approach to child safeguarding is rooted in understanding the risks to children from the organisation, (its staff, programmes and operations) and addressing those risks with measures that create child-safe organisations.

Competence - The knowledge, skills, attitudes and ability to practise safely and effectively without the need for direct supervision.

Commorbidity - Two or more disorders or illnesses occur in the same person. They can occur one after the other or at the same time. Drug addiction or alcoholism and other mental illnesses are often comorbidity.

Dependence - State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. Physical dependence starts when cells of the body cannot function without a substance or drug. Physical dependence can happen with the chronic use of many drugs (including many prescription drugs)

Detoxification - A medically supervised intervention to resolve withdrawal symptoms. Usually it is combined with some psychosocial interventions for continued care. Detoxification could be provided as an inpatient as well as in a community-based outpatient programme.

Drug - Any psychoactive substance, i.e. a substance that, if taken in sufficient dose, can alter mental and physiological processes. Examples of drugs include alcohol, tobacco, illegal substances (i.e. those whose production, sale, or use is forbidden or limited under international and national drug control laws and treaties), volatile substances (gases, fumes from glues, aerosols and similar products), over-thecounter and prescription medicines and new psychoactive substances (e.g. "legal highs"). Drugs are also known as substances or compounds; illegal drugs are also known as controlled or illicit drugs. Note: Food is excluded from this definition.

Drug Treatment - Treatment comprising all structured interventions" specific pharmacological and/or psychosocial techniques aimed at reducing or abstaining from the use of illegal drugs. In the EMCDDA Treatment Demand Indicator Protocol (version 3.0, EMCDDA, 2012), the following definition is provided: an activity (activities) that directly targets people who have problems with their drug use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice. This activity often takes place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems.

Drug Use - The consumption of a drug for purposes other than prescribed medical treatment or scientific investigation. Drug use can be abstinent, infrequent (experimentation), occasional (e.g. less than weekly) or regular (e.g. at least once per week). According to the World Health Organisation, hazardous use describes a use pattern that increases the risk of harmful physical, mental and social consequences for users and their social environment (e.g. family, community), while harmful use describes a use pattern that is already damaging the mental or physical health of users and may have social consequences. Drug use is also known as drug/substance misuse/abuse. However, terms such as "misuse" or "abuse" can be considered judgemental if used to describe drug use in general; they are more suitable for referring to harmful use only

Evidence based - Decision making processes related to policy or practice having included a conscientious review and judicious integration of the best available research evidence, professional expertise and practical wisdom. When the term "evidence informed" or "evidence-based" is used, it should always be accompanied by a clear description of the nature of the evidence it speaks to.

Ethical Drug Prevention - Drug prevention work that is characterised by an ethical and lawful conduct of the provider and orientation towards participants" rights, autonomy and needs (e.g. positive outcomes without harms).

Harm Reduction - According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), harm reduction encompasses interventions, programs and policies that seek to reduce health, social and economic harms of drug use to individuals, communities and societies.

Injecting Drug Use - A process in which one or more psychoactive substance is injected directly into a body using a needle and syringe. Some of frequently used injection drugs are cocaine and heroin.

Methadone - A long-acting synthetic opioid medication that is effective in treating pain and opioid addiction. Methadone is the most commonly prescribed opioid substitution drug.

Opioid Substitution Treatment - This type of therapy supplies illicit drug user with a replacement drug. It usually takes place under the supervision in a clinical setting. Opioid substitution therapy often includes prescribed medicines such as methadone, buprenorphine or suboxone.

Problem Drug Use - The EMCDDA operationally defines problem drug use as "injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines". Most cohort studies on drug

users are conducted among problem drug users and in particular among problem opioid users. The problem drug use EMCDDA key indicator was recently revised and now focuses on a slightly broader concept, high-risk drug use.

Recreational Use - Use of a drug, usually an illicit drug, in sociable or relaxing circumstances, by implication without dependence or other problems. The term is disfavoured by those seeking to define all illicit drug use as a problem.

Rehabilitation - In the field of substance use, the process by which an individual with a substance use disorder achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification and medical and psychiatric treatment). It encompasses a variety of approaches including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or half-way house, vocational training and work experience. There is an expectation of social reintegration into the wider community.

Risk Factors and protective factors - According the World Health Organisation determinants can be positive or negative and they are often referred to as protective or risk factors. Risk factors can increase a person's chance for negative or socially undesirable outcomes (such as the tendency to violence, drug use, increase the chance of obtaining various kinds of diseases ...) Protective factors enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk. During childhood risk can be changed or prevented with school, family and community interventions.

Social Determinants of Health - The social and economic conditions that have an impact on the health of individuals, communities and jurisdictions as a whole and establish the extent to which a person can cope with challenges in life. The Public Health Agency of Canada names the following as determinants: income, social status, social support networks, education/literacy, employment, working conditions, social environments, housing, physical environments, personal health practices, healthy child development, biology, genetics, health services, gender and culture.

Therapeutic community - A structured environment in which individuals with psychoactive substance use disorders live in order to achieve rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from a dependence and are often geographically isolated. Therapeutic communities are characterized by a combination of "reality testing" (through confrontation of the individual's drug problem) and support for recovery from staff and peers.

Treatment Centre - Any agency that provides treatment to people with drug problems. Treatment centres can be based within structures that are medical or non-medical, governmental or non-governmental, public or private, specialised or non specialised. They include inpatient detoxification units, outpatient clinics, drug substitution programmes (maintenance or shorter-term), therapeutic communities, counselling and advice centres, street agencies, crisis centres, drug treatment programmes in prisons and special services for drug users within general health or social-care facilities.

Universal Prevention - In the context of drug prevention, activities that are targeted at groups with an overall average risk of drug use (adapted from Springer and Phillips, 2007). Often, such interventions will address the entire population within a setting (e.g. school, community, society). Universal prevention typically aims to prevent or delay the onset of drug use. Individuals or groups with an above-average risk of drug use are not singled out.

1.Introduction

Globally, the protection and care of children and young people who use drugs receives little attention. It is a controversial and often misunderstood issue and one that is severely underfunded. Global research[4] presents shocking figures and evidence of restrictive laws preventing young people from accessing harm reduction. Rarely are services developed with children under 18 in mind, and organisations often lack capacity to attend to this highly vulnerable group. Young people also report experiencing significant barriers to accessing harm reduction services when they are under 18 due to a number of factors, including staff attitudes and organisational policies and practices.[5]

Drug use among children[6] and young people on the Balkans is becoming an increasingly visible problem calling for a serious approach and urgent response, on the part of professionals working on this issue as well as decision makers, towards introducing changes in the health and social protection system. Such changes, historically speaking, involve political will and funding. Therefore, the Guideline aims to serve as an initial point for realization of these changes. At present, it is of crucial importance for civil society organizations to train their teams well and create programs for children and youth who use drugs as soon as possible, while the competent ministries in every state, mostly the Ministry of Health and the Ministry of Labour and Social Policies jointly work on opening programs for treatment and care of children who use drugs. Pursuant Article 33 from the Convention on the Rights of the Child the state shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances (UN, 1989).

The Guide is primarily intended for civil society organizations working with people who use drugs, as well as professionals involved in the treatment and care of children who use drugs. It is designed to help your organisation and staff to feel safe in commencing this work, and to support you in thinking through the challenging situations and decisions that you face. In some cases, it may lead you to decide that you are not yet ready to go ahead with this work. However, it also offers guidelines for policy creation regarding treatment, harm reduction and care of children who use drugs, and can be utilized by decision makers as well.

Children use drugs from different reasons and not all children become dependent. However, continuous drug use can interfere with a child's development, cause problems with family, friends and environment, legal involvement etc. Consequently, the programs have to cover a broad spectre of activities: starting with universal and selective prevention for specific groups and/or groups exposed to risk, early detection with a prompt intervention to short-term interventions, long-term interventions, subsequent care, reintegration and rehabilitation. Health and social risks for people addicted to drugs can be reduced with harm reduction services, evidence-based treatment, social care and reintegration. Civil society organizations can implement the following programs for children and youth who use drugs: harm reduction programs, treatment programs, programs for socialization and care. Of course, civil society organization can also implement other smaller programs, including counselling and educational activities, however, since such activities have the same objectives with the above mentioned programs, they won't be elaborated separately in the Guide but as part of the other programs.

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4 FHI (2010) Young people most at risk of HIV: a meeting report and discussion paper from the Interagency Youth Working Group, U.S. Agency for International Development, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Interagency Task Team on HIV and Young People, and FHI

5 Krug, A. et al (2015) "We don't need services. We have no problems": exploring the experiences of young people who inject drugs in accessing harm reduction services.J and AIDS Soc. 18

6 In accordance with Article 1 from the Convention on the Rights of the Child, in this text a child means every person below the age of eighteen years.

2. International Legal framework

With regard to international documents pertaining to drug use, children are not mentioned in the texts of the Single Convention on Narcotic Drugs of 30 March 1961 and the Convention on Psychotropic Substances of 21 February 1971 in the context of drug use and trafficking. However, in the second paragraph of the preamble to **the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances**, adopted in Vienna on 19 December 1988, the Parties express a deep concern regarding the fact that in many parts of the world, children are used as illegal consumers of drugs and for purpose of illegal production, distribution and sale of narcotic drugs and psychotropic substances, which entails a great danger.

The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances imposes an obligation on State Parties to ensure that their courts and other competent authorities which have jurisdiction, take into account the factual circumstances as particularly serious and aggravating, in the case of:

- victimization or use of minors;
- a criminal offense in connection with the drug being committed in the penal institution or an educational institution or social service facility or in their immediate vicinity or in other places to which school children and students resort for educational, sports and social activities;

Parties to the Convention are obliged to ensure that their courts or other competent authorities bear in mind the serious nature of the aforementioned circumstances when considering the possibility of early release or parole of persons convicted of such offences.

The key principles for working with children and young people are laid out in the **Convention on the Rights of the Child (CRC)**. The articles most relevant to working with children and young people who use drugs are highlighted below.[7]

Article 33: all appropriate measures to protect children from the illicit use of drugs should be taken. The definition of 'appropriate' is determined by a range of other articles from the CRC and as a result can be interpreted in different ways.

Article 3: The best interests of children must be the primary concern in making decisions that may affect them. When adults make decisions, they should think about how their decisions will affect children. The CRC does not provide a specific definition or set of criteria to determine 'best interest', leaving it open to subjective interpretation.

Article 5: The rights and responsibilities of families to direct and guide their children should be respected. Guidance provided by parents or legal guardians must be directed towards promoting respect for the rights of the child, and must respect the extent to which the child is capable of exercising their rights. However, this article can be applied wrongly, to control the decisions of a child or the actions taken on their behalf.

Article 12: When adults are making decisions that affect children, children have the

7 Fact Sheet: A summary of the rights under the Convention on the Rights of the Child. Available at: www.unicef.org/crc/ files/Rights_overview.pdf

right to say what they think should happen and have their opinions taken into account. The CRC implicitly acknowledges the evolving capacity of children and adolescents to make their own decisions based on their ability to consent to interventions such as medical services. However, different countries designate a range of ages (from 10 to 18) at which an adolescent is judged to have capacity. Adults also often have opinions about when a child is mature enough to make decisions based not on the child's capacity but on social expectations and culturally defined stages of development.

Article 24: Children have the right to the highest attainable standard of health. The UN Committee on the Rights of the Child has raised concerns about the lack of HIV prevention services for children and young people who inject drugs and has recommended the scale up of harm reduction programmes.[8]

UN Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules") point out that juveniles addicted to drugs in pre-trial detention may have special needs, and that medical and psychological assistance is extremely important for institutionalized juveniles, including those who are addicted to drugs.

In this regard, the **United Nations Rules for the Protection of Juveniles Deprived of their Liberty** (the Havana Rules) recommends that "juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programs, administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug – or alcohol-dependent juveniles".

Political Declaration of the United Nations and the Action Plan for international cooperation towards an integrated and balanced Strategy to combat the drug problem in the world[9] recognize that interventions aimed at reduction of drug abuse are too often aimed at the general population and usually with one standard approach, and do not provide specialized programs tailored to vulnerable groups with specific needs. The vulnerable groups primarily include children, adolescents and young people. In this regard, Member States are obliged to provide prevention programs that target and involve children and youth in order to increase their range and efficiency.

8 CRC (2003) General comment No.3 HIV/AIDS and the rights of the child. Available at: www.unicef.org/aids/files/UNHCHR_HIV_and_childrens_rights_2003.pdf

9 https://www.unodc.org/documents/ungass2016/V0984963-English.pdf

3. Legal Frameworka in Western Balkan

Children and youth who use drugs are not sufficiently presented in the legal framework in Western Balkan countries. However here is some examples from Kosovo, Macedonia and Montenegro. For more specific issue regarding legal framework in all Western Balkan countries please read the report - Arising support from understanding and bridging the gaps, published by Juventas.

KOSOVO

- Law on Public Health, adopted in 2007 by the Assembly of Kosovo provides, among other things, for added control and psychological care for youth to promote their integration into a healthy community, consultation regarding physical education in schools and for sports, and consulting with parents and teachers, in case of use of psychoactive substances, such as drugs, alcohol and smoking (Art. 34) Law on Public Health (2007)
- the Law on Social and Family Services (LSFS), adopted in 2005 and amended in 2011 by the Assembly of Kosovo, includes provisions for protection of children. The Law provides that in all matters concerning the provision of services to children and to families, the best interests of the child are the first and paramount consideration [Art. 9 (1)]. The LSFS delegates the competence to the Centre for Social Work to ensure the provision of social care and/or counselling in circumstances where, among others, a child is in need because: the child is without parental care; child's parents (because of psycho-social, addiction or other problems) have difficulty providing adequate levels of care; child is suffering from consequence of family conflict; or other form of social problem renders the child in need [Art. 9 (3)].
- Articles 33 and 34 of the Law on Narcotic Medicaments provide for treatment and curing of drug addiction. Drug-addiction is treated on the base of free will of the person or the legal custodian, or based on a court decision in Kosovo, and can be treated in all licensed health institution of Kosovo. The institutions that deal with treatment and rehabilitation of drug-addiction are obliged to present data for the cases to the National Institution of Public Health [Art. 33]. Moreover, the law provides that curing and social assistance to persons who suffer from drug-addiction should be organized by the Ministry of Health, Ministry of Labour and Social Welfare, Ministry of Internal Affairs and the Ministry of Culture, Youth, Sports [Art. 34].

REPUBLIC OF MACEDONIA

Children and youth who use psychoactive substances are recognized in very few documents issued by the Ministry of Labour and Social Policy (the National Strategy on Alleviation of Poverty and Social Exclusion in the Republic of Macedonia 2011-2021), however, no records are kept on this group. The group is also mentioned in the Law on Narcotic Drugs and Psychotropic Substances (Official Gazette of RM 103/2008), in the part describing the competences of certain ministries, and there is also a mention on the necessity for protection and education of this category of children and youth. The National Drugs Strategy of the Republic of Macedonia (MoH 2014) refers to them in the section on decreasing the demand for drugs, which also prescribes prevention measures, early detection and counselling.

MONTENEGRO

The Law on Education of Children with Special Educational Needs, Rulebook on the manner, conditions and procedures for orientation of children with special educational needs and the Rulebook on detailed conditions for the provision and use of services, norms and the minimum standards of services for children and youth in an institution and a small community group, included in their provisions the children and youth who use drugs. The competent institutions are: the Ministry of Education, primary and secondary schools in Montenegro and the Centre for Children and Youth "Ljubović".

Health care is regulated by: the Law on Health Care, Law on Health Insurance, Law on the Prevention of Drug Abuse and the Law on Protection and Rights of the Mentally Ill, and the Rulebook on detailed conditions for the provision and use of services, norms and the minimum standards of services for children and youth in an institution and a small group community. In addition, Mental Health Improvement Strategy and Strategy for the Prevention of Drug Abuse 2013-2020 stand out. The health policy relevant for this group has been developed and implemented by: Ministry of Health, Ministry of Justice, Institute for Execution of Criminal Sanctions, and health institutions of primary, secondary and tertiary health care.

As regards the field of social protection, children and young people who use drugs are directly included in the following legislation: Law on Social and Child Protection and Rulebook on detailed conditions for the provision and use, norms and the minimum standards of advisory-therapeutic and socio-educational services. The institutional framework consists of: Ministry of Labor and Social Welfare, social work centers, Institute for Execution of Criminal Sanctions and Center for Children and Youth "Ljubović".

The legal framework in the field of labor and employment does not contain norms that directly regulate a position of this category. The institutional framework consists of: Ministry of Labor and Social Welfare, social work centers and Employment Agency of Montenegro.

Criminal Code, Law on the execution of imprisonment, fines and security measures, Law on the Treatment of Juveniles in Criminal Proceedings and the Law on Protection from Domestic Violence contain norms that are directly related to children and youth who use drugs. The institutional framework consists of: Ministry of Justice, Ministry of Interior, Institute for Execution of Criminal Sanctions, the Center for Children and Youth "Ljubović" and social work centers.

4. General principles and values, code of conduct

The Guidelines refer to all types of programs: harm reduction programs, treatment programs, as well as resocialization and rehabilitation programs. Ideally, the programs should complement each other in order to provide as many services as possible in one place. Furthermore, establishing a functional system of cooperation and referral is also crucial.

A. Principles_

The basic principles to be adhered in programs for children and young people who use drugs are the following:

1. Specificity – aiming towards children's/youth needs.

Programs should respond to the specific needs of children according to their age and maturity, alleviate access to services and include the parents/guardians in the treatment.

The needs of many children imply offering drug-specific and age-specific services. It means that you cannot provide the same outreach work with people who inject heroin and with people who takes amphetamines. It is completely different scene with different needs and approach. Be child-specific, separated from adult programs, i.e. ensure that young people have no contact with adult users from adult programs[10]

2. Comprehensiveness

Comprehensiveness is crucial, hence for an optimal response to children's needs an entire spectre of drug-related interventions is required (drug education, prevention, harm reduction and treatment).

3. Competency

The provision of children with medication treatments is guarded by complex legal and ethical issues. Service providers must be aware of the legal requirements, the protection of children's' rights, confidentiality procedures and other issues. The staff must be competent to work with children and have access to the relevant expertise regarding substance use [11].

4. Flexibility

Flexibility in treatment and care of children who use drugs is crucial. Namely, intervention and care services should not be offered only in treatment centres but rather at home, outreach, drop in centres, youth centres etc. [12]

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10 Brighton and Hove Community Safety Partnership, Independent Drugs Commission Report for Brighton and Hove. April 2013: 19

11 Department of health and children. Report of the Working Group on the treatment of under 18 year olds. Presenting to treatment services with serious drug problems..September 2005: 1-5

12 Dekov V, Ignjatova L, Guide for treatment and care of children who use drugs, 2014:12

B. Legal and ethical aspects:

5. A successful help, care and treatment of children imply the involvement of parents and family. However, in certain cases family/guardian involvement or their consent would be impossible. According to experts from the National Treatment Agency for Substance Misuse, a child's decision not to inform the parent/guardian for asking assistance and help, when this is in the child's best interest, should be considered and treatment and care should be anonymous and confidential[13]. National protocols should regulate this issue more thoroughly. With this tool we provide template which help you to develop your organizational policy regarding the issue of parental consent.

6. In cases when the child seeking treatment and care comes from a dysfunctional family, the team has to report the case to the Centre for Social Work, which then further assess whether the parents should lose custody and another guardian be appointed.

7. The children in need of hospitalization have to be provided with safe residential conditions. Hospitalization is 24-hour intensive medical, psychiatric and psychosocial care in residential environment. The duration of such treatments is usually from 6 to 14 days, i.e. as less as possible.[14]

8. In children under 18 years, substitution treatment can be introduced only by a psychiatrist.

9. Children's programs should be separated from adult programs and should ensure that children have no contact with adult users

> If, as is in many jurisdictions, you face legal or regulatory obstacles in this work you will need to carefully consider what risks you are prepared to take as an organisation. For example, if there are age restrictions, some organisations provide services without asking for age, but the risks of this should be carefully considered.
>
> Hiding ages can restrict your ability to collect accurate data on the situation of under 18. It may mean you are not able to respond appropriately if you don't know age and it can cause issues if you need to make a referral. In some contexts working with law enforcement can also help to reduce the restrictions or risks facing organisations. In others, official authorisation may be needed for working with or even approaching young people. In one NGO, where there was considerable fear that distribution of needles and syringes to people aged under 18 could cause funding problems, a decision was made to have any informal policy to continue distribution in ways that could be hidden from regulators.

13 National Treatment Agency for Substance Misuse. Assessing young people for substance misuse. February 2007:8-20

14 Nesrin Diblas, Vincent Hendriks.Scrining and assessment. In: Young people and drugs Care and treatment. Pompidou Group 2006:103-131

C. Weighing risks versus benefits when deciding to provide services to children and young people who use drugs

Before starting to work with children and young people who use drugs it will be useful to weighing the risks and benefits of that kind of work and to create your organizational policy

The following questions will help you to develop a specific policy for your work with children and young people who use drugs.

Instructions

Read out the questions below and discuss as a group

- » Do participants think that the organisation's response to children and young people who use drugs has been adequate and appropriate to date?
- » What risks do we take by not providing them with services?
- » Are there legal/regulatory restrictions on our work that may prevent us helping children and young people who use drugs?
- » Do the risks for children and young people who use drugs outweigh the risks for the organisation in engaging with them? (A consensus building approach should be used to ensure all participants feel comfortable with the policy decision)
- » Are we risking the funding of the organisation or alliances we have built with health authorities, police, etc? What are the risks for the organization? (Aids Alliance, 2015)[15]

Working through the above questions will illustrate your organisation's feelings towards working with children and young people, given the potential implications you face.

If you agreed that you are prepared to work with children and young people, the remaining steps will help you to develop a formal policy and program for this work, which should be accompanied by relevant training and code of conduct/ standard operating procedures for staff and volunteers.

D. Code of conduct

There are different models of code of conduct. We propose that every organization develops their own code of conduct based on the local context, organizational capacity and best practice. During developing your own Code of conduct please use exercise given as Annex 1 and try to include most of statements given below taken from the Code of conduct of Healthcare Support workers and Social care workers in England.

1. Be accountable by making sure you can answer for your actions

This section of the code requires you to recognise and be honest about your limitations. You should always be able to justify what you do and don't do. You should ask for help as soon as you need it and tell your employer about any issues that might affect your ability to do the job. Maintain professional boundaries and behave appropriately at all times.

15 Aids Alliance, Step by Step , A tool for harm reduction service providers, 2015:15

2. Promote and uphold the privacy, dignity, rights, health and wellbeing of service users and their carers at all times

Always act in the best interest of service users, treating them with respect and maintaining their dignity. Promote their independence wherever possible and challenge and report any dangerous, abusive, discriminatory or exploitative behaviour.

3. Work in collaboration with your colleagues to ensure the delivery of high quality, safe and compassionate care and support

You should respect your colleagues, be honest and open with them and make sure you are a reliable and trustworthy member of the team.

4. Communicate in an open and effective way to promote the health, safety and wellbeing of service users and their carers

Make sure you communicate effectively with service users and with colleagues, by being straightforward, accurate and respecting confidentiality wherever relevant. Maintain clear and accurate records.

5. Respect a person's right to confidentiality

Treat all information about service users as confidential. Seek guidance from senior members of staff if any disclosure issues arise.

6. Strive to improve the quality of your care and support through continued professional development.

Undertake continued professional development training and education in line with the competencies you require to do your job well, all with the input of your supervisor. Maintain up-to-date records of your training and, if appropriate, contribute to the learning and development of others.

7. Uphold and promote equality, diversity and inclusion

Finally, as a care worker, you should respect individuals. Promote equal opportunities for your service users and do not discriminate against anyone.[16]

One of the most important questions working with children and young people who use drugs is confidentiality.

While it is important to recognise the right to confidentiality of a child, there are times where the risk of harm faced by a child is significant enough to breech confidentiality. The 'need to know' principle distinguishes when sharing information without the consent of the child would be an unwarranted breach of confidentiality and when it would be warranted.

Decisions such as these may put significant stress on staff, who may feel guilty about betraying the trust of a child. It is important to have a clear policy statement so that staff members know what is required of them and feel that they are acting in the best interest of the child.

16 Keep Children Save, Child safeguarding standards and how to implement them, 2014:2

Children must also be informed in advance about the boundaries of confidentiality and in what situations you would have to disclose information they share. This process can be made much easier if there is a clear reporting process in place. It is important to remember that the principle of best interest of the child should be paramount when deciding what action to take.

There are a number of principles that should be considered when developing code of conduct related to children and young people who use drugs

Principles of harm reduction

If you provide harm reduction program for children and young people who use drugs then the next principles should be part of your organizational policy.

Pragmatism: As harm reduction practitioners, we accept that drug use is a common feature of the human experience. We acknowledge that, while carrying risks, drug use also provides the user with benefits that must be taken into account if drug using behaviour is to be understood. From a community perspective, containing and reducing drug-related harms may be more pragmatic or possible than eliminating drug use entirely.

Humanistic values: In respecting the rights and dignity of the drug user, harm reduction practitioners accept the decision to use drugs as fact. While that doesn't mean we approve of their drug use, it does mean that no moralistic judgment should be made either to condemn or to support their use of drugs.

Focus on harms: The nature of a person's drug use per se is of secondary importance to the risk of harm that comes from use, including health, social, or economic harms that affect the individual, the community and society as a whole. Therefore, as practitioners our first priority should be to decrease the negative consequences of drug use to the user and to others rather than trying to decrease the drug use itself. Abstinence should not be automatically regarded as the long-term goal of treatment; in some cases reducing the level of use may be the most effective form of harm reduction.

Balancing costs and benefits: Some pragmatic process of identifying, measuring, and assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of intervention is carried out in order to focus resources on priority issues. The framework of analysis extends beyond the immediate interests of users to include broader community and societal interests.

Priority of immediate goals: Most harm-reduction programs have a hierarchy of goals, with the immediate focus on proactively engaging individuals, target groups and communities to address their most pressing needs. Achieving the most immediate and realistic goals is usually viewed as first steps toward risk-free use, or, if appropriate, abstinence.[17]

Principle of Participation in service development and delivery by children for children

Services and organisations seeking to serve children and young people should ensure their meaningful participation in all decision-making processes.

17 Aids Alliance, Step by Step , A tool for harm reduction service providers, 2015:38

Principle of Recognition of gender and power relations

A key principle is the recognition that power (or lack of power) impacts on the lives of children and young people. Gender and age also amplify power imbalances. For example, even when girls and women have the knowledge and the will to avoid HIV transmission, negotiating condom use can put them at risk of violence from male sexual partners. Many people at risk are in situations where they do not have power over what happens in their lives.

For people who inject drugs, the decision not to share injecting equipment, or to share less often, cannot always be made objectively. Addiction is a powerful force and exerts a high level of control over people. The immediate need for the drug and the need to avoid arrest are often more powerful forces than the need to avoid HIV infection and to stay healthy. Young people, in particular, are rarely in a position to exert control over their lives [18]

From the template created through this tool, extract your principles and code of conduct and display them as a reminder of how you will work .

E. Safe guarding

Child safeguarding is the responsibility that organisations have to make sure their staff, operations, and programmes do no harm to children, that they do not expose children to the risk of harm and abuse, and that any concerns the organisation has about children's safety within the communities in which they work, are reported to the appropriate authorities. "Do no harm" is a principle that has been used in the humanitarian sector but can equally be applied to the development field. It refers to organisations' responsibility to minimise the harm they may be doing inadvertently as a result of their organisational activities.

Child safeguarding: An overall approach to child safeguarding is rooted in understanding the risks to children from the organisation, (its staff, programmes and operations) and addressing those risks with measures that create child-safe organisations.
Acknowledging risks and implementing measures to address them is fundamental to organisations' strategies and governance. The more this is recognised, the more risks can be prevented.
To achieve this, your organisation needs to consider:

- Where, when and how your organisation affects children and what risks this presents?
- What policies and procedures are needed to prevent harm and how to respond to concerns appropriately?
- Who is the appropriate designated person/s to act as the focal point in an organisation to receive and manage any safeguarding concerns and subsequent inquiry/investigation?
- What safeguarding induction and training is needed to ensure staff know what the organisation expects of them and what to do if they have a concern?
- A clear code of conduct so that all staff understand their professional boundaries when working with children and what is and is not acceptable behaviour
- How to recruit safely?

However, even with the most robust child safeguarding policies and procedures, abuse may still take place from within your organisation. At that point, it is how your organisation responds that is crucial for the child and for the organisation.[19]

For further guidance on safeguarding standards see the toolkit Child Safeguarding Standards and how to implement them.

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18 ibid

19 Keep Children Save, Child Safeguarding Standards and how to implement them 2014,3-4

5.Types of services to be provided by CSOs for children and youth who use drugs, procedures and guidelines

Civil society organizations can implement the following programs for children and youth who use drugs: harm reduction programs, treatment programs, programs for socialization and care. Of course, civil society organization can also implement other smaller programs, including counselling and educational activities, however, since such activities have the same objectives with the above mentioned programs, they won't be elaborated separately in the Guide but as part of the other programs. In order to avoid repeating all types of programs further in the text, the term programs and treatment and care shall refer to all three types of programs: harm reduction, treatment and care and socialization programs, unless otherwise defined.

First Contact - Assessment

Assessment is the process of defining the nature of the problem and developing specific treatment and care recommendations towards solving the problem. It is a comprehensive process encompassing a broad spectre of bio-psychosocial components. Assessment implies clinical examinations of the child's condition and functioning, as well as numerous tests (written and oral), exercises.

The assessment data involves three categories - family, substance use and mental state.

Family – information on: domestic violence, history of trauma, psychological status, legal involvement, financial situation, health, education, housing status, employment.

Substance use – age of first use, substance used and manner, substance misuse treatment and family history of addiction.

Mental state – family history of mental health problems, client history of mental health problems including diagnoses, hospitalization or other treatments, current symptoms and mental status, use of medication and medication adherence.

Comprehensive assessment model

Assessment should determine the severity of the addiction, risk factors, comorbidity mental disorders and related issues.

The recommended methods are: interviews and self-administered questionnaires, observation and laboratory tests.

Relevant sources of information during assessment are considered to be: parents, teachers, peers, adult friends, school representatives, lawyers, social workers, experts involved in previous assessments or treatments, i.e. familiar with the child's situation etc. Written reports or school records, records from institutions where the child was previously treated, as well as juvenile prisons can also be useful. In order to decrease or eliminate any possibility for inaccurate assessment, assessors have to resort to different sources of information. Consequently, assessment and diagnoses should be based on several sources of information in order to develop an appropriately matched treatment plan.

It is not common for children to seek help regarding drug use on their own initiative or voluntarily, rather they are forced to visit the services mostly by their parents. Consequently, children oftentimes deny or minimize the drug issue or manifest resistance in first contact with therapists, institutions, treatment etc. In such cases, assessment begins firstly with approaching the adolescent's denial, minimization and resistance.

A comprehensive assessment aims to:

1. Identify children in need of treatment and care;
2. Determine substance use or addiction, degree of addiction and the specific needs of the child;
3. Learn more of the nature, relationship and consequences related to drug use;
4. Identify problems related to the medical status, mental status, social functioning, family relationships, academic achievement, problematic behaviour
5. Examine the possibility and family's readiness to participate in the assessment and possible interventions;
6. Identify the specific strengths of the child, the family and other types of social support that can be included in the treatment and care planning;
7. Write a report in order to:
    - » Identify and correctly diagnose the severity of the substance use;
    - » Identify factors leading to substance use disorder;
    - » Plan treatment;
    - » Provide details in order to ensure implementation and adherence to the treatment plan until its finalization;
8. Recommend referral to other programs treating addiction and other related issues.

Depending on the stage of drug use, experts should undertake the appropriate intervention. The suggested interventions for each stage are thoroughly explained in Annex 1.

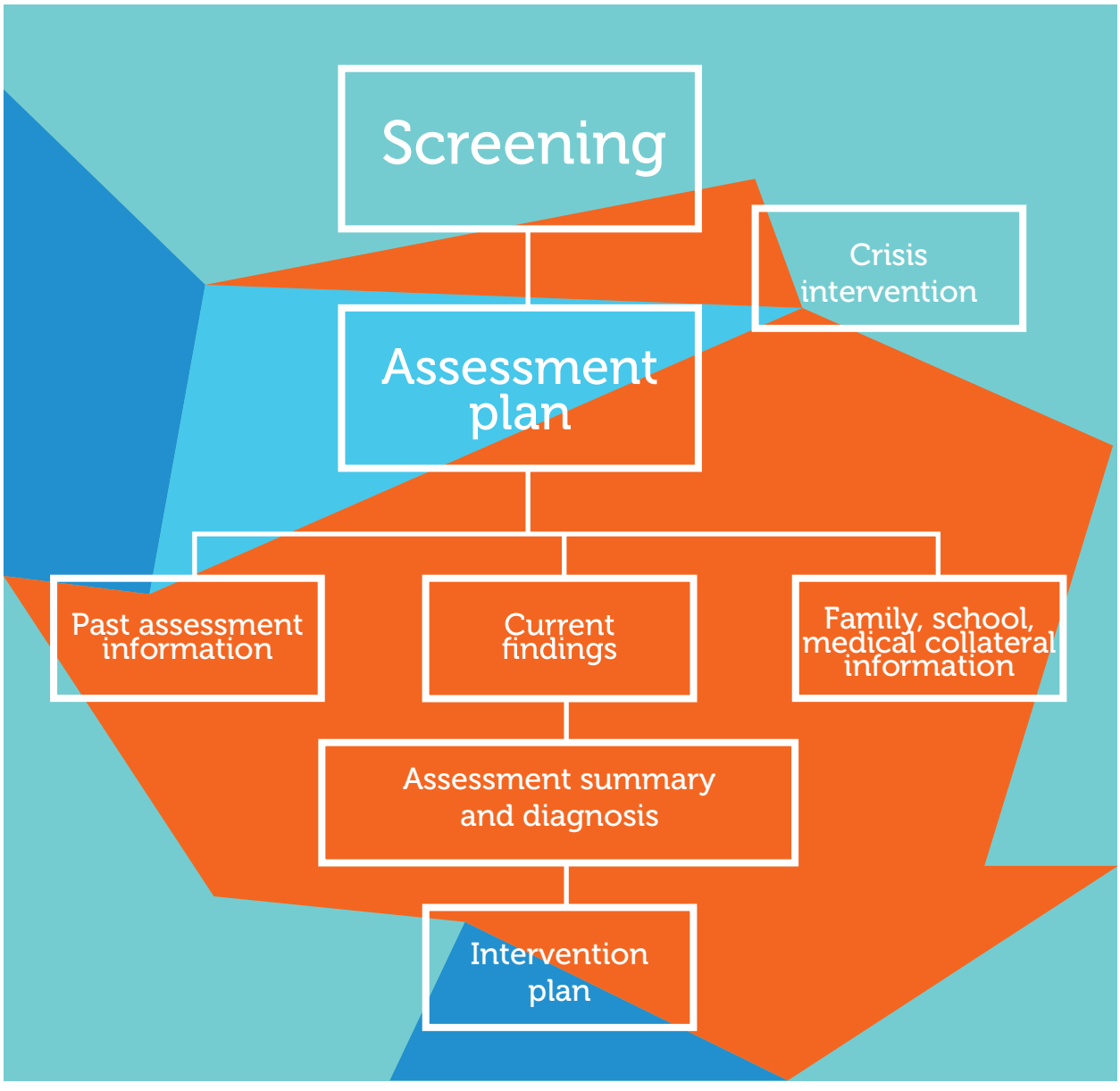
Professionals involved in the assessment

Assessors are trained professionals such as: psychiatrists, psychologists, social workers, health workers and outreach workers experienced in working with children and youth who use drugs. One person is responsible for gathering and interpreting the assessment data. The assessor is involved from the very beginning of the assessment to the finalization of the plan and participates in planning the assistance, care and treatment activities. The assessor ensures that the child receives all necessary services.

The instruments (questionnaires and interviews) applied in the assessment are the following:

- » Teen ASI (Theen Addiction Severity Index; Kaminer et al.1989;1991;1993);
- » ADAD (Adolescent Drug Abuses Diagnosis, Frideman & Utada. 1989);
- » PEI (Personal Experience Inventory, Winters & Henly. 1989);
- » GAIN (Global Aparisal of Individual Needs, Dennis. 1998, 2000, 2003);
- » ADI (Adolescent Diagnostic Inerview, Winters & Henly. 1993) etc. (Nesrin Diblas, Vincent Hendriks. 2006).[20]

20 Nesrin Diblas, Vincent Hendriks.Scrining and assessment. In: Young people and drugs Care and treatment. Pompidou Group 2006:103-131



Graph 1. Screening and Assessment (source: Council of Europe, Young People and Drugs, Care and Treatment. 2006: 113)

Harm reduction programs

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), harm reduction encompasses interventions, programs and policies that seek to reduce health, social and economic harms of drug use to individuals, communities and societies.[21]

The harm reduction concept is a daily part of urban living (e.g. age information on toys in order to prevent suffocation if a part of the toy is swallowed, traffic signs, etc.)
The harm reduction concept applied to the drug use issue implies assisting users who do not wish or cannot quit drug use, in recent years also including the entire user population. Furthermore, the concept treats this issue not only as a health, but also, or even more, as a socio-cultural phenomenon.

21 http://www.emcdda.europa.eu/topics/harm-reduction_en

Harm reduction is based on services and assistance organized according to the so-called low threshold and services under one roof, seeking to improve users' health and social state through:

» Outreach work
» Needle exchange
» Methadone treatment
» Urgent medical care
» Social services

Harm reduction programs do not exclude abstinence.

Activities
Harm reduction programs should provide following activities

A. Needle exchange services
» Free distribution of sterile needles, syringes, cookers, cotton, distilled water, alcohol wipes and vitamin C, making sure the used equipment is collected.

B. Informing and educating users on:
» Drug types and harmful consequences;
» Safe injecting and safe sex;
» Blood born and sexually transmitted diseases.

C. Crisis interventions
» First aid;
» Admission to a health institution.

D. Health care
» Providing general medical care (dressing, abscess treatment etc.);
» Counselling on how to maintain good health.
» Methadone maintenance;

E. Social services and counselling
   a. Offering services that would ensure the practice of social rights;
   b. Assistance in applying for different personal documentation;
   c. Referral and admittance in appropriate institutions;
   d. Offering employment information etc.;
   e. Conversations with the family.

F. Motivating users to seek employment and acquire skills
» Attending workshops;
» Motivate users to graduate or enrol at different skill courses;
» Engage users in specific projects.

Outreach work

The Guide offers a summary of outreach principles and experiences in practice with drug users. It is intended for people who work on developing, implementing and providing HIV protection and health education among drug users.

Promoting a healthy behaviour

Outreach work is a method of health education and offering services. Similar to any health intervention it seeks to promote health behaviour in the following three manners:

- Increasing awareness on health risks;
- Encouraging changes that imply stopping the risky behaviour;
- Maintaining positive changes in behaviour.

It is important to stress that outreach work as a method is complementary with other methods on health and social interventions. Outreach does not replace, duplicate or negate the need for other existing intervention methods but is an addition to them. This method does not offer a simple solution to issues related to encouraging changes in behaviour.

Outreach work seeks to approach target groups, in the specific case children and youth who use drugs. While most intervention methods are institutional and rely on individuals seeking help, outreach work implies contacting target groups outside institutions. When applying this method individuals are not expected to seek help themselves after they have acknowledged health and drug use problems, rather they are approached directly in the community, i.e. where they live, in order to be educated and offered the required services. Consequently, the method can be applied to intervene in the beginning stages of drug use, before usage become harder. Outreach work in HIV context is defined as:

"Community-based activity seeking to promote health and reduce the risk for HIV infection among individuals or groups neglected by other available methods and services."

Outreach work and behaviour changes

The main reason for reaching the "hidden" population of drug users is to encourage changes towards healthier behaviour in them. This can be achieved in two ways:

- Through education and providing prevention materials (sterile ejecting equipment) directly to the community;
- Referral to institutions for drug addiction treatment and institutions that can provide assistance.

These activities are always complementary. Hence, behaviour changes are encouraged:

- **Directly** in the community, through health education and prevention;
- **Indirectly**, when individuals contact institutions.

Types of outreach work

The general rule is, the bigger the number of outreach strategies applied in local settings, the larger the chances for reaching and offering different services to the target population. Therefore, it is very important to determine which type of outreach work will have the biggest effect, or to select a combination of outreach strategies.

There are three types of outreach work:

- Detached approach;
- Domiciliary approach;
- Peripatetic approach.

The detached approach_is undertaken outside institutions, i.e. on the streets, bars, clubs, shooting galleries, train stations etc.

The domiciliary approach is undertaken in homes of children and young people who use drugs. In regions without a street drug scene, users can be reached only at their own or other people's homes where they meet.

Peripatetic approach is undertaken at different institutional forms within the community or at organizations, such as: prisons, hostels, brothels, schools, student dormitories, harm reduction drop in centres etc. This approach, as opposed to the previous two, does not target individuals but institutions/organizations where the target population can be reached. The focus here is placed on widening the circle of people who need to hear the message of health education, as well as on training the personnel in the institutions and organizations in order to be able to educate their clients.

In practice, outreach teams mostly apply a combination of two or all three types of outreach work. The balance between the types is determined according to the local situation.

Types of outreach activities:

- Condom distribution;
- Distribution of injecting equipment;
- Distribution of health behaviour educational materials;
- Distribution of self-help literature;
- Offering information on certain services and referral (e.g. on the types of treatment and centres where the treatments are available, or referral to the appropriate Centres for Social Work in order for the users to practice their social rights etc.);
- General health examination on the spot, examination for sexually transmitted infections;
- Testing for HIV and other blood born and sexually transmitted infections;
- Counselling on HIV and other BBI and STI.

Outreach Teams

There are several possibilities regarding the outreach teams, and the outreach worker being the key factor in each on. This could be an active user, former user or simply a person who is familiar with the scene. The other team members are usually a social worker and medical person or only one of those two, depending on the needs of the user population and the type of activities to be implemented.

Key moments to be aware of when engaging outreach staff to work with children and youth who use drugs are: outreach workers should be young, communicative, reliable, respected and have authority among the children and youth who use drugs, and should have understanding for the problems drug users encounter. It is recommended that outreach teams are a combination of personnel which is part of the community or have an equal status – (active or former users) and of professionals experienced in working within the community.

Treatment programs

Depending on the staff engaged in the treatment programs, the treatment models are divided into:

1. Programs without a specialist (a child/adolescent mental health specialist or specialist in addiction);
2. Programs with one specialist: (a child/adolescent mental health specialist or a specialist in addiction);
3. Programs with specialists from the two fields, i.e. multidisciplinary teams with a specialist in adolescent addiction;
4. Programs with specialists from the two fields, a child/adolescent mental health specialist and addiction specialist, with capacity for short, but intensive treatments, for instance in-patient or day hospital treatment.

Close cooperation within the four treatment models for children who use drugs is of utmost importance in this entire structure. Children will progress through different levels, depending on their state and the treatment needed[22].

According to the environment and type of treatment, treatment programs are divided into:

- Outpatient treatment programs and In-patient/residential treatment programs.
- Outpatient treatment programs include day approach and do not consider night care
- Residential program is 24 hour intensive medical, psychiatric and psychological care implemented in residential settings

These programs offer:

- Detoxification, usually from 6 to 14 days with 24-hour intensive medical and psychological care;
- Psychosocial rehabilitation and social reintegration, as a therapeutic community intended mostly for children with several issues, where treatment duration can last from 3 to 18 months;
- Use of medication in treatment (substitution therapy, antidepressants, psychostabilizers, psychomotor stimulants);
- Continuing Care programs. The end of treatment also implies a high risk of recidivism, hence the need for continuing care after every treatment. Such programs are self-help groups, personal development groups, groups for prevention of recidivism, AAand NA groups (alcohol or narcotics anonymous), professional and personal development groups, housing programs etc.[23].

Psychosocial Treatment

Psychosocial interventions in substance use/dependence treatments in children are crucial. Support in overcoming problems is particularly significant at this age. Consequently, regardless whether the psychosocial treatment is combined with a pharmacological treatment or is exclusive, it has to cover a broad range of interventions towards dealing with dependence and related problems, from cognitive behavioural therapy, systemic, family therapy and therapy for conflict resolution to a creative and occupational therapy for acquiring skills and knowledge.

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22 Department of health and children. Report of the Working Group on the treatment of under 18 year olds. Presenting to treatment services with serious drug problems.September 2005: 44.

23 Lazunga-Koczurowska Jolanta, Piotr Jablonski, Toni Berthel. Treatment and treatment planning. In: Young people and drugs Care and treatment. Pompidou Group, 2006: 142-147.

For those with limited co-morbidities and good social support, young people are offered individual cognitive behavioural or equivalent therapy or skilled counselling.

For those with significant co-morbidities and/or limited social support, young people are offered multi-component programmes (such as multidimensional family therapy, brief strategic family therapy, functional family therapy, or multi-systemic therapy[24]

Motivational and clinical engagement techniques are used to engage the young person, and work with parents, carers or wider family members, to secure their involvement in the care and intervention plan.

Family therapy techniques are used to engage families and to facilitate positive change in a range of areas in the young person's life.

Where appropriate, young people are offered peer-support and group therapies including:

- Group cognitive behavioural therapy - CBT (see Kaminer, 2002; 2008; Dennis et al, 2004). Manuals: CBT-7, (Webb et al, 2002); MET/CBT-5 (Sampl & Kadden, 2001). Also see Dishion et al (1999) 'When interventions harm: Peer groups and problem behavior'[25]
- Psycho-educational interventions
- 12-Step/Minnesota programme, such as Narcotics Anonymous may be considered for older adolescents (16 +) as there is evidence for adult populations, but this is more equivocal for adolescents [26]. For older adolescents and young adults (18+) consideration needs to be given to the appropriateness of other members in the group for each young person.

When pharmacological treatments fail to give results in children, and there is a strong confrontation with the environment, as well as encounters with the law, other treatment options should be offered, including therapeutic community treatment specially designed for children.

Pharmacological Treatment

The pharmacological management of substance use may help reduce self-harm and suicidal behaviour and, with the treatment of co-morbidity attention deficit hyperactivity disorder (ADHD) for example, improve adjustment to school or college. Especially in the context of substitution therapy for those very few young people who develop dependence, the aim is to become drug free. This requires structured treatment with the objective of achieving abstinence.

Pharmacological treatment should be:

- only one component of addressing substance-related needs
- tailored to a holistic assessment of the child or young person's needs
- delivered alongside relevant psychosocial and mental health interventions
- in the context of a clear clinical governance framework

In pharmacotherapy prescribed protocols are followed.

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24 Gilvarry, E., McArdle, P., O'Herlihy, A., Mirza,K., Bevington,D., Norman, M. Practice standards for young people with substance misuse problems. Royal College of Psychiatrists, June 2012:38

25 ibid

26 Kelly, J.F., Myers, M.G. & Brown, S.A. (2000) A Multivariate Process Model of Adolescent 12-Step Attendance and Substance Use Outcome Following Inpatient Treatment. Psychology of Addictive Behaviors Vol. 14, No. 4, 376-389

1. Young people and their parent or carer are given information to enable them to use any medicines correctly and staff check that they understand how to use the medicines as prescribed
2. Prescribing medication is carefully monitored and regularly reviewed by competent and qualified professionals.
3. Where possible (if symptom severity, home setting, staff experience and resources allow) children are offered detoxification, stabilization and treatment in outpatient or home-based setting as an alternative to residential treatment.
4. Children with opiate dependence are offered methadone or buprenorphine for detoxification in appropriate doses according to size and age.
5. When buprenorphine or methadone is used for a long term stabilization treatment, frequent review is required.
6. Children receiving stabilization for opiate dependence are offered psychosocial interventions to supplement this intervention and support their participation and engagement in the treatment towards achieving abstinence.
7. If relapse prevention treatment for opiate use is required for children above 16, ensure good supervision and support from family members when naloxone is considered.
8. Therapists monitor length of substance use, the child's engagement and adherence to the treatment plan[27].

Integrated Treatment and Care Plan

During admission, whether for a medical, psychosocial or combined treatment, the entire team develops a treatment and care plan, engaging the child, as well as the parents or carers if possible. The plan also includes whether and how the child would like the parents/carers/other family member to be involved in the treatment and care services.

The plan clearly defines which team member mentors the child and ensures the treatment and care is coordinated across the programs and organizations/institutions. The child and the individuals involved in the program are aware of the mentor's competences.

The treatment and care plan addresses the child's needs with regards to the physical and mental health, personal, social, financial and educational circumstances, as well as ethnic, cultural and gender background.

Culture, beliefs and affiliation of the child and their family are also important throughout all aspects of the treatment and care plan.

Treatment and care plans for children are comprehensive and efficiently coordinated in order to respond to their needs.

1. For every child being admitted to treatment or care programs a written plan with all planned interventions is developed.
2. The plan is monitored by a professional skilled to provide a comprehensive approach to the child's needs identified in the assessment.
3. The plan is developed in cooperation with the child and includes whether the child would like to include the parents, carers or other family members in the treatment and care.
4. The plan records the child's agreed goals and desired outcomes.

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27 Gilvarry, E., McArdle, P., O'Herlihy, A., Mirza,K., Bevington,D., Norman, M. Practice standards for young people with substance misuse problems. Royal College of Psychiatrists, June 2012:27-37

5. The plan covers the entire treatment, including post treatment, plans for transfer to another program, as well activities for close cooperation with the family, education and other areas.
6. The plan supports the inclusion of parents/carers in its development, as well as the review for possible changes.
7. The plan summarizes the agreed activities with other services and organizations in order to ensure that the child's needs are met regarding education, housing and social protection.
8. The plan covers all areas, institutions and organizations with the capacity and willingness to support the planned interventions (for instance, staff talks to schools, civil society organizations, social support services etc.).
9. Case notes are made to record all professional disciplines and organizations/institutions that jointly agreed on a treatment and care plan to meet the child's identified needs.
10. Children and young people on treatment and care have a professional/mentor responsible to ensure their treatment is coordinated across programs and organizations/ institutions, whose responsibilities are known to the child and all those involved [28].

Here is one example of treatment and care plan for child with problems related to heroin use. The model can be use for any other problems related to drug use.
Table 5. Treatment and care plan[29]

Goal	Action	Person responsible	Indicator of change	Review date
Reduce risk of injecting	Educate and inform on the risk of injecting, referral to a harm reduction program.	N. N.	The individual attends a harm reduction program. He/ she reduce risk while injecting	Every week
Introduce buprenorphine/ methadone treatment	Start prescribing and titrate according to need	Dr M. M.	Supervision of consumption of medication every day.	Every 2 weeks
Stop injecting	Encourage the client to stop injecting as prescription is introduced.	Client	Reduced need for injecting equipment.	Every week
Stabilise buprenorphine/ methadone therapy	Maintain dose once correct dose reached.	Dr M. M.	Supervised consumption of medication every day.	After 8 weeks

28 ibid

29 a modified version shared from the National Treatment Agency for Substance Misuse: Assessing Young People for Substance Misuse, February 2007:16-17

Reduce heroin use	Twice weekly session to encourage how to reduce heroin use.	Psychologist/ social worker	Stop associating with heroin using peers.	6 weeks
Help parents support their children to change their behaviour.	Three sessions for parental support	Psychologist/ social worker	Parents support children in changing current drug use behaviour.	6 weeks
Improved role in society	Encourage graduation from school. Contact school. Contact employment agency, find employment.	Psychologist / social worker	He/she is encouraged to change, attends classes or seeks employment.	6 weeks

Treatment and care plans for children and young people are regularly updated and shared with relevant parties.

1. Plans are regularly reviewed and include discussions with the child about whether the treatment is helping.
2. Depending on the severity, risk assessments in relation to substance use and co-existing problems are reviewed regularly (for instance, 3 to 6 months).
3. The agreed goals of the child and the parents/carers are regularly monitored.
4. Written copies of the reviewed plans are offered to the child, as well as the other involved in the treatment and care – parents/carers, other relevant partners, such as the child's general practitioner etc.
5. For young people approaching the upper age-limit who have to transfer to adult programs, transfer plans are jointly agreed with adult programs and include a six-month overlap in the delivery of treatment and care.
6. Wherever an element of an intervention foreseen in the plan does not take place, reasons for this are recorded and communicated to the child and their parents or carers involved in the treatment and care[30].

30 Gilvarry, E., McArdle, P., O'Herlihy, A., Mirza,K., Bevington,D., Norman, M. Practice standards for young people with substance misuse problems. Royal College of Psychiatrists, June 2012:27-37

6. Functional system for cooperation and referral

For support of the treatment benefits, children and their parents/carers are referred to appropriate institution programs (schools, mental health institutions etc) as well as local voluntary organizations, civil society organizations, peer groups, self-help groups, including culturally specific groups and organizations. A network of organizations and institutions working with children has to be created to this end. Some countries have a specially appointed commission or agency for children to coordinate all programs referring to children [31].

In Balkan countries, focus should be placed on introducing treatment and care programs for children within prisons and institutions for children with educational and social problems. Cooperation needs to be developed with other programs to provide continuity in the treatment and care once children are released from treatment. In this context, the Social Work Centre has an important role in providing care during weekends or days spend outside the institution, primarily right after the treatment ends, i.e. immediately after detoxification.

A meta-analysis suggests that good interpersonal skills, as measured by warmth, empathy and genuineness, and provision of an acceptable rationale for the intended intervention are important 32. Also, preparedness to engage in outreach, such as visiting young people where they are, rather than rely exclusively on clinic visits, and to offer reminders of meetings are likely to aid engagement. Young people should experience care as seamless - where possible, and should have regular contact with the same worker/therapist who, with the support of others as required, is responsible for engaging the trust of the young person; this is a fundamental quality of a helping relationship.

Young people, and where appropriate their parents or carers, are offered a range of evidence based interventions to improve overall functioning and life chances.

A range of psychosocial interventions is offered and delivered according to need, by competent and qualified professionals.

A range of pharmacological interventions is offered and delivered according to need, by competent and qualified professionals (this will only be for a minority of young people).[33]

31 ibid

32 Karver, M., Handelsman, J., Fields, S. & Bickman, L. Meta-analysis of therapeutic relationship variables in youth and family therapy: the evidence for different relationship variables in the child and adolescent treatment outcome literature. Clinical Psychology Review; 2006, 26:50-65

33 Gilvarry, E., McArdle, P., O'Herlihy, A., Mirza,K., Bevington,D., Norman, M. Practice standards for young people with substance misuse problems. Royal College of Psychiatrists, June 2012:27-37

Depending on the type of treatment and care, the team is comprised of professionals: doctor, psychiatrist, pedagogue, social worker, psychologist, occupational therapist, legal adviser, peer worker. It is crucial that the team is multidisciplinary.

Psychosocial and pharmacological treatments are offered by competent and qualified professionals.

Professionals offering treatment and care should be:

» Qualified and have the required competence for the interventions they deliver;
» Supervised by qualified and competent specialists, professionals.

Psychosocial interventions are delivered by professionals competent for developing general skills in children. Piling and his collaborators point to the significant differences in the therapist's willingness, knowledge and performance, which, according to them, is most probably the reason for different results (success) in psychosocial interventions. Therefore, the therapist's general competences are of crucial importance, for instance: building relationship with the client and managing the therapeutic process .[34]

Children and their parents/carers (where possible) receive prompt interventions and treatment through a flexible appointment system that is responsive to their needs.

1. Children receive treatment and other interventions immediately after assessment. Children requiring specialist treatment start treatment as soon as possible but not later than 15 working days of referral.
2. Children and their parents/carers are given information on what to do and who to contact for support and help when required, particularly in emergencies after the programs' working hours.
3. Professionals are resourced to work intensively and flexibly with children and their parents/carers in order to meet their needs and provide and/or maintain their engagement in the treatment.
4. Instead of time-limited interventions for individuals with constant and complex needs, continuing treatment and support is required until there is a need for the intervention.
5. Time and location of meetings or contacts are agreed and regularly reviewed in consultation with the child and their parents/carers (if involved in the treatment), .[35]

Professionals give priority to a flexible approach to engaging children and their parents/carers in the treatment intervention.

1. Children are offered intervention and care in their home or other safe and informal locations in the community (for instance, specialized centres for substance use treatment, youth centres, health centres, civil society organizations etc.).

34 Pilling, S., Yesufu-Udechuku, A., Taylor, C. & Drummond, C. (2011) Guideline Development Group. Diagnosis, assessment, and management of harmful drinking and alcohol dependence: summary of NICE guidance. British Medical Journal 342:d700

35 Gilvarry, E., McArdle, P., O'Herlihy, A., Mirza,K., Bevington,D., Norman, M. Practice standards for young people with substance misuse problems. Royal College of Psychiatrists, June 2012:27-37

2. Personnel insist with assertive actions to engage children who do not attend the agreed appointments and do not participate in the treatment and care program (for instance, reminders, text messages, follow-up of missed appointments and home visits).
3. Personnel inform the referrer and the appropriate organization/institution of the risk that the child might continue not to participate in the assessment or treatment intervention after all steps have been undertaken.
4. Personnel engaged in the treatment and care programs monitor successful and/or unsuccessful engagement in their intervention programs and discuss lessons learned[36].

Professionals provide support and guidance on how children and their parents/carers can help themselves.

1. It is necessary to provide support to children to carry out the plans referring to their personal development and learning, as well as their aspirations and goals.
2. Children receive guidance on how to develop self-help techniques, coping strategies, on how to reduce or abstain from substance use and lead healthy life. These aspects include developing skills and training in the following areas: dealing with drug, alcohol and cigarettes use, sexual and reproductive health, gender identity, diet etc.

Children and their parents/carers receive consistent (fitting) care.

1. Children and their parents/carers (where possible) have regular discussions with professionals included in the treatment and care program about their progress and diagnosis.
2. Children and their parents/carers are given information on the evidence, risks, benefits and side effects of intervention or possible non-intervention.
3. Children and their parents/carers constantly consult with the same professionals on any given intervention, unless their own choice or clinical need demands otherwise .[37]

Measuring the treatment and care outcomes (results) is routinely conducted using validated instruments.

1. Personnel monitor clinical and child reported results in regular intervals using validated instruments specific to the treatment of the substance use, co-morbidity and other co-existing problems (Teen ASI, ADAD, PEI, GAIN etc.).
2. Measuring outcome (results) is conducted from the perspective of the child, the professional providing the treatment and care and the parents/carers.
3. Routine evaluation of the treatment and care outcomes is necessary.
4. Individual data from the outcome measurements are discussed with the child as part of the child's treatment and care planning.
5. Information received from the measured outcome is:

» shared with the child, parents/carers (where acceptable), personnel and professionals who provide the treatment and care services;

» used for evaluation, developing and improving the quality of the treatment and programs [38].

36 ibid

37 ibid

38 ibid

8.Transfer From Child to Adult Program

Programs for children should be independent from those for adults and ensure no contact with adult users.

For children approaching the age limit of the program (for instance they are turning 18 and are transferring to an adult program) it is necessary to make a joint transfer plan to an adult program that will cover a six-month overlap[39]. However, the transfer does not have to occur in those six months. Depending on the assessment, the team can decide that the person remains in the current program despite the age if this is to the person's best interest.

9.Client Assessment of The Program

Children and their parents/carers are encouraged to give feedback on the program and their answers are reported back to them.

Client assessment of the program is systematically included in the work with children and their parents/carers.

- Children and their parents/carers are actively encouraged to give feedback on the program and interventions they receive.
- Children are actively included in the program development.
- Feedback from children and their parents/carers is monitored and used towards evaluation and development of the programs.
- Children's views on the therapeutic relationship with their therapist can and are observed throughout their contact with the program by monitoring their engagement and treatment and by informing about their treatment and care plan.
- Children and their parents/carers are given information on how to make a complaint and are helped in how to access the complaint procedure [40].

39 ibid

40 ibid

10.Conclusion

Children and young people use drugs from different reasons and not all children become dependent. However, continuous drug use can interfere with a child's development, cause problems with family, friends and environment, legal involvement etc. Consequently, the programs have to cover a broad spectre of activities: starting with universal and selective prevention for specific groups and/or groups exposed to risk, early detection with a prompt intervention to short-term interventions, long-term interventions, subsequent care, reintegration and rehabilitation. Health and social risks for people addicted to drugs can be reduced with harm reduction services, evidence-based treatment, social care and reintegration.

Working with children and young people who use drugs is not easy , it is very responsible work.

We hoped this guide has helped you as an organisation think through the issues involved in supporting children and young people who use drugs. This process aims to help you take consistent and proactive decisions about your practice and procedures and develop clearer policies and procedures to work with children and young people who use drugs, especially in contexts with little support or guidance.

In many of the situations we face, there will not be a right answer, but it is hoped that you are better prepared to make decisions on the actions you will take that consider issues specific to working with young people.

This tool provides immediate support to those working in an area that is poorly documented and lacks guidance. While this tool can help you improve practice there is a critical ongoing role for all of us in advocating for better services, better laws and better recognition of the rights of children and young people who use.

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Annex 1[41]

1. Guiding principles

1.1 Organisational values

[Organisation] ..... recognises that children and young people under 18 who use drugs are highly vulnerable and may have different needs compared to older people who use drugs. As an organisation, we hold the following values towards children and young people:

Record your shared values here.

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1.2 Competency and consent

[Organisation] ..... recognises the challenges with providing services to children and young people under 18. We recognise that children may or may not possess the capacity to make decisions on their own behalf. We understand that children and young people differ in terms of maturity and understanding, which affects their ability to make informed decisions.

1.3 Confidentiality

[Organisation] ..... recognises the importance of ensuring confidentiality of all clients that utilise our services. We understand the increased sensitivity of working with children and young people, and recognise that some circumstances may require confidentiality to be breeched when acting in the best interest of the child.

Document the steps your organisation will take to ensure confidentiality, including under what conditions the breach of confidentiality may be warranted. Describe how this information will be shared with staff members and clients.

41 All exercise given in annex 1 are taken from Aids Alliance, Step by Step , A tool for harm reduction service providers, 2015

2. Legal and policy context

2.1 Legal and policy environment

[Organisation] ..... recognises the existence of laws and policies that influence and shape the way in which we work with children and young people who use drugs.

List the main legal permissions, obligations and limitations that are relevant to work with children who use drugs in your country. Also include pertinent government policies around harm reduction, children and young people.

[Organisation] ..... believes that in order to best serve children and young people who use drugs we need to provide an opportunity for them to express their needs.

[Organisation] supports the participation of children and young people in making decisions that will affect them. Through consultation with children and young people who access our services, we understand that children have the following service needs.

List the main needs for services expressed by children and young people during the focus group discussions.

Services provided directly to children who use drugs

[Organisation] ..... recognises the legal context in which we work as well as our obligation and duty of care to promote the health and well-being of children and young people who access our services. [Organisation] ..... offers the following services to all clients, and will extend these services to children under 18.

List the services your organisation will provide directly to children and young people of the main points that support your decision to work with children and young people who use drugs.

2.2 Referral process

In addition to the services listed above, [Organisation] ..... will provide the following services to children through referral with local providers:

List the services your organisaton will provide to children and young people via referrals. This will reflect the services determined to be a priority for children and young people, but will be provided via referral due to low capacity, high risk or both.

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2.3 Participation of young people

[Organisation] ..... recognises that children and young people themselves are best placed to comment on their needs and challenges. We are committed to providing the space and opportunity for children and young people to participate in the decision making process as it relates to them.

Discuss how your organisation will ensure that the opinions of children are solicited and considered/how you will ensure the meaningful engagement and participation of children and young people.

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[Organisation] ..... takes the following steps to ensuring the voices of children and young people are considered: The feedback of children and young people will also help [Organisation] ..... to ensure the ongoing quality of our services.

Document how you plan to collect feedback from the children and young people who use your services.

2.4 Well-being of staff members

[Organisation] ..... recognises the potential for emotional distress when providing services to children and young people who use drugs.

[Organisation] ..... is committed to ensuring the well-being of our staff to ensure that they feel supported and encouraged and are able to work effectively to meet the needs of the children and young people we serve.

Outline the steps you will take to mitigate any negative emotional effects on staff. What support is available?

3. Ensuring child protection

[Organisation] ..... is committed to ensuring the protection and safeguarding of children and young people we encounter from harm as a paramount component of our work. [Organisation] ..... is committed to providing a safe and positive environment for children and upholding our duty of care towards the children and young people who attend our service.

Our child protection policy will ensure that all staff members understand their responsibility and duty of care towards children and young people who inject drugs that are encountered by our organisation. It also ensures that staff are aware of the steps they should take if concerned about the safety and wellbeing of a child.

Outline your child protection policy and the steps an employee should take if they are concerned about the well-being of a child or young person. Refer to or include the code of conduct.

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