MANUAL FOR YOUTH
AND PEER WORKERS

2022

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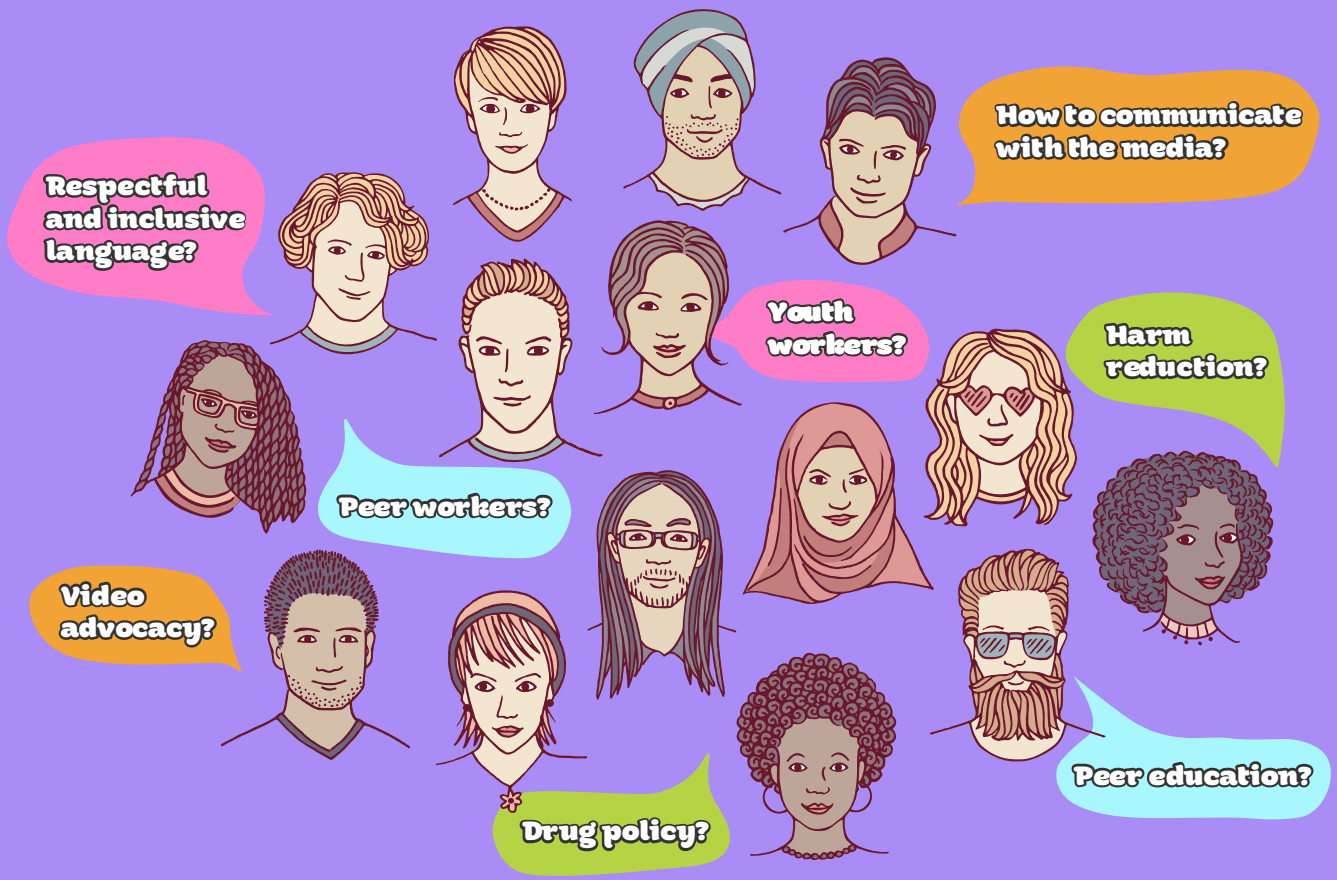
HOW TO COMMUNICATE WITH YOUNG PEOPLE ABOUT DRUGS



Authors — Eliza Kurcevič, Iga Jeziorska, Irena Molnar, Istvan Gabor Takacs, Katarzyna Smukowska, Peter Sarosi, Roksana Karczewska.

Editor — Graham Shaw.

Graphic designer — Kateryna Voloshyna.

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Contents

Acronyms

APSC	Advanced Photo System type-C
BBC	British Broadcasting Corporation
BCE	Before the Common Era
CND	Commission on Narcotic Drugs
COVID	Coronavirus Disease
DoP	Director of Photography
DSLR	Digital Single Lens Reflex [camera]
EHRA	Eurasian Harm Reduction Association
EHRN	Eurasian Harm Reduction Network
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EQ	Emotional Quotient
EU	European Union
FPS	Frame Per Second
GC/MS	Gas Chromatography/Mass Spectrometry
HCLU	Hungarian Civil Liberties Union
HDD	Hard Disk Drive
HPLC	High Performance Liquid Chromatography
IDPC	International Drug Policy Consortium
INDIT	Integrated Drug Therapeutic Institution [Hungary]
INPUD	International Network of People who Use Drugs
IQ	Intelligence Quotient
MILC	Mirrorless Interchangeable-Lens Camera
NGO	Non-Governmental Organisation
NPS	New Psychoactive Substance
PR	Public Relations
Q&A	Question and Answer
RRF	Rights Reporter Foundation
S.M.A.R.T.	Specific, Measurable, Attainable, Relevant, Time-bound
STBBI	Sexually Transmitted and Blood-Borne Infection
SUCCESS	Simple Unexpected Concrete Credible Emotional Story
SWOT	Strengths, Weaknesses, Opportunities, Threats
TLC	Thin Layer Chromatography
UN	United Nations
VAKU	Presumptive Cultural — and Youth Organisation
WB	White Balance
WHO	World Health Organization
YODA	Youth Organisations for Drug Action in Europe

Introduction

Existing drug education at the European level is not fully corresponding to the needs of young people who use drugs. At schools, drug education only focuses on preventive approaches, while in non-formal settings (including youth organisations and other after-school activities), the drug topic is almost never discussed because of a lack, or low level, of competency of youth workers in this area. Youth organisations are an undiscovered niche which may become a place for safe and open discussions about drugs with young people. Youth organisations are playing a crucial role in reaching out to young people and, more importantly, in promoting inclusiveness which is very important when talking about young people who use/might be using drugs. Inclusivness should not only mean the inclusion of particular groups of people, but it should also mean the inclusion and implementation of different methods of work while speaking with young people about different topics, including drugs. Youth organisations might apply prevention strategies, but the harm reduction approach should not be left behind, especially if youth organisations are working with young people who are using drugs. Most importantly, the voices of young people who use drugs should not be left behind — a safe space should be created where youth can raise their voice and openly speak and discuss issues related to drug use, as well as being able to be involved in drug education themselves.

Communication with young people about drugs might be understood differently by different stakeholders. The most common understanding includes the provision of information about drugs, the preparation of preventive actions/activities, or education about drugs. All three ways have differents aims and approaches, but the subject remains the same — communication about drugs with youth.

In this manual, the focus is on communicating drug education with young people and the methods that work when used by youth and harm reduction workers in non-formal settings. As discussed in this manual, effective methods and approaches to drug education should include the following elements:

1. It should be provided by a person who has received special training on substance use and has first-hand experience of substance use;
2. It should be provided in a non-judgmental way, based on scientific evidence;
3. It should be implemented in an interactive manner, using engaging, modern tools and platforms;
4. It should create a safe environment (preferably in small groups); and,
5. It should be provided in a format of open and honest dialogue.

How to use this manual

This manual consists of three complementary parts:

CHAPTER 1

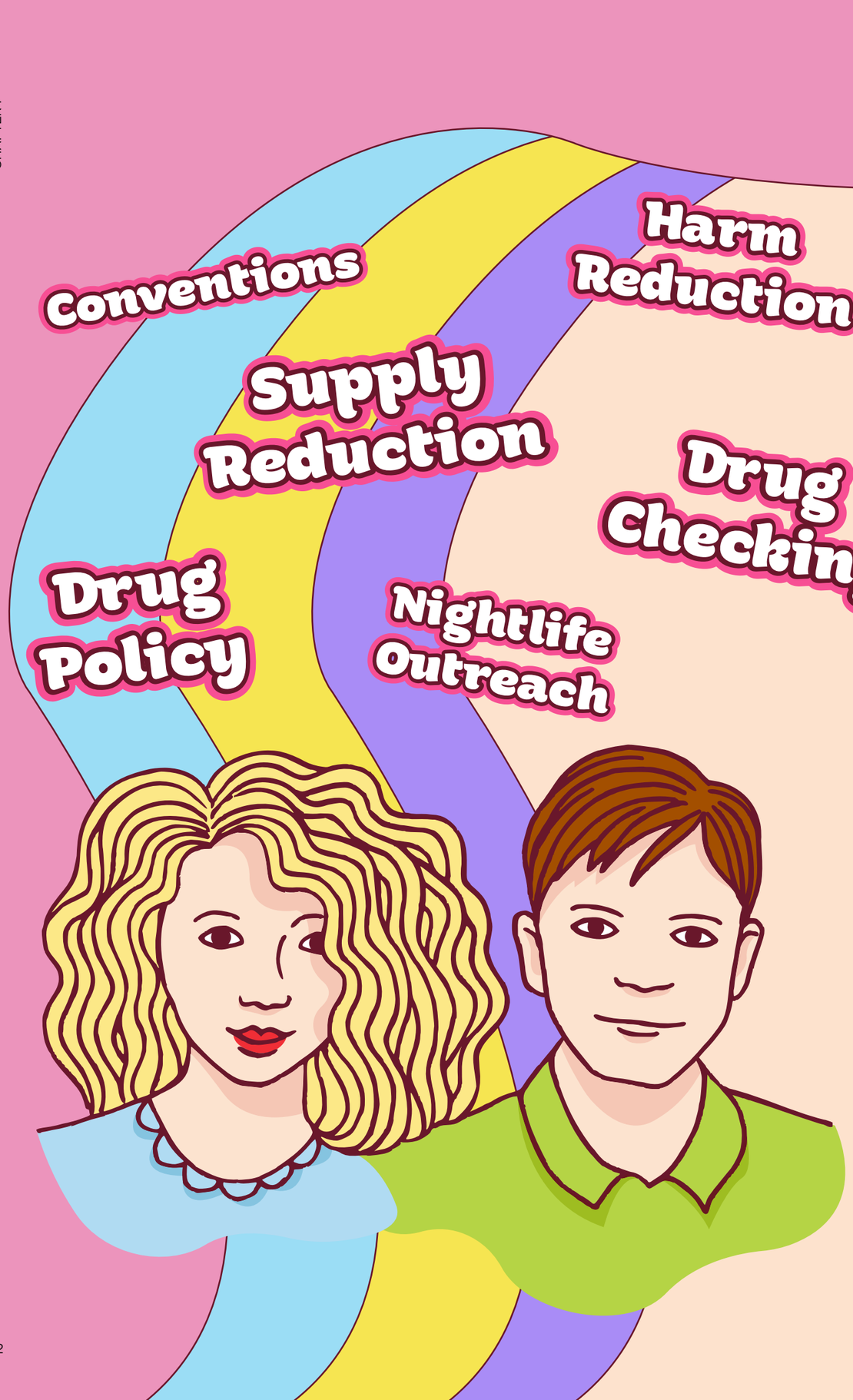
Drug policy, harm reduction and prevention introduces the reader to basic definitions in the drug field. Before preparing any kind of activities/ discussions with young people about drugs, youth workers should have a basic understanding of the drug control framework, harm reduction and prevention. This chapter also reviews the differences between drug education and drug prevention and explains what works and what does not work in drug education. The last part of this chapter focuses on the use of respectful and inclusive language — how we communicate with youth about drugs.

CHAPTER 2

Youth work and peer education describes the importance of involving youth and peer workers in the provision of drug education to young people. It focuses on what is peer work and its effectivness and gives an explanation of the differences between youth worker, peer worker and peer educator. This chapter also reviews ethical considerations in programmes that use a peer-based approach and gives a step-by-step guide on how to plan peer education.

CHAPTER 3

Media and video advocacy in working with youth provides theoretical and practical guidance on how to communicate with media and how to make a video to elicit change. Supporting, or helping, young people who use drugs does not only mean directly helping them with the provision of information or other materials or social/psychological support; it also means enabling them to create videos on issues — which they see as important and want to raise — related to drugs. This chapter describes how to create strong messages for the media and how to work with media (i.e. how to give an interview). Also, this chapter gives many examples on the types of videos, how and what equipment to use to make a video and gives some practical tips on how to compose a video.



CHAPTER 1

Drug policy, harm reduction and prevention

1.1 Drug policy

> *"The formal or informal policies that aim to affect the supply of drugs, the demand for drugs and/or the harms caused by drug use and/or drug markets. In practice, the term 'drug policy' is most commonly used to describe laws and practices that target controlled drugs (rather than uncontrolled or pharmaceutical drugs)."* [1]

Drug policy is a complex issue. However, if you know and understand the components of it, then you are one step ahead in your preparations to start a conversation with youth about drugs. The first component is *a set of documents and practises.* It is important to understand that the word 'policy' is not indicating one document. Usually, it is a set of written documents (such as legal acts) and unwritten but commonly tolerated or used practises in society. Also, it can be named as formal and informal documents and practises. Each policy needs to have *an aim* which is leads us to the second component of the definition. Aim helps to set an intent of what is expected to be achieved within the

1 International Drug Policy Consortium (IDPC), Eurasian Harm Reduction Network (EHRN) (2013). Training toolkit on drug policy advocacy. London, Vilnius; IDPC, EHRN. https://idpc.net/publications/2013/06/training-toolkit-on-drug-policy-advocacy

policy. The aim of a drug policy is to take actions to reduce the supply of, and the demand for, drugs, as well as to reduce risks and harms related to drug use. This leads us to the three core *policy areas* of drug policy which may be considered as another element of the drug policy definition:

1. SUPPLY REDUCTION

consists of actions that respond to the production and trafficking of controlled drugs. For example, in the European Union (EU), drug supply reduction includes the following strategic priorities[2]: the dismantling of organised crime groups that are involved in drug production and trafficking; the removal of drug precursors at EU borders and increased detection of drug trafficking; tackling sales of illicit drugs through online platforms and via postal services; and dismantling illicit synthetic drug laboratories and countering illicit cultivation of drugs.

2. DEMAND REDUCTION

consists of actions that attempt to prevent people from starting to use drugs and reducing problematic drug use. The EU Drugs Strategy 2021-2025[3] has two strategic priorities in this area: preventing drug use and raising awareness of the adverse effects of drugs; and ensuring quality access to treatment and care services. More about prevention will be discussed in Chapter 1.4.

3. HARM REDUCTION

consists of actions aimed at reducing the risks and consequences associated with drug use without necessarily reducing drug use itself. At the EU level, it includes risk and harm reduction interventions[4], such as prevention and treatment of blood-borne infectious diseases, especially HIV and Hepatitis C; and the prevention of overdose by the use of the opioid antagonist called naloxone, including take-home naloxone programmes. The strategy is also focused on the health and social needs of people who use drugs who are imprisoned. Harm reduction will be further discussed in Chapter 1.3.

Another component of the 'drug policy' is the *target* of the policy which, without any doubt, is drugs. The word 'drug' itself can be misleading because it includes both controlled and uncontrolled drugs or, in other words, illicit and legal drugs. In this manual, we will mainly discuss about how to speak with young people concerning controlled/illicit drugs. Controlled drugs are psychoactive substances that are controlled under three United Nations (UN) Conventions of 1961, 1971 and 1988.

2 Council of the European Union (EU) (2020). EU Drugs Strategy 2021-25. Brussels; General Secreriat of the Council of the European Union. https://www.emcdda.europa.eu/drugs-library/council-eu-2020-eu-drugs-strategy-2021-25_en

3 EU 2020, Ibid.

4 EU 2020, Op.cit.

Components that define 'drug policy'

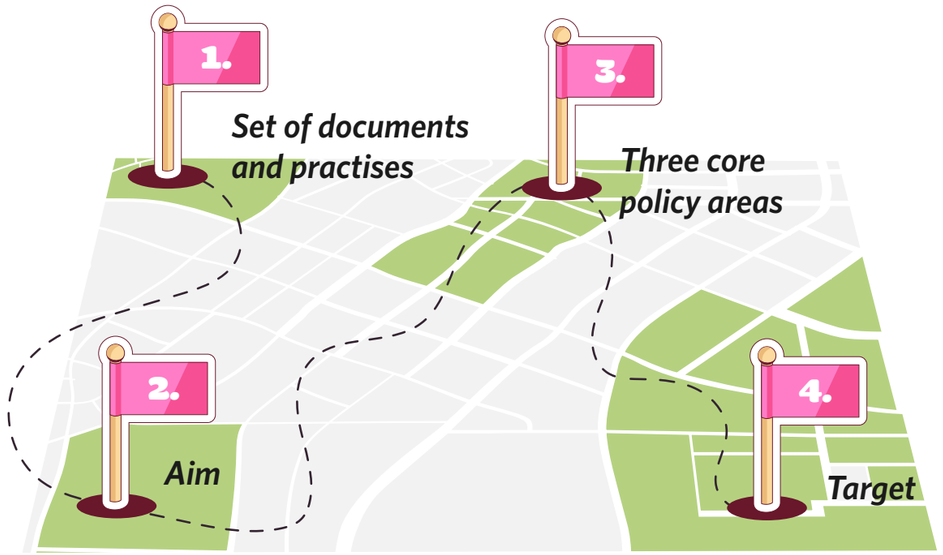


Table 1. Examples of controlled and uncontrolled drugs

CONTROLLED / ILLICIT DRUGS	UNCONTROLLED / LEGAL DRUGS
CANNABIS	CAFFEINE
COCAINE	ALCOHOL
ECSTASY	NICOTINE
OPIOIDS	(NON)PRESCRIPTION MEDICATIONS THAT ARE MISUSED

1.2. Introduction to the drug control framework

Drug policies are part of national, regional and international frameworks. A basic understanding of these systems will help you to not only gain some knowledge, but also to understand how it has been changing over the centuries and how it is affecting the lives of people who use drugs, including young people who use drugs.

For thousands of years, drugs were used for spiritual and medicinal purposes. Examples include cannabis use among the Scythians from the 5th to 2nd century before the common era (BCE)[5]; use of the Amanita muscaria mushroom in Siberia[6], which takes us back to 6,000 years ago; Amazonian use of Ayahuasca plant[7]; Mexican shamans used toad venom; and the North American Indian use of Peyote cactus[8]. These are just a few examples showing that drug use is not a novel activity. Some of the examples are even reaching back to before the common era.

For thousands of years, existing practises started to change and came under control a little over 100 years ago when countries started to realise that drugs are not just an internal issue but also cross borders. The first effort to discuss drug control was made in 1909 in Shanghai where the International Opium Commission, consisting of 12 countries, gathered to discuss questions over the control of the opium trade, which even did not include health concerns; it was solely related to economic and political purpose.

A few years later, in 1912, the same countries met in The Hague, Netherlands, where the 1912 International Opium Convention[9] was adopted. Even though this Convention was more normative in nature, it laid the foundations to the drug control Conventions used nowadays.

5 Butrica JL. (2002) The Medical Use of Cannabis Among the Greeks and Romans. Journal of Cannabis Thera peutics, 2:2, 51-70, DOI: 10.1300/J175v02n02_04.

6 Nyberg H. (1992) Religious use of hallucinogenic fungi: A comparison between Siberian and Mesoamerican cultures. Karstenia 32:71---80. https://www.funga.fi/Karstenia/Karstenia%2032-2%201992-4.pdf

7 Brandenburg WE. (2019) Plant Medicine, Ayahuasca, and Indigenous Culture in the Southern Peruvian Amazon. Wander Medicine. https://www.wandermedicine.com/post/plant-medicine-ayahuasca-and-indigenous-culture-in-the-southern-peruvian-amazon

8 Carod-Artal FJ. Hallucinogenic drugs in pre-Columbian Mesoamerican cultures. Neurología (English Edition), Vol. 30, Issue 1, 2015, pp42-49. https://doi.org/10.1016/j.nrleng.2011.07.010

9 International Opium Convention. The Hague, 23 January 1912. https://treaties.un.org/pages/ViewDetailsIV.aspx?src=TREATY&mtdsg_no=VI2&chapter=6&Temp=mtdsg4&clang=_en

1.2.1. International drug control framework

Nowadays, the international drug control system consists of three UN drug control Conventions:

1. UN Single Convention on Narcotic Drugs (1961)[10];
2. UN Convention on Psychotropic Substances (1971)[11]; and,
3. UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)[12].

The purpose of these Conventions is to ensure that controlled drugs are available only for scientific and medicinal purposes. Treaties also establish a prohibition approach towards production and supply of controlled substances. Each Convention has schedules, or lists, of controlled substances that are classified according to their perceived therapeutic value and the extent to which they are hazardous. The decision as to which list, or schedule, a substance should be included is made by the World Health Organization (WHO). Paradoxically, many substances listed in the 1961 Single Convention did not undergo the proper procedures of the WHO and were allocated to the most hazardous lists. For example, cannabis was included into Schedules I and IV: Schedule I contains the most addictive and harmful substances and Schedule IV contains the most dangerous substances that have very limited medicinal or therapeutic value. Luckily, few initiatives at the UN have been taken and, in 2020, cannabis was removed from Schedule IV of the 1961 Single Convention[13]. This means that from now on, cannabis can be recognised as having medicinal and therapeutic potential; however, it remains controlled for any other kind of purpose.

10 United Nations. Single Convention on Narcotic Drugs, 1961, as amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961. New York, NY; United Nations, 8 August 1975. https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=VI-18&chapter=6&clang=_en

11 United Nations. Convention on Psychotropic Substances. Vienna; United Nations, 16 August 1976. https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-16&chapter=6

12 United Nations. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Vienna; United Nations, 11 November 1990. https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=VI-19&chapter=6&clang=_en

13 Colli M. United Nations Removes Cannabis from Schedule IV Category. Cranbury, NJ; Cannabis Science and Technology, 3 December 2020. https://www.cannabissciencetech.com/view/united-nations-removes-cannabis-from-schedule-iv-category

Table 2. A brief comparison of the Conventions

	The 1961 Single Convention on Narcotic Drugs	The 1971 Convention on Psychotropic Substances	The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic substances
Main purpose	Established a strict universal system for limiting the cultivation, production, distribution, trade or use of narcotic substances for only medicinal and scientific purposes, with special attention to substances derived from plants: opium/heroin, coca/ cocaine and cannabis.	Extended the universal system and introduced control over a hundred synthetic psychotropic substances, such as amphetamines, barbiturates, benzodiazepines and psychedelics. However, the control system in this Treaty is much weaker in comparison with the one imposed on plant-based drugs in the 1961 Convention.	Established special enforcement measures focused on reducing illicit cultivation, production and trafficking of drugs and the diversion of chemical precursors. This Treaty is the most punitive of the three Conventions as it significantly reinforces the obligation of countries to apply domestic criminal sanctions to combat all the aspects of illicit production, possession and trafficking of drugs.
Schedules/ lists	Four schedules/lists of controlled substances were created: I. Substances with addictive properties, presenting a serious risk of abuse; II. Substances normally used for medical purposes and given the lowest risk of abuse; III. Preparations of substances listed in Schedule II, as well as preparations of cocaine; IV. The most dangerous substances, already listed in Schedule I, which are particularly harmful and of extremely limited medicinal or therapeutic value.	Four schedules/lists of controlled substances were created: I. Substances presenting a high risk of abuse, posing a particularly, serious threat to public health which are of very little or no therapeutic value; II. Substances presenting a risk of abuse, posing a serious threat to public health which are of low or moderate therapeutic value; III. Substances presenting a risk of abuse, posing a serious threat to public health which are of moderate or high therapeutic value;	This Treaty has 2 categories for the control of illicit drug precursor substances: Table I. Drug precursor chemicals to produce controlled substances (more critical to production); and, Table 2. Drug precursor chemicals to produce controlled substances (less important to production).
Schedules/ lists		IV. Substances presenting a risk of abuse, posing a minor threat to public health with a high therapeutic value.	
Examples of controlled substances by Convention	Cannabis, cocaine, heroin, morphine, opium, codeine.	LSD, MDMA (ecstasy), psilocybine, mescaline, amphetamines, barbiturates, tranquillisers.	Ephedrine, lysergic acid, acetone, hydrochloric acid.

!!! The term 'illegal drug' or 'illicit drug', which is commonly used in our conversations, is not used in any UN Conventions. Instead, the term 'controlled drugs' is used because substances themselves are not prohibited by the Conventions, rather it is their production and trade that are put under different levels of control (depending on the respective Schedule / List of a drug).

!!! The UN Conventions do not oblige countries to impose any penalty (criminal or administrative) for drug use.

The Commentary to the 1988 Convention[14] regarding Article 3 of the Convention on "Offences and Sanctions" states:

"It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence".

The 1988 Convention does stipulate that a member state should consider **possession for personal use** as a crime but, even so, this provision is *"subject to its constitutional principles and the basic concepts of its legal system".*

14 United Nations (1998). Commentary on the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. New York, NY; United Nations.
https://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_united_nations_convention_1988_E.pdf

1.2.2. European Union Drug Control Framework

Legislation towards drugs as established in each EU country are, first of all, based on international treaties (UN Conventions). However, EU member states are obliged to align their national documents with EU Regulations and drug strategy.

A few Regulations at the EU level to be aware of include:

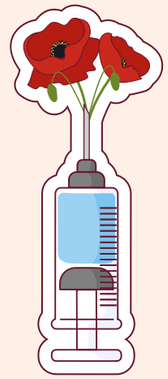
- Regulation (EC) on drug precursors (No 273/2004)[15]. This Regulation establishes unified measures for the control and monitoring of certain substances which are used for the manufacture of drug precursors. The aim is to prevent the diversion of such substances.
- Regulation (EC) laying down rules for the monitoring of trade between the Union and third countries in drug precursors (No 111/2005)[16]. This Regulation lays down rules for the monitoring of trade between the Union and third countries for certain substances which are used for the manufacture of drug precursors for the purpose of preventing the diversion of such substances. It regulates import and export activities.
- Regulation (EU) amending Regulation (EC) No 1920/2006 as regards information exchange on, and an early warning system and risk assessment procedure for, new psychoactive substances (No 2017/2101)[17]. It sets procedures to rapidly detect, assess and respond to health and social threats caused by new psychoactive substances (NPS).

At the end of 2020, the European Commission adopted the EU Agenda and Action Plan on Drugs 2021-2025[18]. This document sets EU drug policy priorities for 2021-2025. The Strategy has four aims:

- to protect and improve the well-being of society and of the individual;
- to protect and promote public health;
- to offer a high level of security and well-being for the general public; and,
- to increase health literacy.

It is a guiding document, based upon which countries may develop their national drug strategies and policies. As already mentioned in the chapter on the definition of a drug policy, there are three policy areas covered in the Strategy:

1. **DRUG SUPPLY REDUCTION —** mainly focused on ensuring security;
2. **DRUG DEMAND REDUCTION —** covering prevention, treatment and care services; and,
3. **HARM REDUCTION —** focusing on the promotion of harm reduction interventions for people who use drugs.



15 Official Journal of the European Union (2004). Regulation (EC) No 273/2004 of the European Parliament and of the Council of 11 February 2004 on drug precursors (Text with EEA relevance). Luxembourg; Publications Office of the European Union.
https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32004R0273

16 Official Journal of the European Union (2005). Council Regulation (EC) No 111/2005 of 22 December 2004 laying down rules for the monitoring of trade between the Community and third countries in drug precursors. Luxembourg; Publications Office of the European Union.
https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32005R0111

17 Official Journal of the European Union (2017). Regulation (EU) 2017/2101 of the European Parliament and of the Council of 15 November 2017 amending Regulation (EC) No 1920/2006 as regards information exchange on, and an early warning system and risk assessment procedure for, new psychoactive substances. Luxembourg; Publications Office of the European Union.
https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32017R2101

18 Council of the EU (2020). EU Drugs Strategy 2021-25. Brussels; General Secretariat of the Council of the EU.
https://www.emcdda.europa.eu/drugs-library/council-eu-2020-eu-drugs-strategy-2021-25_en

The Strategy also covers three cross-cutting themes:

1. International cooperation;
2. Research, innovation and foresight; and,
3. Coordination, governance and implementation.

As a youth worker and/or peer educator, you could contribute to the second and third policy areas as they are mainly related with your work in the field of drugs. Both topics — prevention and harm reduction — will be discussed in more detail in the following chapters of this manual. However, before going deeper into these topics, we would like to present the EU vision and values in implementing these policies. It may help you to understand your contribution to drug education and what actions you can take to support the development of effective drug education.

The second drug policy area is drug demand reduction which consists of prevention (environmental, universal, selective and indicated); early detection and intervention; counselling, treatment, rehabilitation, social reintegration and recovery. All these measures are aimed at delaying the age of onset of drug use and to prevent and reduce problematic drug use, as well as to provide drug treatment, recovery and social reintegration services.

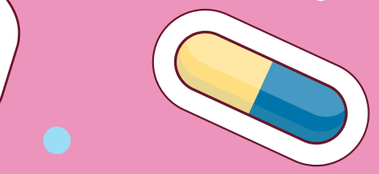
HOW COULD YOU CONTRIBUTE TO THIS?

1. **To educate and discuss with youth about public health.**
2. **To promote life skills to achieve good health and welfare.**
3. **To connect with hard-to-reach youth by starting to use innovative digital platforms or, in other words, to do online outreach.**
4. **To create a group of experienced and trustworthy peers who can reach out to young people and build positive relationships.**
5. **To build partnerships and to cooperate closely with other organisations who have access to young people (other youth organisations and services, student unions, etc.)**
6. **If needed, to refer young people on a voluntary basis to evidence-based, youth-sensitive life experience services that can also respond to specific needs and support the individual through all processes; and,**
7. **To organise events together with young people to fight stigma and discrimination due to drug use, mental health, sexuality and other topics that are affecting young people.**

The third policy area is harm reduction which focuses on approaches that prevent and reduce possible health and social risks for people who use drugs, society and in prison settings; specific focus is given to inmates and their needs.

HOW COULD YOU CONTRIBUTE TO THIS?

1. **To train your colleagues about evidence-based harm reduction services.**
2. **If you are not a harm-reduction service provider organisation, think about developing a safe and youth-friendly space for young people where they can discuss with you about Sexually Transmitted and Blood-Borne Infections (STBBI) and other health issues and find information leaflets on where they can access HIV testing and other harm reduction services. Ensure there is free water, vitamins and snacks to entice people to stay and talk!**
3. **If you are an organisation providing harm reduction services, review your activities or services and adapt them to the needs of young people who use drugs. Open a separate facility just for young people who use drugs. Involve peer workers and educators from the community of young people who use drugs to organise your activities and services. If such actions are not possible, adapt your current facility for youth by allocating a separate room/ space for young people or adapting your working hours to have a specific time for young people to visit your services.**
4. **Create a group of peers, from young people, who are using/have used your services and with whom you build a good relationship. Peer involvement is a key to successful programmes!**
5. **Young people tend to use drugs through various ways. It is important to have different safer drug use equipment (needles and syringes, safer snorting kits, gelatine/vegan capsules, booty bumping kits, etc.).**
6. **If you are working in a youth organisation which is not providing harm reduction services, start to cooperate with a local organisation and join them in providing counselling and services at music festivals, parties and nightclubs.**
7. **Train yourself and youth about overdose prevention. Young people tend to overdose more often in comparison with older people. If Naloxone (an opioid antagonist) is available in your country, ask local health service providers to organise a training on how to administer Naloxone and how to provide first aid.**
8. **If any of your young people under care have issues with law enforcement, try to mediate the conflict and support that individual. Ensure that you have at least 2 contacts of friendly lawyers who can support youth in more serious cases.**



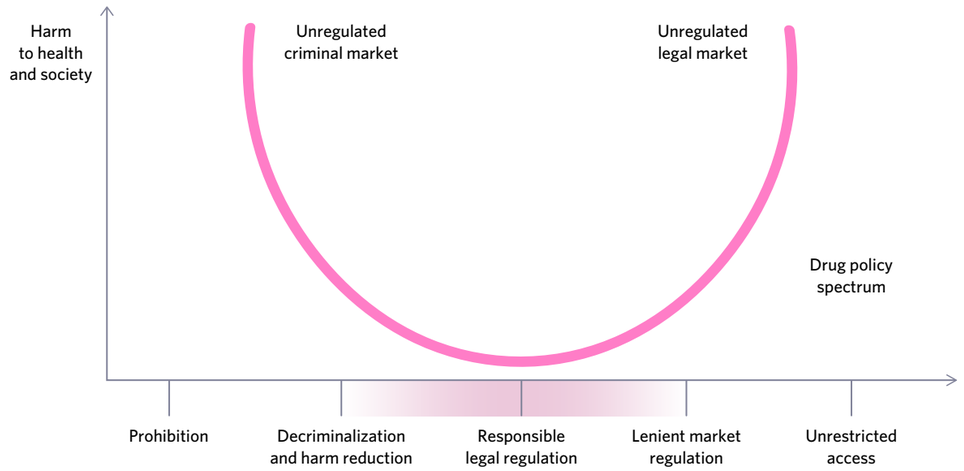
1.2.3. National level drug control framework

Over the decades, decision makers believed — and some still believe — that the only way to tackle the world drug problem is to implement policies called the 'war on drugs', a term that was introduced in the 1970's by the United States President Nixon and referred to repressive, punitive drug policies and a 'zero tolerance' approach to drug use. Now it is widely acknowledged that this approach has failed. Therefore, some countries have taken a human rights and evidence-based approach while developing responses to drug problems whilst some countries are still applying disproportionate penalties on low-level offenders, thus violating the human rights of people who use drugs.

International treaties and regulations serve as guidelines, based on which each country has a right to develop their own national drug policy. Certainly, national drug policy should not contradict international law, but countries can make some exceptions to some provisions of these international documents.

While working with young people, it is necessary to understand in what political environment you live and what consequences can be faced. There are few examples of policies of substance regulation applied at a national level as demonstrated in Figure 1. Each of the examples has different effects and impact on the life of people who use drugs. What is more, existing drug policies in the country usually explain the kind of information/education that can be provided to young people and is what not acceptable. This is why it is very important to understand and evaluate your own situation. Below are discussed a few main examples of existing approaches to regulating substances in the world.

Figure 1. Approaches to substance regulation[19]



19 Global Commission on Drug Policy (2018). Regulation. The Responsible Control of Drugs. Geneva; Global Commission on Drug Policy. http://www.globalcommissionondrugs.org/wp-content/uploads/2018/09/ENG-2018_Regulation_Report_WEB-FINAL.pdf

PROHIBITION or CRIMINALISATION

This policy focuses on punishing people who use/possess (or do any other related act in relation to) drugs by imposing penalties, such as the restriction of liberty, arrest, fine, community service, imprisonment or even the death penalty. These policies were reinforced in the 20th century by the signing of the three UN drug control conventions. It was believed that the drug market can be eradicated. However, 60 years of evidence[20] is showing that such policies have brought numerous negative effects and unintended consequences for people who use drugs, their families and the general public. Negative effects include, but are not limited to, human rights abuses (death penalty, extrajudicial killings, torture, inhumane drug treatment programmes, police brutality); public health crises (the HIV/AIDS epidemic); prison overcrowding; criminal records; racial and ethnic disparities in the criminal justice system; stigma and discrimination. Prohibition policies are not only punishing users but also affect the rise of drug prices which means that people who use drugs require more money and they may engage in sex work or theft in order to buy drugs. Moreover, these laws are leaving people who use drugs with no other choice than to buy drugs from the illegal market, which can be very dangerous (nobody knows the quality and strength of substances) and it may result in an overdose. The last decade has showed that the disappearance of 'traditional drugs' has created a space for the emergence of new psychoactive substances that are very potent and dangerous. Such policies also create an unfavourable environment for harm reduction service providers to reach out to people who use drugs because people are afraid to use such services. Sometimes, such an approach is not even allowed to provide evidence-based harm reduction information for young people because national laws are interpreting such actions as "drug propaganda". Looking from the perspective of the general public, one of the most harmful effects of such drug laws is that instead of focusing on investing taxpayers money into the improvement of health and well-being of people who use drugs, such money is spent on drug law enforcement, the overcrowded prison system and stigmatisation of people who use drugs. As it may be seen, repressive and prohibition drug policies may create more harm than the drugs themselves.

Numerous European countries are criminalising drug use and/or possession, such as **Bulgaria, Hungary, Lithuania and Serbia.**

DECRIMINALISATION

Drug decriminalisation is the elimination of criminal penalties for drug use and possession (in some cases for low-level sales), as well as the elimination of criminal penalties for the possession of equipment for drug use (i.e. syringes). In this case, substances are treated not as criminal issues, but those of health and social. This approach reduces the number of arrested and incarcerated people, as well people with a criminal record. It improves cost-effectiveness by redirecting funding from law enforcement to public health. As decriminalisation is an approach that supports the strengthening of public health, it creates a favourable climate for people who use drugs to seek treatment and removes barriers to the provision of harm reduction services, including services such as drug checking (pill testing). Decriminalisation also helps to mitigate racial and ethnic disparities in the criminal justice system.

A number of countries have chosen to abolish punishment for use and possession without intent to sell. In 2001, **Portugal** abolished criminal penalties for storing all kinds of drugs for personal consumption[21] and directed its drug policy

20 Global Commission on Drug Policy (2016). Advancing Drug Policy Reform: A New Approach to Decriminalization. 2016 Report. Geneva; Global Commission on Drug Policy. http://www.globalcommissionondrugs.org/wp-content/uploads/2016/11/GCDP-Report-2016-ENGLISH.pdf

21 Hetzer H (2019). Drug Decriminalization in Portugal. Learning from a Health and Human-Centered Approach. New York, NY; Drug Policy Alliance. https://drugpolicy.org/sites/default/files/dpa-drug-decriminalization-portugal-health-human-centered-approach_0.pdf

towards health care, significantly expanding harm reduction and access to treatment. In 2009, **Czechia** abolished criminal penalties for possession of drugs for personal use[22] after a study suggested that punitive approaches were ineffective. Sometimes decriminalisation is also applied to drug distribution. For example, in the **Netherlands,** the use, possession and sale of a limited amount of cannabis was decriminalised in 1976[23]. Although the sale of "soft drugs" is still a criminal offense, the prosecutor's office does not pursue coffee shop owners for the violation. Instead, it introduced rules, such as the ban on the sale of cannabis to minors, a ban on advertising and a ban on the sale of more than 5 grams of cannabis. Contrary to popular belief, cannabis has not been legalised in the Netherlands.

Decriminalisation typically means the removal of criminal penalties, but civil penalties (e.g. a fine) may remain; depenalisation typically means a reduction in the severity of penalties, such as the elimination of a prison term, yet can still mean a criminal penalty. Thus, decriminalisation is a subset of depenalisation.

RESPONSIBLE LEGAL REGULATION or LEGALISATION

Legalisation is the process of bringing something illegal into the framework of the law. In the case of drugs, it is an end to the prohibition on their production, distribution and use for non-medical and non-scientific purposes. In the context of drug policy, the term "legalisation" usually refers to a political stance that advocates for the "legal regulation" of drugs or "legally regulated drug markets" of currently illicit substances. With the introduction of legalisation, governments acquire tools to regulate the market, establish control over distribution, curb criminal groups and tax the turnover of substances, most of which become legal and regulated by the State. However, it is impossible to undertake bolder experiments with controlling a number of substances due to international obligations adopted in the middle of the last century. In 2013, **Uruguay** became the first country to legalise cannabis[24] after a half-century ban. The Government of **Canada** also initiated legislative reform and legalised cannabis in 2018[25]. Cannabis has also been made legal in several **US states**[26]. In Europe, **Switzerland** should be mentioned as a good example with its medical prescription model[27] (which includes supervised drug consumption facilities).

Drug regulation should help strengthen the ability of governments to regulate drug markets, meaning the introduction of legal rules and regulations corresponding to the degree of risk of a certain drug and the needs of the local social environment. Legalisation includes the regulation of production (licensing), produce (price, effect and packaging), availability (licensing of sellers, opening points of sale, age control) and marketing (advertising and branding). It is aimed at getting drugs under control so that it is governments and not criminals that make decisions about the availability of certain substances in certain circumstances.

22 Eurasian Harm Reduction Association (2018). The Czech Republic's best practices in drug policy reform. Vinius; Eurasian Harm Reduction Association. https://harmreductioneurasia.org/wp-content/uploads/2018/11/Czech_twe.pdf

23 Rolles S (2014). Cannabis policy in the Netherlands: moving forwards not backwards. London; Transform Drug Policy Foundation. https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf

24 Centre for Public Impact, Inc. Marijuana legalisation in Uruguay. BCG Foundation, 23 November 2018. https://www.centreforpublicimpact.org/case-study/marijuana-legalisation-in-uruguay

25 Government of Canada. Cannabis Legalization and Regulation. Ottawa; Government of Canada, 7 July 2021. https://www.justice.gc.ca/eng/cj-jp/cannabis/

26 Yakowicz W. Where Is Cannabis Legal? A Guide To All 50 States. Forbes, 10 January 2022. https://www.forbes.com/sites/willyakowicz/2022/01/10/where-is-cannabis-legal-a-guide-to-all-50-states/?sh=20de29ead19b

27 Transform. Drug Policy Foundation (2018). Heroin-Assisted Treatment in Switzerland. Bristol, UK; Transform. Drug Policy Foundation. https://transformdrugs.org/blog/heroin-assisted-treatment-in-switzerland-successfully-regulating-the-supply-and-use-of-a-high-risk-injectable-drug

1.3. Harm reduction

"Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws. Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs as a precondition of support." [28]

Harm reduction is an approach which comprises methods and programmes that seek to reduce the harms associated with both drug use and ineffective drug policies. It acknowledges the dignity and human rights of people who use drugs and in helping people who continue to use drugs to minimise negative health consequences rather than preventing drug use itself. Harm reduction measures only came under the spotlight when it became clear that HIV was spreading among people who inject drugs and threatened to seep into the general population. However, approaches similar to harm reduction have long been used for a number of substances in various contexts.

Harm reduction brings significant changes to the life of people who use drugs, their families, friends and communities. A harm reduction approach can:

- Increase referrals to health and social services;
- Increase access to health services by reducing stigma and discrimination;
- Reduce sharing by offering safer use equipment (i.e. needles and syringes, snorting kits);
- Reduce the spread of HIV, hepatitis and tuberculosis;
- Reduce overdose deaths and other drug-induced deaths among people who use drugs;
- Increase knowledge about safer substance use;
- Increase knowledge about safer sex and sexual health and increase condom use.

28 Harm Reduction International (2022). What is harm reduction? London; Harm Reduction International. https://www.hri.global/what-is-harm-reduction

1.3.1. Harm reduction goals

There are few harm reduction goals that you should keep in mind:

- Reduce negative health and social consequences associated with drug use for people who cannot, or do not want to, stop using.
- Improve the health of people who use drugs by treating them with dignity and respect.
- Give a wide selection of alternative approaches (evidence-based prevention, care and treatment programmes) which seek to prevent or end drug use in order to make an informed decision about individual needs. Many people who use drugs (including young people who use drugs occasionally) do not need treatment.
- Keep communities of people who use drugs safe and alive.
- Reduce harms of repressive and ineffective drug laws and policies.

1.3.2. Harm reduction principles

In order to further understand the philosophy behind harm reduction, it is important to discuss the main principles[29]. A harm reduction approach:

1. Accepts that drug use is part of our world and chooses to work on reducing its harmful effects rather than ignoring it;
2. Understands that drug use is as a complex issue and that some ways of using drugs are safer than others;
3. Establishes quality of individual and community life and well-being as the criteria for successful interventions and policies;
4. Applies non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live;
5. Ensures the meaningful and routine involvement of people who use drugs and those with a history of drug use in the development of programmes and policies designed to serve the community;
6. Empowers peer involvement in programmes;
7. Recognises that poverty, class, racism, social isolation, past trauma, gender-based discrimination and other social inequalities affect people's vulnerability to deal with drug-related harms; and,
8. Does not ignore the real harm and danger that can be associated with drug use.

In order to provide youth-friendly counselling and have an effective conversation on drugs with youth, you should apply these principles in your communication and/or service provision.

1.3.3. Examples of harm reduction interventions and how it can be implemented in youth and peer work

There are many harm reduction interventions, such as needle and syringe distribution programmes, supervised consumption sites, opioid substitution treatment and overdose prevention programmes. In this manual, we will concentrate on a few examples which may be implemented in your work. Before introducing you to the interventions, you should keep in mind that the majority of young people are not going to require any kind of harm reduction strategies. However, access should be ensured to services and information by young people who need and want to learn about safer drug use and to move in a safer direction.

29 Principles of Harm Reduction (2020). New York, NY; National Harm Reduction Coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/

1.3.3.1. Nightlife outreach/party working/peer education

In comparison with older counterparts of people who use drugs, it is harder to reach young people who use drugs and to involve them in conversation about their drug use and harm reduction. Young people have their own environment where they use drugs. Usually, they do not use drugs in traditional places where older drug users frequent. Also, the circle of people with whom younger people use drugs does not involve experienced people who use drugs. This makes it hard to find, and reach out to, these younger people. However, this can always be achieved through outreach and peer involvement.

As the name of this activity suggests, it happens/is provided at parties and festivals and it addresses peer education and harm reduction related to behaviours undertaken in the nightlife environment. In practice, it can be a combination of three types of activities:

1. Operating an education and information stand

where items are made available to partygoers to reduce the harms associated with the risky behaviours that they can possibly undertake by providing information aimed to educate on health protection and the possibility of reducing harm resulting from their behaviour, as well as to distribute various harm reduction materials such as: a breathalyser; condoms; disposable snorting equipment; earplugs; chewing gum; blankets; charcoal filters for joints; water; vitamins and supplements; fruit; and where legal, colorimetric tests for drug checking; if possible, a first aid kit (bandages, plasters, dressings, disinfectant, etc.);

2. Running a psyhelp service

a type of emergency intervention aimed at reducing the harm resulting from difficult experiences under the influence of psychoactive substances of a medical, psychological, psychiatric, psychedelic or existential/spiritual nature. This involves care provided by a sober person to a person under the influence of substances and, in practice, involves: supportive conversation and providing a safe and comfortable setting until sober and, if the person's health is in immediate danger, calling for medical assistance. Where possible, psyhelp activities should take place in a specially prepared area staffed by qualified party workers-trip sitters. The same services can be also provided in the premices of your organisation. You just need to ensure a quiet space, well trained and friendly care givers and an understanding of how to support people whether they have a fearful or joyful state of mind.

3. Patrol

making rounds of the party area, offering water to partygoers while looking out for people who may need help. In the case of finding someone that seeks assistance, the patrollers will take them to the psyhelp/medical/harm reduction point or, if this is not possible or urgent help is needed, they will provide help immediately. It is important to react to signs of physical, psychological or sexual violence, etc., and, if necessary, to make contact with the organiser, the club manager, security or medics. Due to the subject matter of the activities and the age appropriateness of the content, only an adult who has undergone training can become a party worker.

The content of the training should include: effects of selected substances (dosage, symptoms, overdose); risks and effects of mixing substances; first aid (classic procedures, but also recognition and procedures in case of overdose); ethics of how party workers work; the practice of party working — how to organise activities; how to communicate with the target group; communication in club culture — communication in a team of party workers; communication with organisers/clubs; communication with partygoers; psyhelp — basics of dealing with people who have overdosed on substances; basics of drug laws in force in a given country; familiarity with educational and prevention materials on the stand, including the rules for using colorimetric tests. When working in a party environment, the party worker must keep in mind first and foremost their own safety and comfort as the ability to help partygoers depends on this. Such comfort can be improved by organising shifts so that those working at the party have the opportunity to rest (especially important during long parties and when working in a noisy place).

Depending on the type of music event, the profile of the target group for whom party workers provide their services is different and different substances are more commonly used by partygoers. There are several substances 'common' to most types of party, such as alcohol, cannabis and MDMA.

However, it is characteristic of psytrance parties that psychedelics are more commonly used than other psychoactive substances. These will most commonly be LSD, psilocybin (found in psilocybin mushrooms) and DMT, but there are plenty of less common psychedelics. Due to the nature of the substances used, the dangers inherent in the use of substances in this group can arise during these events — difficult psychedelic experiences that can focus on psychological sensations. In addition, psychedelics generally last longer than other substances, so people at psytrance parties may be under the influence of drugs for longer. Due to these two reasons, psytrance events may require increased psyhelp activities.

In contrast, at events with other electronic music genres, such as techno, drum'n'bass, trance, hardcore and dubstep, the use of psychedelics is less common and the use of stimulants is more frequent. These substances have a shorter duration of effect but are often repeatedly dosed by users — they take another dose of the same substance when they feel the effect of the previous dose wearing off.

It is also worth adapting activities to the type of event due to its duration and the space in which it takes place.

Club events are generally shorter, lasting one night, and take place in an enclosed club space. These places have weaker ventilation, the event participants may be hot when dancing intensively under the stage where there is no access to fresh air. There may also be less space in clubs to set up a partyworker's stand, or even no space at all to set up a psyhelp zone. On the plus side, there is access to running water in the taps in the toilets.

Festivals are events lasting several days and usually take place outdoors. Because of this, it is necessary to involve a bigger team of educators to work at festivals. If the organiser does not provide indoor space for harm reduction initiatives, it is necessary to bring tents to protect the stand and the psyhelp zone from rain or heat. At festivals, it is generally not a problem to fit a psyhelp zone as long as it is possible to protect that much space under the roof. Access to running water is worse than in clubs. Taking place outdoors is a plus with regards to ventilation (useful for intensive dancing), but a minus can be cooling in the evening. At festivals blankets in the psyhelp zone are more useful than in clubs.

Outreach and peer education shouldn't be limited only to the parties and festivals. The same services can be provided in places, where young people love to gather and spend their time. One of great examples of peer education and outreach interventions is Vistula River Project by the Foundation of Social Education in Warsaw, Poland.

BEST PRACTICE

YOUNG WAVE

Vilnius, Lithuania

"Young Wave" is a grassroot youth organisation based in Vilnius, Lithuania. It is providing education and information on safer ways to use substances during music festivals and parties. During such events, the "Young Wave" team has their info tent/table where people can come and discuss about different substances, risks and harms related to drug use and to receive information about drug combinations. "Young Wave" activities are not limited only to festivals and parties. The organisation has a safe space in "Vilnius Night Hub", a place where people can come for peer consultation, information or just to relax and stay in a safe space. This space is located in the heart of Vilnius Street where most parties occur.

BEST PRACTICE

INTEGRATED DRUG THERAPEUTIC INSTITUTION (INDIT)

Pecs, Hungary

INDIT is an organisation which is providing services from prevention to rehabilitation. One of their services is called "Bulisegely" which is a party aid service. In this service, prevention, harm reduction and interventions are applied in work with clients.

They are participating in different parties, but also in some music festivals in which they create a "HAVEN" — a safe place for resting, talking, drug education and guidance. Around 35 volunteers (mostly psychologists, socials workers and peers) are interacting with festival participants. In "HAVEN", people can also find flyers about drug policy, STIs, safe partying, magnesium-calcium water, sugar tablets, salty snacks, medicine, clothing, blankets and beds.

BEST PRACTICE

VISTULA RIVER PROJECT BY THE FOUNDATION OF SOCIAL EDUCATION

Warsaw, Poland

The Vistula riverbank in Warsaw is a place well liked by young people. Youth gathering there not only spend their time with peers, but also to use different psychoactive substances (especially alcohol). It is raising concern as to the health and behaviour of young people as there is seen to be an increase in the use of substances by adolescents.

The Vistula River Project is run by the Foundation of Social Education in Poland. It is an outreach programme which aims to provide education and interventions about drugs and drug use next to the Vistula River during the summer season. It has street workers who are doing outreach and speaking with young people about drugs and drug use. It also has psychologists and paramedics who can do an intervention if it is needed.

1.3.3.2. Drug checking (pill testing)

It is an evidence-informed harm reduction practice that allows people who use drugs to detect the dangers of:

1. Drug contamination — street vendors do not care about the quality of the substance, just about profit; thus, they sell mixtures of substances as another specific substance. This significantly reduces the safety of psychoactive substances. In addition, drugs may be contaminated with residue from their production process.

2. Sellers selling one substance as another, e.g. claiming to sell LSD when the substance is in fact the more dangerous 25B-NBOMe, which is a New Psychoactive Substance (NPS). NPS are cheap and easy to obtain (and legal in some countries) making their widespread presence on the black market an increasing problem. Unlike traditional drugs, NPS are not well researched and modern science does not know the long-term effects of taking these substances, nor does it have answers as to what to do if an overdose occurs. Those who choose not to use drugs after having tested their substance reduce the risk of taking a substance that is more harmful than traditional drugs.

Consequently, testing can help to change the style of use to a more conscious one. Through such testing, people who use drugs can check their substances and find out whether the substance in their possession is really what they thought it is.

Substance testing has two main objectives:

1. to prevent the use of drugs that are too strong, contaminated, or are a different substance than the user expected; and,

2. to provide information on safer drug use and harm reduction and thus increase the knowledge of users on these topics, which can be a form of peer education.

In an interview with the BBC, Dr Henry Fisher, a chemist at The Loop (which runs a laboratory testing service at music events) declared that up to 20% of people who test substances at events throw away their drugs after receiving the test results. Similar results were found among people who tested their drugs at the Groovin' the Moo festival in Canberra, Australia: after receiving the results, 18% of participants decided not to use illegal drugs at the festival and 12% said they would use less[30]. This, of course, depends on the results; if they indicate contamination or a different than expected composition of the substance, people often prefer to get rid of the more dangerous substance. However, if the drugs are of high purity, they are usually kept.

Different types of tests are possible under different circumstances and may involve different substances. The following are presented in order from the simplest and cheapest method to the most difficult and expensive:

FENTANYL TEST STRIPS

detect fentanyl, an extremely active synthetic opioid whose derivatives are often up to 50 to 100 times stronger than heroin. Fentanyls are largely responsible for opioid overdoses due to their extreme activity, even in doses invisible to the eye (they are found in counterfeit drugs, new psychoactive substances and even non-opioid substances such as cocaine or MDMA, for example). Fentanyl strips are used after creating a solution of the substance with water in which the test is placed. The result is just like a pregnancy test — based on the presence of one or two strips. This test is very simple to do and interpret the result. It can be used under almost any circumstance.

COLORIMETRIC TESTS

check the presence of a substance but not the purity or strength of the substance. They are liquid chemical reagents that change colour when a substance is present. These tests are relatively easy to use but basic knowledge of the possible type of substance possessed is required (specific reagents should be selected on this basis). At least two tests must be used (reagents have a range of reactions) as many substances react with the same colour, so more tests should be used for exclusion and, preferably, a whole set of 4-5 tests reacting to a particular type of substance. 90% of the admixtures will react with 1-out-of-3 tests and 95% with 1-out-of-5. Using all the tests will increase the probability of detecting more possible admixtures. The more reagents are used, the more accurate the result will be (e.g. when there is a mixture of several substances).

THIN LAYER CHROMATOGRAPHY (TLC)

checks purity (number of components and concentration — by stratification of components of a substance on a special 'plate') and requires specialised apparatus/equipment (UV lamp, % rulers, pipettes, test liquids). TLC does not replace compositional identification reagents — colorimetric reagents should be used anyway to be sure. Can be homemade but requires time and more preparation. It is of medium difficulty to use and to interpret the results.

HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

involves separating the components of a substance by spreading them under pressure on a special column using a solvent. Thus, HPLC makes it possible to identify substances and to test their purity. This method, like any other, has its limits. Particularly problematic is the identification of compounds which are not expected in a given sample, e.g. rare admixtures or by-products of chemical synthesis. However, it is relatively inexpensive for a laboratory test.

GAS CHROMATOGRAPHY-MASS SPECTROMETRY (GC/MS)

is a laboratory test. It involves separating the components of a substance in special apparatus and then subjecting them to a process which makes it possible to identify the substance, determine its quantity and detect impurities. The GC/MS process is very accurate and requires large and expensive equipment. Unfortunately, it is impossible to do at home.

Testing of psychoactive substances takes place through four mechanisms:

1. The customer orders the test with delivery by post. The customer tests themselves on the basis of the instructions enclosed with the test.

2. Selling the tests at the point of sale of a test vendor or reseller; the customer tests themselves on the basis of the instructions included with the test.

3. Distributed at partyworkers stands. Assistance by partyworkers in running the test is possible depending on the legal regulations in force in the country concerned. Whatever the legal situation regarding substance possession, the peer educator can help peers to interpret the test result, e.g. on the basis of a reaction film made by the user such as in the toilet of a club.

4. In a number of European countries, it is possible to operate drug testing laboratories. This allows for more accurate testing. In addition, the results of such testing can be used to monitor the drug market and thereby support early warning systems. Laboratories can be either:

   — stationary (the client sends a sample to the laboratory and gets feedback with the test results); or,

30 Al-Juzi A. 'My day with the drug testing squad...'. London; BBC Three, 31 August 2018. https://www.bbc.co.uk/bbcthree/article/92063060-2ca3-4d9a-a6a2-538e47394f58

— outdoor mobile laboratories set up during music festivals (the client takes a sample to the laboratory and receives feedback with test results).

It is important that a harm reduction worker (peer worker, peer educator) has a private conversation with the client after the test has been given or performed (if permitted by law). The potential risks of substance use and ways to reduce the risks (e.g. moderating the way of substance use or adjusting the dose) should be discussed. It is also useful to inform the client about health or education services available. Substance testing is a good opportunity to reach drug users with harm reduction and health promotion services. Projects related to drug testing are: Energy Control (Spain); Check!t (Austria); Check!n (Portugal); Bunk Police (USA); DrogArt (Slovenia); and Dance Safe (USA, Canada).

BEST PRACTICE

THE LOOP

London, United Kingdom

The Loop is a NGO which is providing drug checking at nightclubs and at music festivals. On-site checking is carried out by a team of experienced volunteer chemists. The service gives the opportunity to share harm reduction information with people who use drugs; inform about potential risks and harms of use; enable people who choose to use drugs to make informed choices; to provide information that can be sent out via social media, other media channels and information points relating to particular substances in consultation with police and medical services to reduce drug related harm on-site and to minimise the possibility of a major public safety incident.

1.3.3.3. HIV/AIDS prevention, care and support

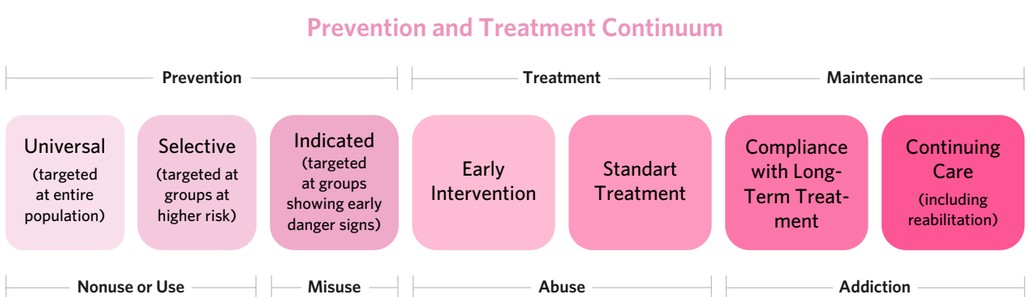
Peer education has been used in many areas of public health, including nutrition education, family planning, substance use and violence prevention. However, HIV/AIDS peer education stands out owing to the number of examples of its use in recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and impact of peer education in the area of HIV/AIDS prevention, care and support have also increased.

Typically it involves recruiting members of a specific at-risk group to encourage members to change risky sexual behaviours and to maintain healthy sexual behaviours. Even though most of HIV/AIDS prevention activities have been aimed towards people who inject drugs, sex workers and men who have sex with men, there has been a fairly recent change of approach, underlining the importance of safer practices among all groups, especially youth.

1.4. Prevention

Drug use prevention is any activity that is aimed at preventing, delaying or reducing drug use and/or its negative consequences across the lifespan of an individual. It applies to legal drugs (tobacco, alcohol), illegal drugs (cannabis, MDMA, LSD), medication (Subutex) and other substances, such as inhalants. Prevention can also be applied to addictive behaviours, such as gambling. Figure 2 shows where prevention lays withing continuum of care for substance use disorders.

Figure 2. Continuum of care for substance use disorders[31]



1.4.1. Prevention aims

The general aim of drug use prevention is very broad and it seeks the healthy and safe development of people to realise their potential and contribute to their communities.

The primary objective is to help people avoid or delay the initiation of substance use and dependency behaviours.

1.4.2. Types of prevention

There are a few categorisations of prevention:

1. Primary, secondary and tertiary prevention;
2. Universal, selective and indicated prevention; and,
3. Environmental, developmental and informational prevention.

Shortly, to gain a better understanding we will review each categorisation of prevention.

31 Graphic adapted from Institute of Medicine (US) Committee on Prevention of Mental Disorders, Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. National Academies Press (US). DOI: 10.17226/2139

1.4.2.1. Primary, secondary and tertiary prevention

The categorisation of prevention as primary, secondary and tertiary is still used in public health, but rarely. It is now replaced mainly with the second and third categorisations mentioned above. However, as it is relevant, we will have a short overview of all categorisations.

Primary prevention aims at preventing drug use before people start using. It also aims at delaying the age of initiation of drug use. Examples of such prevention can be programmes for schoolchildren that aim to teach skills to avoid smoking or using any other drugs.

Secondary prevention targets individuals who have already started using drugs. It aims to stop drug use or reduce harms related to drug use. It promotes safer and less harmful ways of using drugs. As an example, targeted training for people who use drugs and their family members on overdose prevention, needle and syringe programmes and peer support can be mentioned.

Tertiary prevention aims to provide support and treatment for people who are using drugs and who are drug dependent. This type of prevention strives to enable the individual to give up drug use. Examples of tertiary prevention include facilitation of entry into an opioid substitution treatment programme and case management.

Figure 3. The intersection of prevention and harm reduction efforts[32]

32 Recovery Research Institute. Special Topics and Resources: Harm Reduction. Boston, MA; Massachusetts General Hospital, undated.
https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/

1.4.2.2. Universal, selective and indicated prevention

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) classifies prevention into three categories[33]: universal, selective and indicated. This categorisation is based on the overall vulnerability of the people addressed — the known level of vulnerability for developing substance use problems distinguishes between the categories rather than how much or whether people are actually using substances.

Universal prevention addresses entire populations and targets the development of skills and values, norm perception and interaction with peers and social life to avoid or delay initiation of substance use. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programmes. Universal prevention interventions can be included into the school curriculum, afterschool programmes and parenting classes.

Selective prevention addresses groups, families and communities where substance use is often concentrated and focuses on improving their opportunities in difficult living and social conditions. Selective prevention targets the entire group regardless of the degree of risk of any individual within the group, such as children of adult drug users or students who are failing academically.

Indicated prevention addresses those already using, or engaged in other high-risk behaviours, to deal and cope with the individual personality traits which make them more vulnerable to escalating drug use. Indicated prevention interventions are designed to prevent the onset of substance abuse in individuals who do not meet the medical criteria for drug dependence but who are showing early danger signs. Individuals can be referred to indicated prevention programmes by parents, teachers, school counselors, school nurses, youth workers, friends or the courts.

1.4.2.3. Environmental, developmental and informational prevention

This approach combines function dimensions and type of prevention to identify and map prevention strategies with more precision. It distinguishes prevention into three groups: environmental, developmental and informational prevention interventions.

Environmental prevention interventions aim to limit the availability of maladaptive behaviour opportunities through policies, restrictions and actions. For example, legal requirements or economic (dis)incentives.

Developmental prevention interventions aim to promote adaptive behaviours and prevent maladaptive behaviours by development of skills that are key in the socialisation and social development of appropriate behaviours. For example, parental monitoring practices and individual social or life skills.

Informational prevention interventions aim to focus on attentional processes via communications that increase knowledge and raise awareness about specific risk behaviours. This could include mass media campaigns to raise awareness.

33 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2009). Preventing later substance use disorders in at-risk children and adolescents: a review of the theory and evidence base of indicated prevention. Thematic papers. Luxembourg; Office for Official Publications of the European Communities.
https://www.emcdda.europa.eu/system/files/publications/562/EMCDDA-TB-indicated_prevention_130796.pdf

Table 3. Prevention Forms and Functions: Illustrative Examples for Substance Misuse Preventions[34]

	Universal	Selective	Indicated
Environmmental	Legislation to prohibit substance use; suppresion of international supply routes.	Tergeted enforcement and actions to deal with drug dealing in high risk neighbourhoods; athlete drug testing programmes.	Legal orders to prevent high-risk individuals from accessing alchohol; imprisonment.
Developmental	Social/life skills programmes, for school students that provide young people with skills to cope with social influences.	Family/parenting programmes with families in the most deprived areas in the region or country; or home visiting programmes with vulnerable pregnant women.	Individual councelling programmes with adolescent males with impulse control problem.
Informatioanal	Mass media campaigns to raise awareness of the danger of drugs.	Informational interventions targeted at young males in deprived neighbourhoods with strong gang cultures.	Normative feedback or motivational interviewing interventions for individuals who screen positive for substance misuse.

1.5. Differences between drug education and drug prevention

If we would ask a person about drug education, it is more likely that the person will start to speak about drug prevention. Drug prevention covers various programmes, strategies and interventions, thus people are prone to put drug education under the umbrella of drug prevention. Even though these two approaches can complement each other, they should not be used interchangeably. In a broad sense, drug education differs from drug prevention by its meanings, functions and practices. Table 4, below, reviews the differences between these two approaches.

34 Foxcroft DR. Environmental, Developmental and Informational Interventions: A Novel Prevention Taxonomy to Better Organise and Understand Substance Misuse Prevention. Addicta: The Turkish Journal on Addictions, Autumn 2015, 1(2), 66-78. DOI 10.15805/addicta.2014.1.2.027

Table 4. Differences between drug prevention and drug education

DRUG PREVENTION	DRUG EDUCATION
— Drug prevention typically **seeks to interrupt a pattern of drug use.** The aim of drug prevention may be to bring behaviour change within a population. — Drug prevention is understood as planned interventions that work to prevent or delay the onset of drug use. — Interventions are developed in a way that is more challenging to create trust with individuals. — Prevention interventions sometimes may sound prescriptive, i.e. giving instructions on what to do and what not to do. — A prevention approach may be based on judgments. — Preventive interventions are usually one/few times lectures/activities. — Usually only selective information is provided to individuals (for example, explaining about the harms of drugs). — A prevention approach does not have the aim to change repressive and stigmatising laws and policies.	— Drug education **does not have to have** an intended prevention outcome. It aims to bring new knowledge and understanding about drugs and drug-related harms within the population. — Learning outcomes for a drug education programme should not seek to prevent, delay or reduce drug use. — It is based on mutual understanding and trust. — A person is free to make their own informed decision about drug use. — A drug education approach is based on non-judgmental conversations. — Drug education is an ongoing process. — Drug education applies an holistic approach and provides a full range of information about substances (by explaining the harms of drugs it can also explain how some drugs are used in medicine, etc.). — A drug education approach includes information about drug laws and policies and empowers people to advocate for changes to repressive approaches.

1.6. What works and what does not work in drug education

Many programmes focusing at preventing the initiation of substance use or the minimisation of drug use and risks related to it are ineffective for several reasons, including:

— Programmes do not have a theoretical framework;

— They are inadequately designed;

— There is no evidence-base justifying the programmes;

— Programmes are not suitable for the setting in which they are used.

While preparing for an activity with young people about drugs, keep in mind the following DON'TS!

Don't

USE ANY KIND OF SCARE TACTICS

(no drug-related horror stories or movies, images of people of how they looked before using drugs and now, no police with sniffer dogs, etc.). This has nothing to do with changing a young person's behaviour.

Don't

PRESENT ONLY INFORMATION

It cannot ensure that youngsters will understand it and apply it in their daily life, nor to make any changes to their behaviour.

Don't

TEACH HOW TO SAY NO TO DRUGS!

It's outdated and ineffective.

Don't

invite people in recovery, or who have experience with drug dependence,

TO PROVIDE TESTIMONIALS

Young people usually don't relate their own behaviour to guest stories. Also, young people may wrongly interpret such stories as easily achievable "success".

Don't

ORGANIZE ONE-OFF TALKS

Inviting a doctor or police officer to speak about not using drugs is ineffective as it usually includes passive listening and the invited guest may not have the skills to deliver information in a way that young people can learn and understand what was said.

Don't

SHAME DRUG USE OR NORMALISE IT.

It is very important to use the right language when speaking about drugs, describing risks and harms and trying to make it understandable for young people.

So, what does work with young people while communicating about drugs?

HOLISTIC APPROACH TO DRUG EDUCATION

It includes not only information about drugs and safer drug use, but also the development of personal and social skills as well as how to cope with challenging situations (i.e. when somebody has an overdose, etc.).

ACTIVE LEARNING AND PARTICIPATORY APPROACH

Try to make your activities interactive and inclusive and allow young people to interact with each other. The more actively involved the participant is in the activity, the more effective that activity is likely to be.

STRUCTURED AND CONTINUING PROGRAMMES

As was mentioned, one-off talks or sporadic activities are not effective. When planning your activities, think about a few structured sessions which will have follow-up.

APPROPRIATNESS

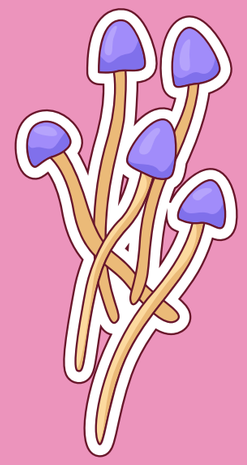
It is never too early to talk to a young person about drugs if the conversation is age appropriate. It is also important to consider the developmental level of young persons and local youth culture. Your activities should help to reflect the realities and experiences of the target group.

COMMUNICATE ABOUT SHORT-TERM CONSEQUENCES

An emphasis on drug use related risks should focus on short-term rather than long-term consequences. Drug education programmes should focus on the immediate risks of drug use (i.e. dangerous contaminants, taking an unknown drug, not knowing the strength of a drug, effects of drugs, risks of mixing drugs).

CHALLENGE DRUG MYTHS AND BREAK STIGMA

Loads of information around the drug topic are full of misconceptions and myths. Include it in the discussions with youth and challenge commonly held drug myths by providing evidence-based information.



VOLUNTARY PARTICIPATION

Do not force young people to participate in the activity if they are unwilling. In the case that youngsters are below the legal age, you should also ask for parental consent.

ACKNOWLEDGE PARTICIPATION

At the end of the programme you may give certificates of completion to the participants and acknowledge their input and efforts.

BUILD AND ENSURE TRUST

Establish rules/agreement with participants before starting the activity. This will help to keep activities respectful and confidential so that young people will feel safer in the environment where the activity is organise

1.7. Using respectful and inclusive language in communicating with young people

The language used when speaking about people who use drugs, or any other key population, has a significant impact on how these communities view themselves and how they are viewed by others. The words and phrases that we use in conversations with people who use drugs may have a powerful impact on further communication with them. What is more, incorrect language may create stigma, and stigma results in discrimination. Therefore, we should be thoughtful and inclusive, as well use respectful language.

1.7.1. Guiding principles for respectful language

The Canadian Public Health Association has developed guiding principles for respectful language[35] when speaking about sexuality, drug use and sexually transmitted and blood borne infections. The following are the main principles which should be kept in mind while having a conversation with young people:

- **Words matter.** Some words can make people feel excluded and can also impart stereotypes based on a person's identity. Stigmatising language can make people feel unwelcome or unsafe in our environment.
- **Language changes.** Language is a living thing and it is changing over time. This means that it may change through time and you need to keep yourself updated with changes. Every effort should be made to use appropriate words when having conversations about drugs.
- **Mindset matters.** It is ok sometimes to not know how to explain some things. Do not be afraid to be wrong and make a conversation. If somebody corrects your language, stay open and empathetic and take the opportunity to learn from people who may know and understand language better.
- **Person first.** Use 'person first' language. This approach is focused on delivering more person-centred care. Prioritise a person's identity rather than other characteristics (e.g. 'person living with HIV' rather than 'HIV-infected').
- **Be inclusive.** Try and use language that is as inclusive as possible. Instead of saying "guys" while referring to a group of people, use "folks". Or instead of using "husband/wife", use "partner", which is more neutral and less misleading language.
- **Be specific.** Use language that is based on how people identify themselves. The best way to figure it out is to ask people directly what language is comfortable to them.
- **Be critical.** Before introducing or describing someone based on personal characteristics (such as race, gender identity, (dis)ability, use of substances, etc.), ask yourself whether it is relevant and necessary to do so.

35 Canadian Public Health Association (2019). Language Matters. Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma. Ottawa, ON; Canadian Public Health Association. https://www.cpha.ca/sites/default/files/uploads/resources/stbbi/language-tool-e.pdf

1.7.2. Examples of respectful and inclusive language

Below you can find a table with some examples on how you can improve your language when speaking about drug use and sexuality. Keep in mind that not all of these words may be adapted to your culture and realities. In some cases, it simply may not be translated to your language. Or in some other cases, there are some other alternative words in your language which may not be translated to English but which are respectful while communicating with people from key populations.

Table 5. Respectful and inclusive language: what to use and what not to use

USE	DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use, Person who occasionaly uses [substances]	Recreational users, Casual users, Experimental users
Person with drug dependence, Person with problematic drug use, Person with substance use disorder, Person who uses drugs (when use is not problematic)	Addict, Drug/substance abuser, Junkie, Dope head, Pothead, Smack head, Crackhead, Druggie, Stoner
Problematic drug use	Drug habit
Abstinent, Person who has stopped using drugs	Clean
Actively uses drugs, Positive for substance use	Dirty (as in "dirty screen")
To respond, To program, To address, To manage	To fight, To counter, To combat drugs and other combatant language
Safe consumption facility	Fix rooms

USE	DON'T USE
Person in recovery Person in long-term recovery	Former addicts, Reformed addict, Ex-user
Person who injects drugs	Injecting drug user
Opioid substitution therapy, Opioid agonist therapy	Opioid replacement therapy
Substance use	Substance abuse
Person who uses alchohol	Alchoholic
Sexual contact (e.g., oral, vaginal, anal, frontal) without a condom/ dental dam/glove/PrEP/other method of protection from STBBI	Risky sex, unprotected sex
Having multiple partners	Promiscuous (promiscuity is the practice of engaging in sexual activity frequently with different partners)
Controlled drugs	Illicit/illegal drug use/possession

USE	DON'T USE
Person living with HIV	HIV-infected
Contracted/acquired [STBBI]	Became infected
Tested negative/positive for...	Clean/dirty with respect to urine toxicology
Key populations	Vulnerable populations
Sex worker, People involved in the sale or trade of sex	Prostitute
Transition	Sex change
Person who is/has been incarcerated	Convict
Person convicted of (alleged) offence	Drug offender