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United Nations Office on Drugs and Crime



COUNSELLING IN TARGETED INTERVENTION FOR INJECTING DRUG USERS

– A Resource Guide





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Abbreviations

AVE	Abstinence Violation Effect
BCC	Behaviour Change Communication
DASS	Depression Anxiety Stress Scale
DIC	Drop-in-Centre
DOTS	Daily Observed Treatment Strategy
GFATM	Global fund to fight AIDS, Tuberculosis and Malaria
Hep C	Hepatitis C
HRG	High Risk Groups
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
MARP	Most at-risk Population
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NDPS Act	Narcotic Drugs and Psychotropic Substances Act
NGO	Non Governmental Organisation
ORW	Outreach Worker
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PE	Peer Educator
PM	Programme Manager
RPT	Relapse Prevention Therapy
SACS	State AIDS Control Societies
STI	Sexually Transmitted Infections
SUD	Substance Use Disorder
TB	Tuberculosis
TI	Targeted Intervention
TISS	Tata Institute of Social Sciences
UNODC ROSA	United Nations Office on Drugs and Crime, Regional Office for South Asia
WHO	World Health Organisation

Preface

The practice of injecting drug use which was reported since the early 1980s has been steadily spreading to different parts of India. Associated with this spread has been an increase in HIV prevalence rates among injecting drug users (IDUs). IDUs engage in both unsafe injection and sexual practices that increase the risk for HIV transmission. Among various population sub-groups, HIV prevalence is the highest among the IDU population in India, as evident from recent reports of the National AIDS Control Organisation (NACO).

In response to the increasing HIV prevalence among IDUs, NACO has responded by setting up a number of Targeted Interventions (TIs) for IDUs. Key to the national response is services such as needle syringe programmes and opioid substitution therapy, counselling and behaviour change communication. With enhancing numbers of interventions in the country, the gap in training and capacity-building of service providers is being acutely felt.

Saksham is the GFATM's (The Global Fund to Fight AIDS, Tuberculosis and Malaria) Round 7, HIV/AIDS counselling component in India. As the principal recipient of this component, Tata Institute of Social Sciences (TISS), is responsible for providing strategic leadership and direction to the programme. Saksham aims at enhancing capacities of institutions of higher learning that conduct HIV/AIDS counselling training programmes in India, and thus contribute towards responding to the needs of the national programme. The module 'Counselling in Targeted Intervention for IDUs' is prepared by UNODC in partnership with TISS, as a fulfilment of one of the important activities in Saksham, i.e. to develop a training resources in counselling for IDU TIs.

United Nations Office on Drugs and Crime (UNODC) is the lead UN agency mandated to assist the Government and civil society on HIV prevention and care among injecting drug users. UNODC has adopted a comprehensive package approach which includes a wide variety of measures, ranging from drug dependence treatment, including drug substitution treatment to outreach services providing IDUs with information on risk-reduction, referral to services, clean needles and syringes, condoms, voluntary counselling and testing, treatment of sexually transmitted infections, and antiretroviral (ART) therapy. UNODC has been working closely with the Government of India in developing a comprehensive and sustainable National AIDS Programme for the drug-using population.

The module is for use by trainers who would train the counsellors working in IDU TI. The module is a package consisting of three separate documents and prepared by a group of experts with experience in drug-related counselling as well as

harm- reduction. It is hoped that this module will serve as a valuable tool in building the capacity of the counsellors working in IDU TI and aid in providing quality services to the IDU population.



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First and foremost, thanks are due to the National AIDS Control Organisation (NACO) for providing this opportunity for developing this module. Thanks are also due to the leadership role provided by the UNODC ROSA and TISS.

The authors have relied upon a variety of resource materials to develop this manual. Important among these are:

- ◆ *Counselling for Drug Addiction Individual, Family and Group – A field guide for trainers and service providers*, MSJE and UNDCP, 2002.
- ◆ *Substitution Therapy with Buprenorphine for Opioid Injecting Drug Users*, NACO, 2008.
- ◆ *A Manual for Working with IDUs (Harm Reduction/Outreach Training Module)*, NACO, 2009.
- ◆ *National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections*, NACO, 2010.
- ◆ *HIV Counselling Training Modules for VCT, PPTCT and ART Counsellors*, NACO, 2010.
- ◆ The resource material developed and used by the authors for providing harm-reduction and OST training to various TI NGOs working with NACO.
- ◆ Other training manuals developed by the authors (*Reaching Out to Female partners of IDUs* – being developed for UNODC and NACO; *Substance Use Disorders: A Manual for Paramedical Personnel* – developed for WHO [India] and Ministry of Health and Family Welfare, Government of India; *Training on implementing OST*, being developed for DFID TAST and NACO).

This draft manual has undergone peer review by eminent experts in the field as well as by NACO. The authors are extremely thankful to these experts who have provided their valuable feedback, which has helped in polishing and refining this module.

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About the module...

The goal of the third phase of National AIDS Control Programme is to halt and reverse the epidemic of HIV in India by 2012. One of the important components to realise this goal is to provide interventions to those at highest risk of HIV through targeted interventions. Injecting drug use is recognised as an important behaviour which contributes to the continuing spread of HIV infection in India. To prevent this, NACO has significantly scaled-up targeted interventions specifically for IDUs throughout the country. The focus now is on improving the quality of interventions provided by these TIs. To improve the knowledge and skills of the staff working in TI, they have to be constantly trained and their capacity has to be built.

One of the important outputs of the TI is to provide counselling and by doing so, change their behaviour from high-risk to low-risk. In case of IDU TIs, the counselling staff, not only has to provide HIV-related counselling, but also has to support the IDU during periods of his drug use as well as during his attempts to stop drug use. In this regard, the counselling staff has to play the role of HIV counsellor as well as drug counsellor. Currently, there are no training materials specifically targeted towards counselling for injecting drug users.

Tata Institute of Social Sciences (TISS) is charged with building the capacity of all the counsellors in programmes funded by NACO, especially those working in Integrated Counselling and Testing Centres (ICTC) as well as those working in the centres providing ART medicines to HIV-positive individuals through the Global Fund round 7 activity. A component of this activity is also to deliver quality training modules for training the counselling staff working in IDU TIs.

Components of the module

Standard counselling training programmes for IDUs especially in the context of harm-reduction services is available in only a few centres in the country, as a result of which, there is a dearth of trainers who would be able to impart training to the IDU TI staff on specific counselling issues. However, there is no dearth of trainers who are well-versed in the art of counselling and training. The module is prepared taking these facts into account. The module is for the trainers who would be able to use the materials provided in the module for training the counselling staff of the IDU TIs.

The module is conceived of as a package and is divided into three components:

- ◆ **Resource Guide for the trainers:** In this, the chapters are written in such a manner that the trainers who are well-versed in counselling but not in drug use disorders would be able to grasp the essentials and then use this knowledge to train the IDU TI staff.

- ◆ **Facilitator’s Manual:** This part deals with how to conduct trainings on each of the sessions and chapters described in the resource book. The manual also contains power-point slides, which can be used by the trainers, if there is a didactic classroom session to be taken. At places where group activities or role plays have to be conducted, the objective, method and desired outputs have been described.
- ◆ **Counsellor’s Handbook:** This is a small handbook for the TI staff who will carry out counselling, and can be used as a ready reckoner. This book contains important summary points of the sessions on which the staff have been trained.

The module is also made available in a CD version so that power-point slides to be used in the training can be readily copied and used by the trainers.

How to use this module

The module is to be used by the trainers who would conduct training for the IDU TI staff on counselling in the context of IDU TI setting. The trainers are expected to initially read the resource guide and make themselves familiar with the topics on which they have to conduct sessions. After going through the resource guide, the trainers shall then, read the facilitator’s manual to get an understanding on how to plan and conduct each of the sessions outlined in the manual.

Targeted interventions for IDUs – an overview

Background

There are an estimated 2.27 million people living with HIV/AIDS in India. Among the general population, the prevalence of HIV is 0.29%; 88% of all infections are in the most productive age group between 15-49 years. The HIV prevalence is not a generalised epidemic, as is the case in some of the African countries.

About 87% of the HIV infections in the country are due to unprotected sex. Unsafe sexual contact between sex workers and their clients account for a large proportion of these cases. HIV transmission through injecting needles is only 1.7% of all transmissions. However, it is a major HIV transmission route in the north-eastern region. Perinatal transmission and infections due to transfused blood and blood products account for a very small proportion.

HIV is present in all the states of India. However, the spread of HIV is not uniform—either geographically or among population groups. There are certain states and districts which are more affected by HIV as compared to others. Similarly, there are certain population groups which have higher HIV prevalence as compared to the general population. These population groups, because of their behavioural characteristics, are more vulnerable to HIV infection; such groups are called high-risk groups (HRGs) or the currently used term – Most at-risk Population (MARP). These HRGs include female sex workers (FSW), men having sex with men (MSM) and injecting drug users (IDU).

High risk groups – characteristics

The HRGs have certain characteristics as a unit which makes them vulnerable to HIV infection.

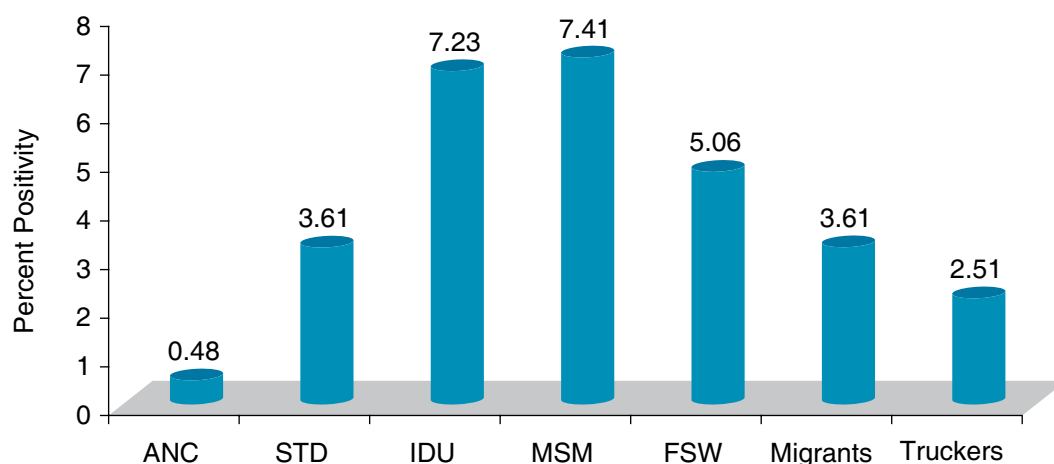
- ◆ The HRGs practice certain behaviours which place them at risk for HIV infection, if they do not practice safe behaviours.
- ◆ The behaviour practices are not subscribed by the law of the country, resulting in terming the practices (and by extension, the HRGs) as illegal.
- ◆ This also results in stigmatisation of the HRGs and being discriminated against by other sections of the society. As a result of this stigma and discrimination, the HRGs do not come out and seek risk-reduction services.
- ◆ In addition, the HRGs are also reluctant to seek services provided within the ambit of the mainstream services for the general population.

All of these factors make the HRGs hidden and isolated from society, and make them prone to contracting as well as transmitting HIV infection.

HIV prevalence among HRGs

As per the sentinel surveillance report of NACO, 2008, the HIV prevalence among HRGs is 10-15 times more than that among Ante-natal Clinic attendees. The graph below provides the HIV prevalence among different HRGs. The HIV prevalence also differs depending on the particular HRG. Thus, while FSWs have a HIV prevalence of about 5%, in case of both IDUs and MSM, the HIV prevalence is among the highest in any population group – 7%. Recent surveillance reports that the HIV prevalence among the IDUs has further increased and is the highest for any population group.

Figure 1: HIV prevalence among different population groups



Source: HIV Sentinel Surveillance and HIV Estimation 2007: A Technical Brief.

Approaching the HRGs for HIV prevention

As discussed above, as a result of their practices being seen as illegal and also due to the stigma and discrimination against them, the HRGs are often reluctant to avail of health care and HIV prevention services if these services are delivered at those places, which are meant for the general population.

Accordingly, various models of providing services to the HRGs have been tried out. Out of these, the most successful model has been the providing of services exclusively for HRGs. Thus, these services are targeted towards a particular population group and called **Targeted Intervention**. TI has been advocated as the approach to be adopted for providing HIV prevention services to HRGs. Thus, TIs:

- ◆ Are for people within the community who are most at risk of HIV infection.
- ◆ Are adapted to be culturally and socially appropriate to the target audience.
- ◆ Focus on limited resources and where they can be used to the best benefit.
- ◆ Effectively use the language and culture of the people being targeted.
- ◆ Acknowledge that barriers to accessing health-care services exist for some populations within communities.

- ◆ Acknowledge that people who are at risk of HIV infection are often marginalised from the broader community, and are stigmatized and discriminated.

Apart from requiring a targeted approach, it is also seen that HRGs do not actively seek the services and do not come out in the open due to the fear of stigma and discrimination, and also fear of being caught by the police. As a result, the HRGs have to be actively sought out in the field where they are, and services provided there. This type of service is called as '**outreach**' services, and is the backbone of a TI. Outreach means providing services to the HRGs at their 'doorstep' i.e. where the HRGs are likely to be found in the community.

The outreach services can be provided in two ways: using members from the general community or using the same community members as the target group. The latter approach is called as the '**peer education**' approach. Studies have proven that using the peer education approach is the best way of reaching out to the HRGs. Some of the advantages of using peer educators (PE) are:

- ◆ As PEs also belong to the same community as the target community, identification of the HRGs becomes easy.
- ◆ The services provided by the peer educators are more acceptable as the HRGs feel that one of their own is providing services and advising them on behaviour change.
- ◆ The PEs enjoy the trust and warmth of the HRGs, resulting in easy penetration into the network of the HRGs.
- ◆ The chances of stigma and discrimination from the PEs towards their own HRGs are minimal.
- ◆ PEs also become a role model for the HRGs to try and follow a reduced risk behaviour.

Evidence suggests that using such outreach peer-based models of targeted intervention has been able to prevent HIV among HRGs, if implemented well.

The National AIDS Control Organisation (NACO), which is the governmental agency mandated to deal with HIV-related issues in the country, has emphasised the role of TI in providing HIV prevention services for HRGs since the second phase of the National AIDS Control Programme (NACP). Under NACP II, a number of TIs were established in the country for all the HRGs, including IDUs.

The overall goal set by the NACP III is to halt and reverse the HIV epidemic by the end of NACP III. The third phase is for a five year period, that began in July 2007. The objectives of NACP III are:

- ◆ Prevention of new infections.
- ◆ Care, support and treatment.
- ◆ Strengthening capacities.
- ◆ Building strategic information management systems.

The emphasis is on prevention, and about 2/3 of the overall budget is for preventive activities. There is a thrust on scaling-up services for those in need. The TI programme has received a major boost, and the current aim is to provide universal coverage of all the HRGs through TIs. It is proposed in NACP III that at least 80% of the total HRGs would be covered with HIV prevention to realise the goals set out in NACP III.

Targeted interventions for IDUs

Injecting drug users are one of the three HRG populations recognised by NACO to be vulnerable for contracting and transmitting HIV infection in the Indian context. The subsequent chapters provide details on the drug use scenario, types of drugs, profile of IDUs as well as various approaches for addressing the problem of drug use, including harm-reduction. However, it must be mentioned here that harm-reduction as a strategy for reaching out to the IDUs has been endorsed in the National AIDS Prevention and Control Policy, in 2002 by the Government of India. The TI for IDUs also follow the same principle as for other HRGs mentioned above – the peer-based outreach model of TIs.

The TIs are run by NGOs, which are contracted by the respective State AIDS units, called State AIDS Control Societies (SACS), set up by NACO for managing HIV-related programmes. A particular geographical area is demarcated for a NGO, which is given a target (number of HRGs) to be reached with HIV prevention services. The services provided under an IDU TI include:

- ◆ Counselling on risk-reduction and behaviour change (Behaviour change communication, BCC).
- ◆ **Risk-reduction materials:** Needle syringes, abscess prevention materials (spirit swabs, distilled water, etc.), and condoms.
- ◆ Detection and treatment of Sexually Transmitted Infections (STIs).
- ◆ Treatment for health-related aspects – general medical conditions, abscess management, etc.
- ◆ Counselling on drug-related aspects.
- ◆ Opioid Substitution Treatment (OST), if the TI is accredited for providing OST services.
- ◆ Referral to appropriate agencies for other services:
 - ▲ **HIV-related services:** ICTC, ART, etc.
 - ▲ **Drug-related services:** Detoxification, rehabilitation, OST.
 - ▲ **Others:** Night shelters, vocational training, etc.
- ◆ Facilitating formation of support groups as well as some self help groups.

To provide the above mentioned services, two approaches are used by TIs:

- ◆ **Mobile-based services: through an outreach team**

The outreach team consists of an outreach worker and his team of peer educators. While an outreach worker may or may not be from the IDU community, the peer educators are either current or former injecting drug users. The team visits the “hot spots” – areas/places where the IDUs are likely to congregate. Such places can be areas where the IDUs visit to procure drugs, rest after consuming drugs or their homes. At such hotspots, the following activities are carried out:

- ▲ Befriending the IDU clients.
- ▲ Collecting basic information about the IDU.
- ▲ Providing risk-reduction materials (needles/syringes, abscess prevention materials and condoms) and basic behaviour change communication.
- ▲ Motivating them to visit the DIC for receiving additional services.

At some TIs, the counsellor also makes field visits and provides counselling to the IDUs either one-to-one or in groups (group discussion).

◆ **Static-based services: through a Drop-in-Centre (DIC)**

A DIC is also established by NGOs, preferably at a place which is closely located to the hotspots. The DIC generally consists of 3-4 rooms: a room for counselling, a room for rest and recreation, an abscess dressing room with a nurse, and a doctor's room for medical examination. A nurse/ANM, counsellor (ANM taking over the function of counsellor in most cases), and a part time doctor (visiting the DIC 2-3 times a week) are stationed at the DIC along with some of the outreach staff. The following activities are carried out at DIC:



- ▲ Screening for STI, abscess and other general medical conditions, and treatment provided as required.
- ▲ Abscess management – including dressing and cleaning.
- ▲ Counselling for risk-reduction and other drug-related issues.
- ▲ Arrangements for IDUs to take rest.
- ▲ Recreation by provision of recreational materials such as television, carom board, etc.
- ▲ Group discussions and facilitation of support group formation.
- ▲ Provision of risk-reduction materials, including needles/syringes and condoms.

For overall management of the TI programme, a programme manager is employed by the TI. The programme manager, apart from helping and guiding the TI team in carrying out the above mentioned activities, is also involved in:

- ◆ Monitoring and supervision of the programme.
- ◆ Submission of regular reports to relevant officers/agencies.
- ◆ Carrying out advocacy for ensuring smooth implementation of the IDU TI programme – in collaboration with the general community, local leaders, medical community, law enforcement authorities, as well as other stakeholders.
- ◆ Establishing linkage and networking with other agencies to ensure smooth referrals and provision of services to the IDU client.

A co-ordinated effort from all the staff of the TI, combined with the involvement of the community members/beneficiaries of the programme ensures the success of the IDU TI programmes.

Understanding drugs & drug use disorders: The basics

A drug¹, broadly speaking, is any chemical substance that, when absorbed into the body of a living organism, alters normal bodily functions. In the area of Substance Use Disorders (SUD) a drug or a substance is any chemical that, upon consumption, leads to changes in the functioning of the human mind and more specifically leads to a state of intoxication.

Some of these psychotropic substances, like alcoholic beverages and nicotine (tobacco), are legally allowed for trade and consumption in India (albeit in a strictly regulated fashion). These are called **Licit** (or Legal) substances. The trade and consumption of many other substances are strictly prohibited and are therefore called **Illicit** (or Illegal) substances. The World Health Organization (WHO) lists the following classes of substances in the section on substance use disorders.

Box 1: Substances listed by WHO

Substances listed by WHO

- | | |
|-----------------------------|---|
| ◆ Alcohol | ◆ Other stimulants , including caffeine |
| ◆ Opioids | ◆ Hallucinogens |
| ◆ Cannabis | ◆ Tobacco |
| ◆ Sedative Hypnotics | ◆ Volatile solvents |
| ◆ Cocaine | |

A brief description of common substances of use is as follows:

Alcohol

One of the oldest and most popular psychotropic substance/drug known to mankind is alcohol. In the ancient Indian texts one finds mention of *Madira* and *Sura*, which are believed to be alcoholic preparations. “distilled spirits” such as whisky, brandy, rum, vodka and gin contain 35% to 50% (usually about 42% in India) alcohol, whereas beers ordinarily contain 4 to 8%. Wines usually contain approximately 12% alcohol. Due to these variations, alcoholic drinks are measured in “Standard units”; one standard unit of alcohol is 10 ml of absolute alcohol. The rule of thumb for comparison is,



¹ Throughout this document, terms ‘drug’ and ‘substance’ have been used interchangeably.

one Standard **Drink** = ½ bottle of Standard Beer = ¼ bottle of Strong Beer = 1 peg (30 ml.) Spirits = ½ packet of Arrack (i.e. country liquor) = 1 glass (125 ml.) of table wine. The effects of alcohol on the user depends on the level of alcohol in the blood (called: blood alcohol concentration or BAC) and are as follows:

Table 1: Effects of various levels of blood alcohol concentration

BAC in mg/dl	Effects
Around 40-80	Feeling of happiness, feeling of relaxation and talking freely, some clumsy movements of hands and legs, reduced alertness but user believes himself to be alert.
More than 80	Noisy, moody, impaired judgement, impaired driving ability.
At 100-200	Blurred vision, unsteady gait, talking loudly, slurred speech, quarrelsome, aggressive, gross motor incoordination.
At 200-300	Inability to remember the experience – blackout.
More than 300	Coma and in higher levels, even death.

Alcoholic drinks available in India can be divided into Indian Made Foreign Liquor (IMFL), which are drinks made in India according to specifications of international brands; Indian Made Country Liquor (IMCL), which are drinks made in India with government licence; and Home-Brewed Country Liquor (HBCL), which are illegally brewed. Most cases of toxicity develop due to other chemicals substances added to such home-brewed liquor to make them stronger.

Opioids

Opium is the prototype opioid which is derived from the poppy plant. An opioid is any drug that acts like opium in the human body (as described below). They may be – naturally-occurring substances, such as morphine; semi-synthetics such as heroin and oxycodone that are produced by modifying natural substances, and pure synthetics such as methadone that are not produced from opium but act just like opium on the human brain. When given to a subject who has not previously experienced the effects of the drug, opioids produce an unpleasant feeling. However on continued use, injecting heroin or morphine produces a short lived (less than a minute) intense experience ‘rush’. It is described as a state of profound happiness. There is also pain relief due to the inability to feel any pain (opioids are used as medications for pain-relief for this property) and a dreamlike state characterised by decreased responsiveness to the environment.



Heroin, popularly called 'smack' or 'brown sugar' is one of the very common forms to be used. Heroin may be smoked, chased (inhaled) or **injected** (intramuscular or intravenous), however 'chasing' (inhaling the vapours emanating from a heated metallic foil) is the commonest mode of heroin use in India. Several other opioids that are used as medications (for pain relief) are also abused. Common among these are codeine cough syrups, morphine and pentazocine injections, dextropropoxyphene capsules and buprenorphine tablets/injections.

Cannabis

Cannabis is derived from the plant *cannabis sativa*, which grows in the wild all around the world including India. In low doses, cannabis causes a state of well being (high) and a dreamy, state of enjoyment. This is generally followed by a period of drowsiness. Even relatively modest amounts of cannabis can impair coordination and make the operation of heavy machinery hazardous. Perceptual and sensory distortions also occur. Subjective sense of time seems to be much slower than it actually is. In higher doses, confusion and mental/behavioural problems may occur.



Cannabis is available in various forms: *bhang*- paste of leaves of the plant or dried leaves, *ganja* – dried flowering stem of the plant and *charas* or hashish – extracted from the resin covering the plant. It can be smoked in cigarettes, or in clay pipes (most common method in religious settings and rural areas) or in water pipes like the traditional hookah. Interestingly, though products of the same cannabis plant, *bhang*, which is used in various religious festivals, is legal in India; while *charas* and *ganja* are illegal.

Nicotine

Nicotine is the main active chemical in tobacco, yet another legal and popular substance used the world over. Nicotine generally causes heightened alertness and improved functioning in continuous repetitive tasks. Users also report relaxation and decrease in fatigue with smoking, and irritability, restlessness, anger and frustration with difficulty in concentrating and sleeping, while trying to quit.



Tobacco is the commonest substance of use in India, is legally and socially sanctioned and so used in a wide variety of ways including smoking, chewing, applying to gums, sucking and gargling.

Sedatives/hypnotics

These are medications that are prescribed by doctors to reduce anxiety and produce sleep. They are also abused because of their easy availability and cheap price. Though a detailed discussion is outside the scope of this chapter, certain medications like Diazepam,



Nitrazepam and Pheniramine are widely used. These may be used either in tablet preparations, as **injections** or as cough syrups.

Cocaine and other stimulants

Cocaine is a common substance in the Americas and Europe, it is extracted from the leaves of a plant that grows in some Latin American countries. As of now, it is not widely available in India. It is generally 'snorted' (inhaled). Its use causes a short-lived sensation (7 to 10 minutes) of 'rush' which is felt intensely pleasurable by the user. Therefore it is not generally taken continuously but in 'binges' or 'runs' where it is taken every thirty minutes to a few hours, for three to seven days consecutively. There are some other stimulants called **Amphetamine Type Stimulants (ATS)**. These cause activation of the brain thereby increasing alertness, producing euphoria, improving performance and decreasing fatigue.

Hallucinogens

These are also called **Psychedelics**. These are a group of various drugs that have the common property to alter how a person sees or hears things (i.e. produce hallucinations).



Inhalants

These are substances that give vapours without heating. They are mostly petroleum products and are ubiquitous, present with glue, thinners, cleaners, solvents etc. The vapours are 'huffed', sniffed or 'bagged' (breathed in from a bag). Their use also produces a rush and sense of wellbeing and an urge to reuse after only five to six minutes. On regular use, however, they are associated with brain damage and multiple liver and lung problems.

Box 2: Injecting drug use

Injecting Drug Use (IDU): A special mention needs to be made about this pattern of drug use whereby the users inject themselves with drugs. In India almost all IDUs inject opioids with or without sedatives/hypnotics. The opioids which are popular among IDUs in India for injecting are: Buprenorphine (brand names Tidigesic or Norphine), Pentazocine (brand name Fortwin) and heroin/smack. These are often mixed with other sedatives/hypnotics like Diazepam, Phenargan, Avil etc. Particularly in north-eastern India, injecting of Dextropropoxyphene (brand name Proxyvon, Spasmo-proxyvon) is also seen.



Apart from the risk inherent to the substance used, injecting drug use poses additional risks such as injection-site infections, thrombosis (blood vessel gets clotted), skin necrosis (skin becomes dead and falls off), and the spreading of various infections, most notable HIV (Human Immune-Deficiency Virus). More details of the risks may be found in the chapter on risks related to injecting.

Important concepts/definitions associated with substance use

Various terms have been used to describe the phenomenon of substance use. These include terms such as 'Use', 'Abuse', 'Misuse', 'Dependence' etc. It must be understood that not all users of substances are addicts or dependents. Indeed, a person goes through various stages of substance use, before turning into a 'dependent' drug user.

Use: Use is simply the ingestion of alcohol or other drugs **without experiencing any negative consequences**. It may be **social use**, like in parties; **recreational or experimental use**, **dietary practice** or may be a **religious ritual**.

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

Misuse: When a person experiences negative consequences from the use of alcohol or other drugs, it is misuse.

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

Abuse: Abuse is a maladaptive pattern of use resulting in physical, social and even legal harm, or continued use in spite of such negative consequences.

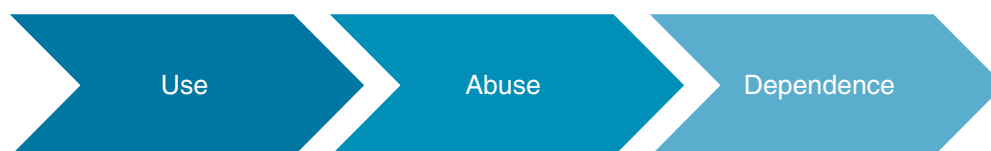
Example: The same 40-year old man continues drinking alcohol even after the incident and continues to experience further negative consequences.

Dependence: A cluster of physiological, behavioural and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.

Thus, the stages of Use, Abuse and Dependence on a symptom can be seen as a pattern of substance use in increasing order of severity (see illustration).

The detailed criteria on dependence are mentioned in the chapter on assessment and diagnosis.

Figure 2: Pattern of substance use



Common substances used in India

Tobacco, alcohol, cannabis, opium and heroin are the major drugs of abuse in the country.

The following table gives the estimate of various substance users in the country.

Table 2: Estimate of users of various substances in India

Substance used	Percentage of males who are “Current Users” i.e. used the substance in the last month (in %)*	Estimates of number of users in the country (in million)*	Dependent users in the country (requiring urgent treatment, in million)*
Tobacco	55.8	162.86	–
Alcohol	21	62.5	10.5
Cannabis	3	8.7	2.3
Opiates	0.7	2.0	0.5

*Source: The extent, pattern and trends of drug abuse in India: National Survey, United Nations Office on Drugs and Crime Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India, 2004.

It must be remembered that India being a vast country, has a lot of variation in the substance use pattern. However, in general, drug abuse is seen in both rural and urban parts of India. Mostly young adult males are affected by substance use. However, a small minority of women also indulge in substance use. Unfortunately, many substance users do not seek treatment.

It has been estimated that we have about 200,000 injecting drug users (IDUs) in the country. A large majority of them are men.

Causes of substance abuse and dependence

There is no simple answer to the question – “why do people take drugs?” It is safe to say that there are some biological factors (factors inside the individual who is using the substance) as well as some factors in the environment which interact together to give rise to substance dependence.

Figure 3: Factors leading to substance dependence



Brain researchers have found a pleasure centre in the brain, which becomes activated when ‘good’ (i.e. likable) things like food, sex, music come our way. It has been shown that drug use stimulates the same pleasure centre and therefore is felt by the user as a highly satisfying and rewarding experience, resulting in repeated use. Availability, social sanction and peer pressure are the chief drug-related factors that promote initiation and continuation of drug use. Many drug users also try to counteract their “painful feelings” by taking drugs.

Figure 4: Various factors leading to substance use

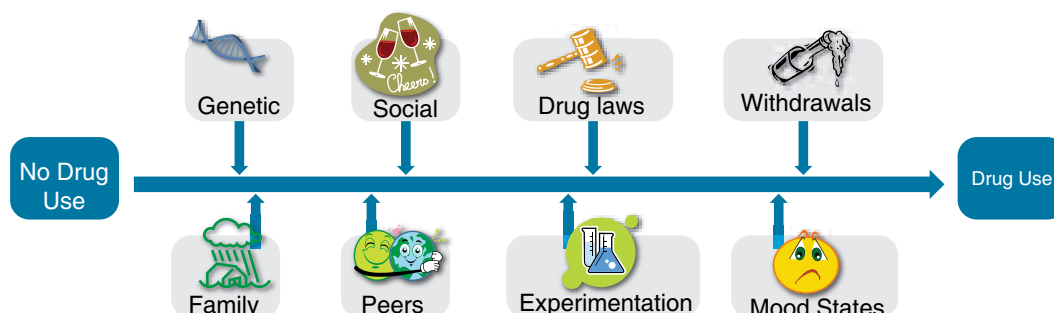
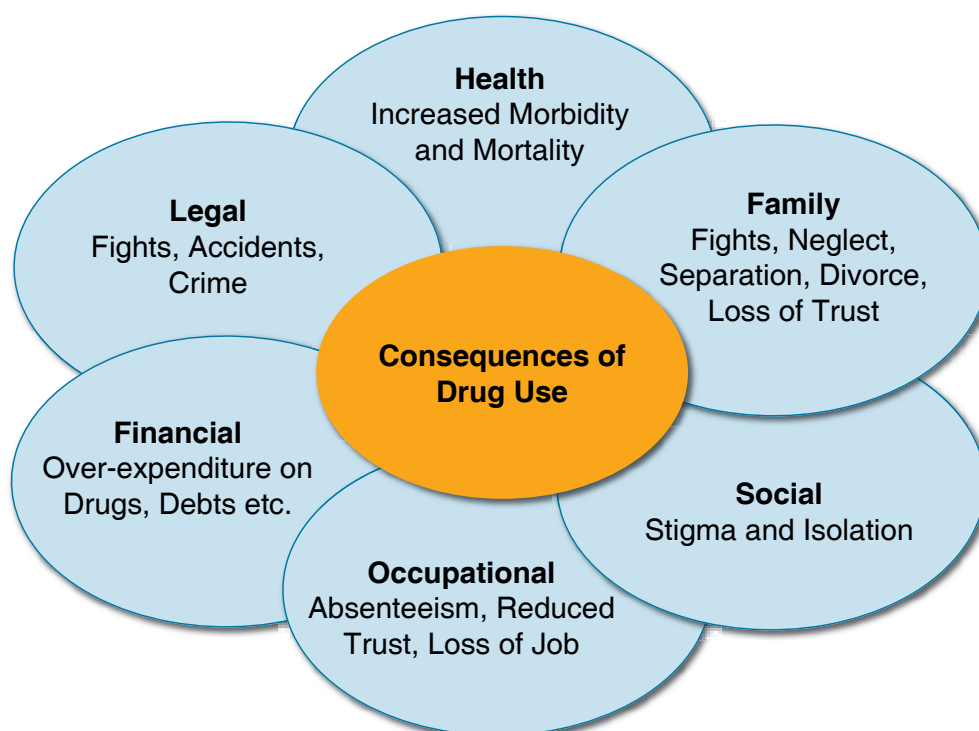


Figure 5: Consequences of substance use



Substance use has widespread consequences on the user, his family and society at large:

- ◆ **Physical consequences:** Physical complications of drug use are numerous and differ from substance to substance. In general, any drug harms the body by acute use through intoxication and overdose toxicity. Chronic (long-term) use causes harm to almost all organ systems of the human body. Jaundice and liver-diseases (alcohol), dementia/loss of memory (alcohol), heart problems (tobacco and alcohol), cancer (tobacco and alcohol), lung diseases (tobacco), viral hepatitis (IDU), HIV (IDU) and psychiatric illness (most drugs) represent only a tiny fraction of the list. Even sudden stoppage of drugs by a dependent user can cause severe physical symptoms in the withdrawal state, which sometimes may be fatal.
- ◆ **Social/familial/economical consequences:** It must be remembered that the segment of the population, which is most commonly affected by substance use, is young adult males, who are the most productive members of any society:
 - ▲ Direct economical loss of money spent on substances.
 - ▲ Loss in productivity.
 - ▲ Absenteeism from work.
 - ▲ Being expelled from job etc.
 - ▲ Adolescent users drop out from school, thereby curtailing all future earning capabilities.

Multiple physical complications and recurrent hospitalisations drain money. The stigma of substance use prevents them from getting jobs even when they are trying to quit substance use.

Family members of substance users bear the major burden in the following ways:

- ▲ Money being diverted from family funds for sustaining substance use behaviour.
- ▲ Family suffers from the stigma of drug use and discrimination.
- ▲ Substance users are often in conflict with family members.
- ▲ In India, as most users are males and dominant members of the family, women suffer silently from marital physical abuse, sex without consent and risk of HIV infection secondarily transmitted to them by their husbands.
- ▲ Children of such dysfunctional families often suffer from psychiatric illness, and have increased chances of also becoming substance users themselves.

Society at large suffers from loss of productivity and an increased burden to support and treat these potentially productive members. Crime rates rise and rash behaviour often causes accidents and destruction of property.

- ◆ **Psychological consequences:** Psychological complications range from lack of wellbeing to frank depression and other mental illnesses. Any underlying mental illness is generally aggravated by substance use.
- ◆ **Legal consequences:** Substance users are always at conflict with the law. They are often incarcerated when caught with illicit substances and a life revolving in and out of jail follows, thereby severely hampering any chances of securing gainful employment. Though the law in India (NDPS Act) has provision for arranging for suitable medical treatment of substance users, in lieu of sending them to jail, it is seldom practised. In order to sustain substance use behaviour, many users are forced to indulge in illegal activities like stealing, robbing and peddling drugs. Vandalism, rash driving, intoxicated behaviour often brings them to court.

Such dire consequences of drug use make it imperative to develop strategies that will help in early identification of substance users and treat them effectively to minimise the harmful consequences of substance use.

Understanding HIV/AIDS & STIs: The basics

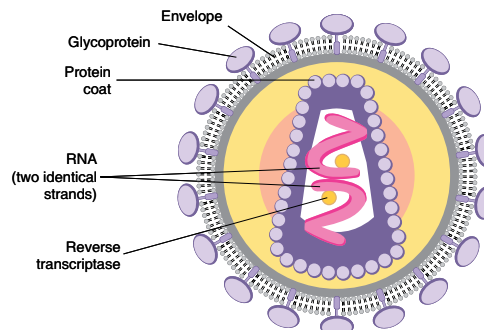
What is HIV?

The term **HIV** stands for “**H**uman **I**mmunodeficiency **V**irus”. If we break down all these three terms, it would mean that this is a **Virus** which, upon infection, leads to a deficiency of the **Immune System** in **Humans**.

How are viruses unique?

Before discussing this infection in detail, it is very important to understand what exactly are viruses? Viruses, basically are micro-organisms, which are considered to be a connecting link between the living and non-living. They are so tiny that they cannot be seen by the naked eye, or with an ordinary microscope. They can only be seen through special electron microscopes. Since they are on the boundary of the living and non-living, they cannot sustain/multiply outside a living body. In other words, all viruses require another living organism to thrive and multiply. Yet another property of viruses is that they are very fragile. They tend to destroy rapidly outside the cells of a living organism. The attached picture shows a single HIV virion.

Figure 6: A single HIV virion



What is AIDS?

Many people tend to think that the terms HIV and AIDS are synonymous and interchangeable with each other. It must be understood that while HIV is the name of the micro-organism which causes the infection, AIDS is the name of the disease which results due to HIV infection. In other words, HIV causes AIDS. The term AIDS is also an acronym, which stands for:

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

Thus, AIDS is a disease ('Syndrome'), which is characterised by a deficiency in the body's immune or resistance system, which makes the body vulnerable to other infections and diseases.

It must be noted that not everyone who is infected with HIV, develops AIDS; many people are able to live a normal and healthy life despite being infected with AIDS. The time duration after which HIV infection develops into AIDS is variable.

How does HIV spread? (or does not!)

HIV transmission

Certain conditions must be met as requirements for HIV transmission to occur from one individual to another. At the most basic level – “HIV must be present in sufficient quantity and it must get into the bloodstream”:

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

As stated earlier, HIV being a virus cannot survive easily outside the human body. The box below lists some important issues surrounding the survival of this virus.

Box 3: HIV survival outside the body

HIV Survival Outside the Body

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

Thus, for transmission to occur, the body fluid which contains the virus must enter into the body of another individual. It must be noted that in an infected individual, not all body fluids contain enough HIV to be able to infect another, as listed below.

Box 4: Comparison of infectious and non-infectious body fluids

Infectious fluids in the body	Non-Infectious fluids in the body
◆ Blood (including menstrual blood)	◆ Saliva
◆ Semen	◆ Tears
◆ Vaginal secretions	◆ Sweat
◆ Breast milk	◆ Faeces
◆ Pre-seminal fluid	◆ Urine

As seen in the table above, only certain body fluids have the potential to infect another individual. Consequently, HIV can be transmitted through the following routes:

- ◆ Sexual contact.
- ◆ Direct blood contact.
- ◆ Mother to baby.

Sexual contact: risks

While all varieties of sexual contact between an infected individual with another individual are fraught with the risk of HIV transmission, this risk is not uniform. The following list shows certain varieties of sexual contact, with varying degrees of risk.

- ◆ Peno-anal sex has more risk than peno-vaginal.
- ◆ Peno-vaginal sex has more risk than oral sex.
- ◆ Sex between an infected male and non-infected female has more risk than infected female and non-infected male.
- ◆ The risk is substantially more in the presence of injuries. Hence risk is more in coercive/violent sex.
- ◆ The risk is more in presence of other Sexually Transmitted Infections (STIs).

Direct blood contact: risks

The direct blood contact is the most efficient route of transmission of HIV infection, since blood has the highest concentration of HIV as compared to other body fluids. Direct blood contact may occur in a variety of situations, all of which have varying degrees of risk of transmission:

- ◆ **Blood transfusion:** which also includes blood-product transfusion, has the highest risk.
- ◆ **Sharing of injection equipment:** among various injection equipment, sharing of needles is associated with highest risk, followed by sharing of syringes, followed by sharing other injecting paraphernalia. The risk also depends upon the type of injections; intravenous injections are associated with higher risks as compared to intramuscular injections.
- ◆ **‘Needle sticks’:** yet another route of transmission is accidental transmission in health care settings known as “needle stick injury”, while injecting (or while performing a surgical procedure), health care staff may accidentally injure themselves, with instruments, previously used upon patients. This applies to staff involved in the Needle Syringe Exchange Programme as well.
- ◆ **“Shaving Blade Injury”, Tattooing, and Piercing:** All these situations have very low but definitely present risk.

Mother to baby: risks

HIV infection may be transmitted from an infected mother to her baby in all the following stages of life:

- ◆ **Before birth:** since the baby shares mother’s blood.
- ◆ **During birth:** accidental contact with the mother’s blood during delivery.
- ◆ **Through breast feeding:** though the quantity of virus is small in breast milk, it is enough to cause infection in the baby.

While it is important to know, how HIV spreads, it is equally important to know, how HIV does not spread.

Box 5: Activities that do not spread HIV

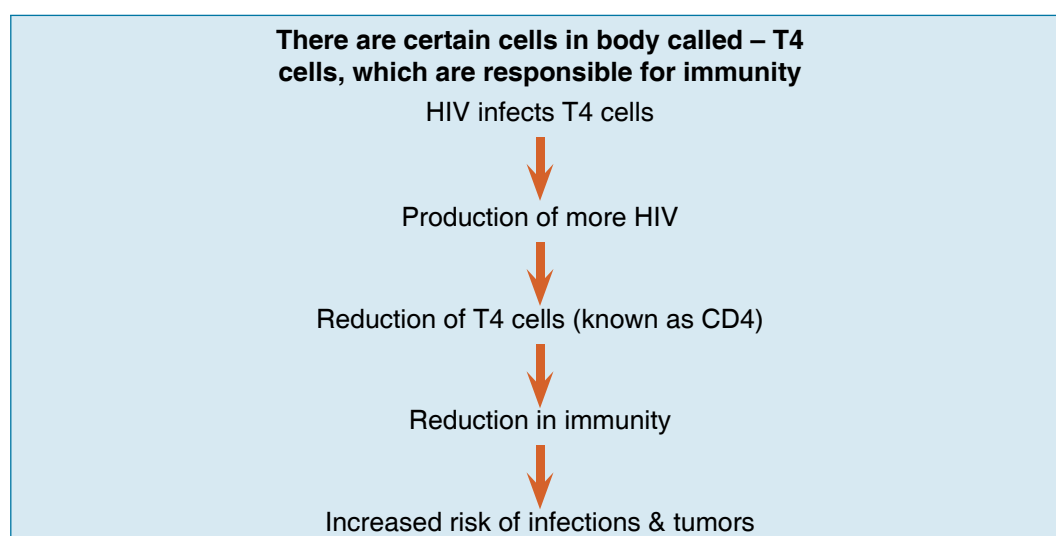
HIV does NOT spread through

- ◆ Shaking hands
- ◆ Kissing
- ◆ Hugging/sharing clothes/food/utensils/towels/toilets
- ◆ Insect bites
- ◆ Human bites

What happens after HIV enters the body?

As stated earlier, HIV causes AIDS by weakening the immune system of our body. Our bodies are normally protected by “white blood cells” against diseases. These white blood cells help fight diseases that attack our bodies. However HIV is a stronger than the white blood cells; it attacks and weakens the white blood cells. Consequently, when our bodies no longer have enough white blood cells to protect them (AIDS), other diseases and infections can attack us and eventually kill us. The process has been explained in the flow chart below.

Box 6: Chain of events after HIV enters the body



The HIV test

The human body produces certain specific chemicals, in response to detecting some foreign agents (i.e. infections). These chemicals are called **Antibodies**. After HIV enters the body, it infects cells and is recognised by our immune system as ‘**Foreign**’. In response to this foreign invasion, our body produces antibodies. After a period of time, these antibodies are detectable through laboratory tests in our blood. When these antibodies can be detected in someone’s blood, it is regarded as a “Positive HIV Test”.

However, the process of production of antibodies can take from three to six months, known as the ‘window period’. During this period, antibodies are not detectable in the blood (i.e. ‘negative HIV test’), but the person remains infected and can infect others.

HIV infection: symptoms

Even without AIDS, people infected with HIV may experience certain troubling symptoms. These include:

- ◆ Significant weight loss.
- ◆ Persistent fever.
- ◆ Persistent diarrhoea.
- ◆ Persistent cough.
- ◆ Persistent generalised swelling of lymph glands.

Treatment of HIV/AIDS

Many people mistakenly believe HIV/AIDS to be a deadly condition. It is true that death rates among people suffering from AIDS are very high. However, advances in medical science have ensured that with proper treatment and care (known popularly as Anti-Retroviral Treatment or ART), individuals with HIV/AIDS can prolong their lives considerably and can enjoy a reasonable degree of quality of life. Thus with regard to HIV/AIDS, "Treatment is available; Cure is elusive."

It has been shown that effective and regular treatment of HIV/AIDS:

- ◆ Prolongs life.
- ◆ Reduces infectivity.
- ◆ Reduces likelihood of opportunistic infections.
- ◆ Improves quality of life.

However, ART is costly (but available almost everywhere in India, free-of-cost at the government hospitals). In order to be effective, the treatment needs to be long-term (life-long) and sustained. The treatment is also associated with side-effects/resistance. Thus remaining in the follow-up care of the doctor is crucial for people on ART.

Prevention is better than cure!

Thus, at this moment, like almost all health conditions, prevention appears to be much better than cure (or treatment) for HIV.

How to prevent HIV infection

- ◆ Do not share instruments such as razor blades, needles and syringes. If sharing cannot be avoided, then insist on using sterilised instruments.
- ◆ Cover cuts and wounds with water-proof plasters or a piece of clean cloth.
- ◆ Do not have sex until you are married and then stay faithful to your partner. Avoid multiple partners. If not possible, use condoms.
- ◆ Women with HIV should seek advice before getting pregnant because they may pass on HIV to their babies. HIV-positive mothers can transmit the HIV virus to their babies through breast feeding. However, breast feeding is the best food for babies, as it protects against many other diseases.
- ◆ Either the infected mother exclusively breast feeds her baby for not more than 3 months or only uses alternative feeds. Avoid mixing breast milk with other fluids or foods. Go to the health-worker for advice on alternative feeds.

Box 7: Vulnerability for HIV – gender aspects

Who is more vulnerable for HIV? Men or women?

It has been shown that though a far higher number of men are infected with HIV, as compared to women, women are more vulnerable to HIV, due to various **Biological, Socio-cultural and Economic factors**.

Biological factors

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

Socio-cultural Factors

- ◆ Position of women in society:
 - ▲ Less bargaining power.
 - ▲ Lower levels of education and literacy.
- ◆ The age difference between couples and trend of early marriages.
- ◆ Social values regarding sexual behaviour between men and women.

Economic factors

- ◆ Women have less of a say in economic matters:
 - ▲ Hence less bargaining power.
- ◆ Sex trade (women as sellers and men as buyers).

Sexually Transmitted Infections (STIs)

As the name suggests these are infections which are transmitted from one person to another through the sexual route. These infections are usually caused by micro-organisms such as bacteria or viruses. The box below lists the names of some common STIs.

Box 8: Common forms of STIs

Common STI

- ◆ Syphilis
- ◆ Gonorrhoea
- ◆ Chancroid
- ◆ Herpes
- ◆ LGV

Common symptoms of STI

Since these infections are transmitted through sexual routes, they affect primarily the sex-organs of the body. Consequently, the common symptoms of the STIs also pertain to various sex organs such as:

- ◆ Genital discharge
- ◆ Genital ulcers
- ◆ Genital growth

- ◆ Anal growth
- ◆ Anal ulcer
- ◆ Anal discharge
- ◆ Painful swelling of scrotum
- ◆ Swelling in the groin

It must be noted that if the mouth and tongue of an uninfected person comes into contact with genitals of an infected person (during oral sex), the symptoms such as discharge and ulcer can be experienced in and around the mouth also.

Consequences of STI

STIs can be dangerous and may sometimes lead to grave health consequences. While there is the obvious **risk of transmission to partner**, untreated STIs can lead to an **increase in symptoms leading to pain and disability**. Additionally, this may result in **spreading of infection to other parts of body** with damage to other body organs. In the context of HIV however, STIs themselves are associated with an **increased risk of HIV**. Indeed, persons suffering from STIs have a 2 to 4 times increased risk of getting HIV infection.

Linkage of STI with HIV

When an HIV-infected individual performs sex with another uninfected individual, the healthy, unbroken skin and mucous membrane of genital organs, does attempt to resist invasion and prevent entry of HIV-infected body fluids inside the body. In the presence of other STIs however – if they are associated with ulcer or discharge—there is an enhanced risk of mixing of body fluids. Thus, having other STIs increases the risk of HIV transmission.

Treatment of STIs: syndromic management

Till a few decades back, many of the STIs were difficult-to-treat conditions. However, with advances in medical sciences, it has now become possible to treat STIs effectively.

Since a wide variety of micro-organisms have been implicated in the causation of STIs, a “syndromic management of STIs” has been recommended. This approach recommends that such medicines be given for treatment, which will cover all the possible organisms that might cause a symptom or a group of symptoms.

In order for treatment to be effective and acceptable to the patients, the World Health Organisation (WHO) recommends that:

- ◆ As far as possible a single oral dose of medications is to be used (per day).
- ◆ Drugs should be chosen on basis of no resistance amongst organisms.
- ◆ Drugs should have no or minimum side-effects.
- ◆ Drugs should be affordable.

In almost all government hospitals, facilities exist for diagnosis and treatment of STIs.

Approaches to address drug use problems

As described elsewhere in this document, drug use is associated with a wide variety of adverse consequences or harms. These harms adversely affect not only the drug-using individual but also his/her family, community, society and country. Consequently, since time immemorial, various strategies have been adopted to keep problems related to substance use under control.

Let us imagine a fictional city 'X', where there are a large number of shops selling alcoholic beverages, legally. There are also some drug peddlers who indulge in selling illegal drugs like ganja and heroin, but illegally and clandestinely. A large number of people in the city drink alcohol, a large proportion of whom are using alcohol in the pattern of Abuse or Dependence. These people and their families are suffering from problems related to alcohol use. There is also a substantial chunk of the population who use illegal drugs like ganja and heroin; some also inject heroin and are at risk of getting infected with HIV, and subsequently transmitting HIV infection to their wives. What are the various approaches that could be adopted by this city to protect its residents from the adverse consequences of drug use?

Supply reduction

The first popular response to all drug problems is usually, "let us stop or control the availability of drugs in this city." Such an approach is inherently intuitive and appeals to the masses and administrators alike. It has the potential to evoke the natural human instinct of striking at the root cause of the problem. Thus, a very common approach to address substance use problems has been to disrupt the supply and availability of drugs. This may take two forms:

Regulated supply of legal drugs: Whereby legal substances like alcohol are available but with certain regulations. There are restrictions regarding the locations in which alcohol could be sold/bought/consumed, the age group of people who can sell/consume it, the timing of the day when it could be sold/bought. Additionally, the cost is also kept under regulation through imposing duties and taxes. All these strategies aim at discouraging the consumption of alcohol.

Total prohibition of illegal drugs: Whereby certain drugs are declared totally illicit, so that their manufacture, production, trafficking, purchase, possession and consumption are declared illegal acts under the law. Enforcing laws such as the Narcotic Drugs and Psychotropic Substances Act (1985) of India is an example of such a strategy, whereby drugs like heroin, opium, ganja, cocaine are totally illegal in the country (and indeed in most of the world).

Thus, in the city 'X', enforcing alcohol availability regulations (like increasing the taxes on alcohol making it costlier, reducing the number of shops selling alcohol,

reducing the number of hours for which alcohol shops would be open) could be adopted to discourage alcohol use among people. For illegal drugs like heroin and ganja, strategies such as strict policing to stop all trafficking of drugs, seizures of drugs, strict punishment to those found indulging in trafficking or consumption may be adopted.

However, can the adoption of such strategies help those who are already dependent on these drugs? Individuals who are dependent on these drugs will continue to suffer from distressing withdrawal symptoms and thus will continue to indulge in using these drugs, keeping themselves and their communities exposed to further harms and risks. Clearly we need to think of strategies to help such individuals too.

On the other hand, just adopting these supply control strategies will not reduce the desire and curiosity among users and non-users of these drugs to use them. Young people particularly may continue to feel attracted towards the lure of these drugs. In other words, even though supply may be curtailed, the demand for these drugs will continue to exist. To address this, we need additional strategies.

Demand reduction

Certain strategies may be adopted to reduce the demand for drugs itself. These strategies may again take two forms:

- ◆ **Primary prevention:** Strategies aimed at young people to discourage initiation of drug use (such as enhancing awareness about ill-effects of drugs, teaching life-skills, coping skills and drug-refusal skills to young people).
- ◆ **Treatment:** Identification of drug users, particularly those who fall in the categories of abuse or dependence; providing effective treatment for them.

However, it must be realised that even by adopting both – supply reduction and demand reduction strategies – we cannot expect a total control over drug-related problems in our fictional city X. Since drug dependence is known to be a chronic, relapsing condition, not all individuals receiving drug treatment will be able to stay away from drugs for long. Similarly, no amount of law-enforcement will be able to totally abolish the supply of drugs. Thus:

- ◆ There will always be some people using drugs.
- ◆ Among these users:
 - ▲ Some may not be willing to give up drug use altogether.
 - ▲ Many others may have tried but failed.
- ◆ All such drug-using individuals will be at continued risk of drug-related harms.

To help such individuals, a different type of approach would be required.

Harm-reduction

This approach entails “*policies and programmes that are aimed at reducing the harms from drugs, but not drug use per se.*” Inherent in this approach is the belief that even if drug use cannot be stopped completely, it should still be possible to help drug users to reduce the harms faced by them as well as their communities. Since it has been proved that relying only on supply control and demand reduction

strategies will continue to expose society, to drug-related harms, the ‘harm-reduction’ approach comes across as a viable and pragmatic alternative.

Indeed, over-reliance on supply control approaches may even increase the harms associated with drug use. For instance, in the city ‘X’, some drug users are habituated to taking heroin through the ‘chasing’ method. Suddenly due to very strict law enforcement the supply of heroin is reduced and as a result the heroin is available but at a very high cost. As a demand reduction strategy there are some drug treatment centres in the city ‘X’, but not all drug users are keen to take treatment. Some have attempted taking treatment but have relapsed into drug use again. In this situation, a lot of drug users will be forced to look for cheaper alternatives to the chasing route of using heroin and may start taking drugs through the injecting route (which is a considerably cheaper and efficient route – see chapter ‘Understanding Injecting Drug Use’). Thus, the inadvertent result of strict law enforcement is exposing some individuals to further harms and risks.

Thus, for such individuals we need strategies which allow using drugs, but with considerably reduced risk to the individual and society. Though the concept of harm-reduction can be applied to all kinds of harms associated with drug use, in practice the term has been used to describe approaches and strategies aimed specifically at reducing the risk of HIV among IDUs. The box below lists the important principles of ‘harm reduction’ approach.

Box 9: Principles of harm-reduction

Principles of Harm-reduction
Recognises the intrinsic value and dignity of human beings
Seeks to maximise social and health assistance and minimise repressive and punitive measures
Does not judge drugs and drug use as good or bad, rather it emphasises the reduction of drug-related harm
Encourages safer drug use
Recognises the competency of users to make choices and change their lives
Challenges conventional drug policies and their consequences

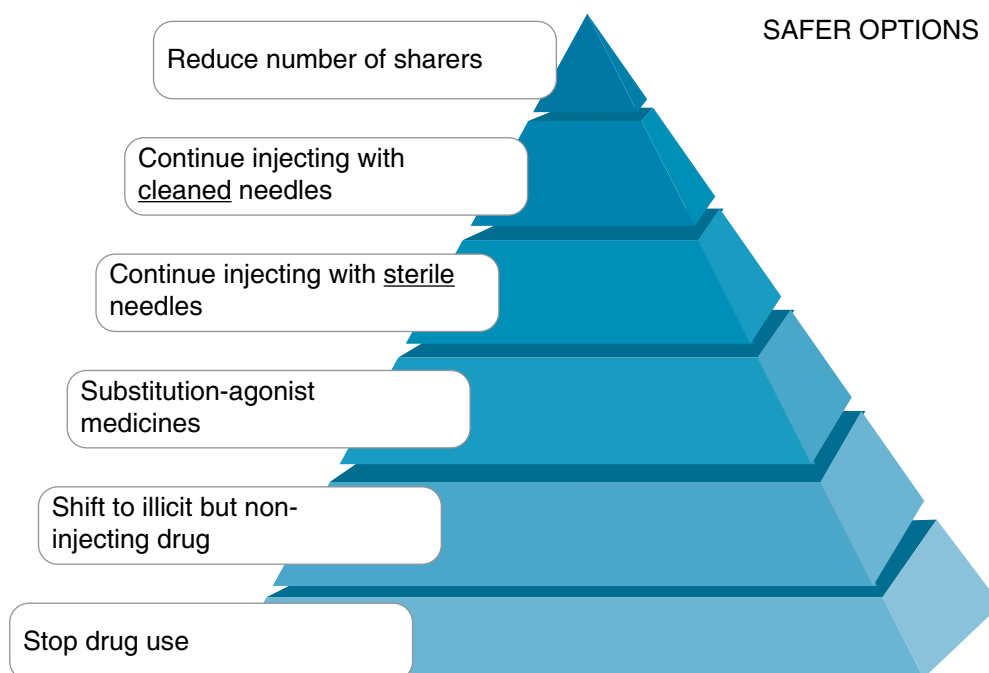
Harm-reduction strategies

Various strategies are employed in the harm-reduction approach. These are:

- ◆ **Educational interventions.**
- ◆ **Needle Syringe Exchange programmes.**
- ◆ **Outreach.**
- ◆ **Oral Substitution Therapy.**

Educational interventions: These interventions are aimed at providing the requisite information to IDUs about safer options, and educating them on safer injecting methods. The educational strategies work best when the information provided is factual, clear and delivered through peers, since IDUs are (like most of us) more receptive to the information provided by their peers (i.e. by people like them). The figure below shows a pyramid of safer options for an IDU to reduce the risk of HIV. As can be seen at the bottom of pyramid, the best and safest option for an IDU would be to, of course, stop drug use completely. However, since this may not be feasible for most IDUs, the next best option would be to stop injecting, and so on.

Figure 7: Risk-reduction through education



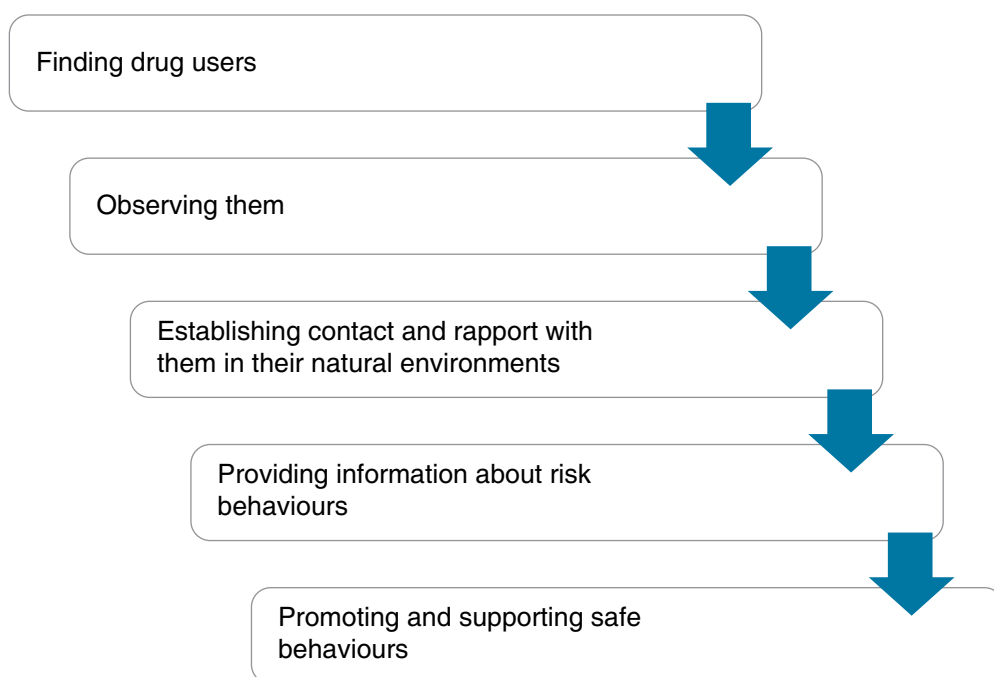
Needle Syringe Exchange Programme: These programmes work on the philosophy of providing sterile and new needles and syringes to IDUs, in exchange of old, used and potentially infected ones. The 'exchange' component has multiple benefits. First, it ensures that all the used injecting equipments have been collected from the IDUs and destroyed under supervision, minimising the risk of reuse and accidental exposure. Secondly, it provides an opportunity for frequent contact with IDUs, during which not just needles and syringes but education and other services can be delivered.

The needle syringe programmes often generate controversy wherever they are started. Many people tend to oppose them on the grounds that these programmes amount to encouraging drug use. However, research conducted throughout

the world has clearly established that these programmes are very successful in reducing the risky behaviours, adopting safer behaviours, reducing the risk of HIV, encouraging the entry of IDUs into drug treatment programmes etc. Additionally, there is no evidence from anywhere in the world, that these programmes have led to an increase in drug use.

Outreach: The term ‘outreach’ literally means, reaching out. As the attached illustration shows, outreach involves a number of steps. Outreach should be seen as a mode of delivery of services rather than a harm-reduction strategy per se.

Box 10: Model of outreach services



A more detailed description of outreach could be found in the Training Module developed by the NACO on Harm-reduction, “Working with Injecting Drug Users”.

Oral Substitution Therapy: Described in another chapter.

Understanding injecting drug use

As described in the earlier chapters, drugs can be taken through various routes. All these routes have their own advantages and disadvantages for the user (summarized in the adjoining table).

Box 11: Various routes of drug-taking

Route	Characteristics
Oral	<ul style="list-style-type: none"> ◆ Only very few drugs can be taken through oral route. ◆ In general the oral route is one of the least efficient routes of drug intake since: <ul style="list-style-type: none"> ▲ A lot of the drug is destroyed (especially by the liver) before it reaches the brain. ▲ It takes substantially longer for the drug to reach the brain and exert its effects. ▲ However, oral route is also least harmful for taking drugs, in general.
Smoking/ Inhalation/chasing	<ul style="list-style-type: none"> ◆ Drug reaches the blood circulation through lungs and then onwards to the brain fairly early. ◆ This route is harmful as it damages the linings of the lungs and can give rise to various respiratory diseases.
Injecting	<ul style="list-style-type: none"> ◆ The most efficient route of drug intake. ◆ Drug reaches brain fairly quickly and gives sudden effects. ◆ Requires much less amount of drug (hence cheaper). ◆ Most damaging or harmful route of taking drugs.

Thus, the injecting route of the drug is the most efficient and also the most harmful route. By-and-large, it is seen that drug users who choose to take drugs through the injecting route, have a relatively severe degree of drug dependence. Not all drugs can be taken through the injecting route though. In India, almost all injecting drug users inject one or the other opioid drug. Thus, the important thing to remember is that a very large majority of IDUs in India are Opioid Dependent.

The **common drugs injected in India** are:

- ◆ **Heroin (pure/white heroin/ 'No. 4')**: This is injected mainly in the north-eastern states, as pure heroin is very costly and difficult to procure in other parts of the country.
- ◆ **Heroin (Smack/brown sugar)**: This is not readily injectable as it comes in the form of crude, impure powder. Before injecting, a user has to prepare

or 'cook' the drug. Typically, most users would mix the powder with an injectable sedative drug (like chlorpheniramine), boil it, filter it with a cotton swab and then inject it.

- ◆ **Buprenorphine (Tidigesic/Norphine) or pentazocine (Fortwin):** These are probably the most popular drugs for injecting among IDUs in India. Typically most users mix them with one or more of the following sedatives for enhancement of the effects: Diazepam (calmpose), chlorpheniramine (Avil), Promethazine (Phenargan).
- ◆ **Dextropropoxyphene (Proxycvon/Spasmo-Proxycvon/SP):** This drug is available as capsules and NOT AS INJECTIONS. Still some users (seen only in the north-eastern states, very rarely in other parts of the country), open the capsules, take the powder out, mix it with another liquid/drug and then inject it.

Injecting drug use in India

Historically, the use of certain intoxicating substances has been prevalent in India for many centuries now. Traditionally, various cannabis derivatives, opium and locally-brewed alcohol were the substances of use. Until the early twentieth century, many of the drugs which are currently illicit were regarded as legal. Non-medical or non-prescription use of psychotropic medications was also observed. In the 1980s, however, with the introduction of heroin in India, the situation changed to a great degree. Many users of a traditional, plant-based (and relatively less potent) drug like opium shifted to a modern, synthetic (and more potent) drug, that is, heroin.

In the 1990s, many heroin users switched to injecting modes of taking opioid drugs. The phenomenon was first noted in the north-eastern states of Manipur and Nagaland. Gradually however the phenomenon of injecting drug use spread initially to bigger cities. In the last few years however, injecting drug use has spread to many more parts of the country. Currently, India figures among the developing and transitional countries with the "largest populations of IDUs". The National AIDS Control Organisation estimates that currently there are about 2 lakh IDUs in India. Similarly, HIV among IDUs is also progressing in India at an alarming rate. At the national level, IDUs are the vulnerable group (among other vulnerable groups such as Female Sex Workers and Men-Who-Have-Sex-with-Men) which has the highest prevalence of HIV. The states/areas particularly affected by HIV among IDUs are: Manipur, Nagaland, Mizoram, Punjab, Chandigarh, Delhi, Kerala, Tamil Nadu and parts of Orissa, Bihar, and UP.

The usual drug use career

It has been seen in India, that it is very rare for drug users to start their drug-use careers with injecting. Typically, most IDUs start as users of other drugs. Usually the first drugs people start taking (usually in adolescence) are tobacco and alcohol. Thereafter people start smoking cannabis (ganja or charas). This is followed by a period of using opioids through non-injecting route; mostly smack/brown sugar through chasing. After this, drug users start taking opioids through the injecting route. However, there are always exceptions to this rule. Some users start taking opioid injections directly, without an intervening period of brown sugar chasing. Additionally, sometimes people are given prescriptions of opioid injections for health reasons (such as pain) by doctors. Some people thus, start taking opioid injections legitimately as pain-killer medications, but gradually develop dependence on it.

Common profile of people who inject drugs

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

Injecting practices

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

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

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

The most risky aspect, from a public health perspective is however, sharing of injection equipments. Injecting is very often a group activity. It is not unusual for a group of IDUs to have fewer injecting equipment than required. Consequently, IDUs sometimes share their injecting equipment. The sharing may involve:

- ◆ Sharing needles
- ◆ Sharing syringes
- ◆ Sharing injecting paraphernalia (i.e. the cookers or pots in which drug has been prepared for injecting)

The box below lists some of the reasons why IDUs share their injecting equipment. All of these sharing practices are associated with risk of transmission of various blood-borne infections. The important ones among these are HIV, Hepatitis-B and Hepatitis-C.

Box 12: Reasons for sharing injection equipment

Reasons behind sharing injection equipment

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

Yet another issue which makes injecting risky is the risk of overdose and toxicity. Through other routes like the oral route or smoking, it is relatively easier to control the amount of drug one is ingesting. For instance, while chasing heroin, a person may start realising that he is getting deeply intoxicated now and may stop chasing further. Indeed, with severe intoxication, it would anyway be very difficult to perform the act of chasing. With the injecting route however, it is possible to inject a large amount of drugs within seconds, which may lead to toxicity. Thus overdose deaths which are rare with other routes of drug use, remain a possibility with injecting route.

Box 13: Risks and harms of injecting drug use

Risks and harms specifically associated with injecting drug use

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

Assessment and diagnosis in drug use disorders

Introduction

In most cases, before an IDU comes in contact with the counsellor, he/she would have been contacted by the ORW or PE in the field. The IDU would then be referred by the PE/ORW to the DIC. In such cases, the counsellor, who would have some prior information about the client, should then proceed to make further assessment about the IDU client. In some cases, the counsellor may be the first point of contact for the IDU, during the counsellor's field visit to the hotspots. During such field visits, the counsellor may have only a brief period for assessment of the IDU.

Assessment of the IDU client is very important for a number of reasons. It forms the cornerstone for understanding the client and helps in providing appropriate care and support.

Assessment – uses

While assessment of an individual is usually useful to diagnose and treat a patient, in drug dependence management, the utility of assessment goes much beyond that. Assessment serves the following important purposes:

- ◆ Building a rapport with the IDU – the time spent in assessment provides an opportunity for the counsellor to build a relationship of trust and harmony with the client and helps in building confidence of the client in the counsellor.
- ◆ Measuring the extent of problems faced by the IDU – through a proper assessment, the type of problems faced by the IDU can be understood.
- ◆ Planning referrals.
- ◆ Planning appropriate management of the client.
- ◆ Motivate the client for seeking help.

Assessment is not a one-time task. Often, the counsellor is not able to complete all the aspects of assessment in one session. More than one session may have to be conducted to complete the required assessment. This may be because of the client's lack of trust towards the counsellor, state of intoxication, or because of the setting in which the assessment is being carried out (e.g. in the hotspot).

Methods for conducting assessments

Assessment can be carried out by eliciting information from the client, conducting a physical examination, applying standardised tools and also by laboratory investigations. In a TI setting, however, assessment is usually carried out by eliciting information from the IDU client. In very few cases, the IDU may be accompanied

by family members. In such cases, further information can also be elicited from the family members.

Areas of assessment

The following areas need to be explored to understand the extent of problems faced by the IDU client. Exploring all of these areas would provide a comprehensive understanding, as well as help in planning further management of the client:

- ◆ **Basic socio-demographic profile:** The client's age, sex, marital status, educational status, place of residence. Gathering this information would help in getting a rough sketch of the client.
- ◆ **Details of drug use:** During the first session, it may be difficult for the counsellor to get a detailed drug use history. In such cases, the counsellor should prioritise and focus on the current drug use status. Three important issues are to be asked about so as to assess the drug use status:
 - ▲ **Type of drug:** Drug that an IDU would be using. For e.g. heroin, buprenorphine, pentazocine, cannabis, etc. In cases, where the counsellor is not able to know the exact chemical name, he/she should write the local name which is used in the community and find it out from other staff later.
 - ▲ **Frequency and amount of drug:** It is important to know the number of times an IDU is using the particular drug. This is especially true for determining whether the IDU is dependent on the particular drug or not. In addition, knowing the number of injections would also help in better outreach planning for the IDU.
 - ▲ **Mode of use of drugs:** The manner in which the particular drug is consumed should be assessed. While certain drugs such as alcohol are consumed only orally, other drugs such as opioids, can be consumed either orally (e.g. opium, liquid prepared from poppy straw), by the inhalational route (e.g. smoking/chasing heroin), or through the injecting route (e.g. injecting heroin or pharmaceuticals).
 - ▲ **Last dose of drug used:** It is important to know whether the IDU is currently intoxicated or in withdrawal. In addition, this information is also important for deciding whether to initiate OST, if the TI offers OST to the IDU clients.
- ◆ **Complications with drug use:** complications resulting from drug use can occur in multiple spheres of life. All of the following areas should be actively enquired:
 - ▲ **Physical:** Health hazards associated with drugs, both local (redness or swelling at injection site, wounds, sores, blocked veins, etc.) and systemic (affecting lungs, liver, heart, etc.). In case, there are indications of physical damage, the client should be referred to the visiting doctor for further assessment and examination.
 - ▲ **Legal:** Involvement in illegal activities to obtain drugs (e.g. thefts, pick-pocketing), arrests/detentions by the local police, whether ever charged under NDPS act, driving under intoxication of drugs, physical fights under intoxication of drugs.
 - ▲ **Occupational-financial:** Inability to work productively, accidents at workplace due to intoxication, frequent absenteeism at work, loss of job (unemployment), frequent change of jobs, loss of income, debts, etc.

- ⤴ **Marital/familial/social:** Fights with family/spouse due to drug use, neglect of household responsibility, physical violence towards family members, outcast from family, separation/divorce, homelessness, stigmatisation due to drug use in the society, etc.
- ⤴ **Psychological:** Guilt and shame due to drug use, anxiety, depression, etc.
- ◆ **High-risk behaviours:** This is an important aspect of assessment of the client. The client should be actively asked about high risk behaviour. The risk behaviours can include those which put the client at risk of HIV as well as other health conditions. In case of IDUs, high risk behaviours include both injection-related and sex related behaviours:

- ⤴ **Injection-related:** An IDU is at greater risk of contracting HIV infection due to the practice of injecting drugs. Injecting is a much more efficient vehicle of HIV transmission as compared to hetero-sexual intercourse. Injecting drug use is often a group activity, resulting in sharing of needles and syringes.



The needles and syringes are shared due to a number of reasons: non availability of clean needles and syringes when the IDUs need them, financial difficulty in procuring needles and syringes, myths related to sharing (e.g. sharing leads to increased bonding among the group members). Apart from direct sharing of needles and syringes, an IDU is also at greater risk due to sharing of other equipment used in the process of injecting. This would include, for example, cotton swabs used for filtering, alcohol bottle caps used for heating, tourniquets, etc.

Sharing of needles/syringes as well as other injecting equipment places an IDU at risk of other infections too. Hepatitis B and C are infections which are fast spreading among the injecting drug- using community. Compared to HIV, Hepatitis B & C virus spread more efficiently with a very small amount of blood. To protect oneself from these hepatitis-causing viruses, an IDU must observe utmost precaution and hygiene during injecting. In addition, practices such as not cleaning the site before injecting, injecting into an artery, injecting into those veins considered dangerous for injecting (e.g. femoral veins, veins in the neck region, hands, breast area, etc.), poses a risk for causing infections, and other medical conditions such as artery blockade, blockage of veins leading to gangrene and necrosis.

To get a complete picture of the hazards posed due to his/her practice of drug injection by a particular IDU, the counsellor must ask the IDU to detail out the entire process of injection. With this, the counsellor would be able to pick up the high risk behaviour and practices associated with injecting drugs.

- ⤴ **Sex-related:** Apart from injection-related risk behaviour, an IDU is also at risk of acquiring HIV and other STI through the sexual route. Some high risk sexual risk activities include sexual intercourse without using condoms, multiple sex partners, sexual intercourse with female

sex workers, anal intercourse without condoms, etc. An IDU, under the influence of the drugs he/she has consumed, has less chance of using condoms during the sexual act, because of loss of judgment during intoxication. Some IDUs also indulge in commercial sexual acts to procure drugs. If an IDU is also a commercial sex worker (female or male), the same should be noted during assessment.

- ◆ **HIV-related knowledge and belief:** The counsellor should try to know the knowledge level of the client on HIV and HIV-related risk behaviour. Instead of asking close-ended questions, the counsellor should ask open ended questions. For e.g. instead of asking “whether blood transfusion causes HIV”, the counsellor should ask “what are the common modes of transmission of HIV”. Assessing the current knowledge level would help in understanding whether the client has any myths/misconceptions related to HIV/AIDS. This incorrect knowledge should then be taken up during counselling sessions and be corrected.
- ◆ **History of referrals sought by client:** Details of all the type of referrals sought by client prior to coming in contact with the service provider should be noted. In particular, focus should be given on referral to HIV testing (ICTC), STI clinic, detoxification services, tuberculosis diagnosis and testing centre.
- ◆ **History of medical and mental illness:** Enquiries should be made for the presence of any co-occurring medical illness. An IDU is also prone to psychiatric illness. The prevalence of psychiatric illness is more in those who are dependent on drugs as compared to those who are not dependent. Details of the psychiatric illness, including signs and symptoms, and related assessment is described in later chapters.
- ◆ **Current living status:** Details of where the client is currently living, with whom, and the nature of his relationship with whom he/she is staying should be sought. This provides an understanding of the social support that the client receives.
- ◆ **Motivation level:** The motivation level of the client to reduce the high risk behaviours including drug use should be assessed. The details of how to assess motivation will be covered in later chapters. Assessment of motivation through motivational interviewing also provides an opportunity to enhance the motivation of the client.

Diagnosis

In addition to the assessment in the form of eliciting information from the client, additional information can also be obtained by examining the client. Examination includes both physical and mental examination. Physical examination is to be carried out by a medical doctor who is trained in medicine. Mental status examination can be carried out by a counsellor.

After completing the assessment, a diagnosis of the drug use status and other medical conditions of the client should be made. It should be seen whether the client is dependent on a particular drug or not. This would entail understanding what “dependence syndrome” means and also other terms such as ‘abuse’ and ‘harmful use’. These terms have already been discussed in earlier chapters. In addition, involvement of high risk behaviours should be specifically mentioned in the diagnosis. Finally, co-morbid medical conditions should also be mentioned in the diagnosis.

As described in the previous chapter on basics of drugs, there are various terminologies used for drug use disorders. The two commonly used terms are 'abuse' or 'harmful use' and 'dependence'.

A. Dependence

Three or more of the following experiences exhibited at some time during a one year period:

1. **Tolerance:** A need for significantly increased amounts of the substance to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of the substance.

For e.g., an individual would have started with 60 ml of whisky to obtain pleasure; however with continuous use, he has to consume 160 ml of the same to obtain the same level of high.

2. **Physiological withdrawal state:** Characteristic symptoms which appear upon stoppage/reduction of a substance after prolonged use. The patient uses the same (or closely-related) substance to relieve or avoid withdrawal symptoms. Every class of substance produces its own set of signs/ symptoms of withdrawal. For e.g. alcohol withdrawal would produce tremors, sweating, nausea/retching/vomiting, insomnia, palpitations with tachycardia, hypertension, headache, psychomotor agitation and in severe cases, hallucination, disorientation and seizures.
3. **Impaired capacity to control:** Substance use behaviour in terms of its onset, termination or level of use as evidenced by the substance being often taken in larger amounts or over a longer period than intended; or by a persistent desire or unsuccessful efforts to reduce or control substance use.
4. **Preoccupation with substance use:** Manifested by important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time spent in activities necessary to obtain, take or recover from the effects of the substance.
5. **Continued use:** Despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.
6. **Craving:** Strong desire to use substance.

B. Harmful use

A state of drug use behaviour that constitutes the following:

A pattern of substance use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

Synthesis of assessment

At the end of the assessment, the counsellor should synthesise the findings obtained during assessment which will help him/her in formulating a plan for helping the client further. The synthesis should typically include the salient features of the client's history with focus on immediate issues or priority issues at hand. Thus, for e.g., if the assessment shows that the client is not motivated to reduce the high risk behaviours associated with IDU, then the counsellor should focus

on improving the motivation level, rather than focus on referring the client to TB diagnosis and testing or detoxification services. A typical synthesis would mention the background of the client in terms of socio-demography, current drug use status and dependency status, involvement in high risk behaviour (both injection and sex-related), motivational level, referral status and current level of social support.

Tips for successful assessment

Some clinicians or counsellors are able to perform better assessment than others. There are a number of factors that govern a successful or better assessment:

- ◆ **Establishment of rapport:** If the assessor is able to form a good rapport with the client, the chances of client co-operating with the assessor and answering truthfully increases manifold.
- ◆ **Non-judgemental attitude:** The counsellor should not judge the client on the basis of his drug use behaviour, HIV status, physical condition, relapse or other factors such as religion, sex, etc.
- ◆ **Effective communication:** The counsellor should be able to articulate his/her thoughts clearly and be able to answer the client's queries as truthfully as possible.
- ◆ **Patient listening:** The counsellor should listen to the client patiently about his/her problems.
- ◆ **Confidentiality of the responses:** The counsellor should ensure that confidentiality is maintained with regards to some of the information provided by the client. At places, where the information has to be shared with other staff members, the counsellor should take prior permission from the client before doing so.
- ◆ **Drug using status of the client:** If the client is under intoxication or is suffering from withdrawals, then the counsellor will not be able to assess the client effectively. In such cases, the client should be asked to return for assessment when he/she is feeling better.
- ◆ **Outcome of assessment:** The client should be informed about the benefits of carrying out the assessment (e.g. referrals, better health status, etc.). Otherwise, the client would feel that the assessment is being carried out to fulfil some of the obligations of the counsellor (e.g. maintain records).

Carrying out a good assessment requires much patience and practice on the part of the counsellor. With time and effort, a motivated counsellor is able to assess a client effectively in a short period of time.

Counselling: Basic issues, skills & techniques

The therapeutic or relational climate is of utmost importance regardless of the counselling technique used. It is in this relational climate that the client would feel comfortable and safe enough to disclose himself – his pattern of use, his behaviours, his thoughts/emotions regarding substance use. It is the counsellor's responsibility to establish such a climate and build a therapeutic relationship with the client. This would finally set the stage for the eventual change process. The important aspects of building rapport with the client are:

- ◆ Specific counselling skills.
- ◆ Counselling techniques.
- ◆ Characteristics of a counsellor.

Specific counselling skills

The counsellor needs to understand that the basic difference between him/her and other people in the client's life are the techniques and skills that he/she uses during the counselling sessions. It is these techniques that make the conversation more meaningful and useful for the client. The counsellor can make use of one or more techniques as the need arises. Some of the specific techniques that can be used by the counsellor during the session are:

- ◆ Opening techniques.
- ◆ Structuring the session.
- ◆ Open-ended versus closed-ended questions.
- ◆ Picking up non-verbal language.
- ◆ Listening and types of listening.

Opening techniques

Change is possible only if the client can trust the counsellor. It is important for the counsellor to understand that he is dealing with the kind of clients who may have trust issues and may have difficulty in talking immediately about their problems. However, by using the right opening techniques and skills, the counsellor can facilitate rapport-building. Certain important aspects of an opening session are:

- ◆ **The Greeting:** The counsellor should greet the client in an accepting and warm manner. The counsellor needs to remember that he is dealing with another human being and not just a "file number". The counsellor can greet the client with a "hello" or "Namaste" and address him/her by name.

Box 14: A list of don'ts while talking to a new client

DON'Ts.....

It is generally not advisable to:

- ◆ Use a greeting gesture, which may not be socially acceptable (e.g.: In some Indian cultures, shaking hands with a opposite sex person may not be acceptable).
- ◆ Straightaway start asking questions about their problems.
- ◆ Adopt a business-like attitude as if taking a job-interview.

- ◆ **Opening topic:** The counsellor should first take/clarify the demographic information before enquiring about substance use information. The information about substance use and associated complications and behaviours must be taken sensitively.
- ◆ **Physical Arrangement:** The counsellor should make sure that the setting is comfortable for the client, as well as allows for privacy. The client may not feel comfortable to divulge sensitive information if the room is too noisy and full of people. An adequate audio-visual privacy as is possible in the given setting should be provided to ensure a good counselling session.
- ◆ **Confidentiality:** The counsellor should first speak to the client alone as he/she may not be comfortable to divulge sensitive information in front of family members. The counsellor should also assure to the client that the information given by him/her would be kept strictly confidential and will not be discussed without his permission.

Structuring the initial session

By structuring the session, the counsellor provides the client with a framework or orientation for counselling. It reduces ambiguities and helps the client to know what to expect. The ground-rule is that the counsellor needs to be honest with the client. In the initial session itself, the counsellor needs to set the rules, guidelines and expectations from future sessions. For example:

I understand that you are trying to understand the risks of using injections. I can help you understand that. But you must understand that change is a collaborative process. I will be acting like a facilitator, but it is you on whom the onus of change lies. I also understand that you may not be able to stop high-risk behaviour from using injections immediately, but I would appreciate it if you do not come for the session in an intoxicated state...



Note: The counsellor may feel a bit awkward in placing the responsibility of change on the client. But it is important for them to understand that not only would the client appreciate honesty on the part of the counsellor but also would make active efforts towards the change process.

Open-ended versus closed -ended questions

Open-ended questions are those that cannot be answered with a simple, “Yes” or “No” or “one or two-word responses.” Its advantages are to open an interview, to elicit specific examples and elaborations, or to motivate client to communicate. Closed-ended questions can be answered in one or two-word phrases or “Yes” or “No”. It is used to interrupt an over-talkative client, to narrow the topic of discussion and to

obtain specific information. The counsellor should be able to use either of the type as and when applicable, but the focus should be on asking open-ended questions.

Examples

Closed-ended: Are you scared?

Open-ended: How do you feel?

Closed-ended: Are you concerned about what will happen to you if you are tested positive for HIV?

Open-ended: What do you think you might do/feel if the HIV test results are positive?

Closed-ended: Is your relationship with your wife really bad?

Open-ended: Tell me more about your relationship with your wife.

Non-verbal language

The counsellor also needs to 'listen' to non-verbal signs, like, speech (pitch/tone/volume), eye-to-eye contact, posture, gestures, and pauses. These signs can give an important clue to what might be going on in client's mind.

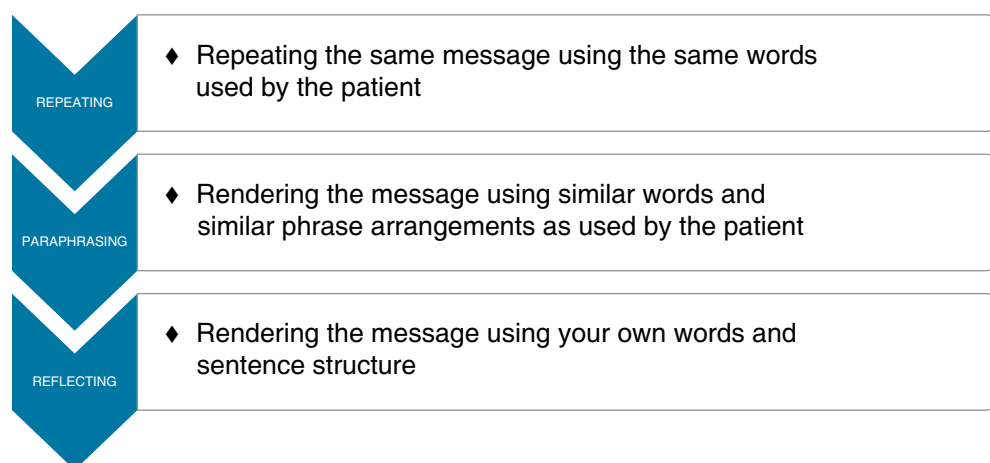
Examples

Client: I have never stolen money to buy injections... always got from friends.

The counsellor observes that the client is restless, not making eye-to-eye contact and his tone becomes low when he says that. So the counsellor says: Hmm... so you are telling me that you have never stolen money, but it's hard to believe that friends would always give you money for injections. I assure you that whatever information you give to me would be kept confidential, so you can freely tell me the truth.

Listening

Figure 8: Different levels of listening



More than words, it is the listening skills that make all the difference in a counselling situation. The skill of active listening may not come naturally, but the counsellor can and must develop it through practice. Listening to what the client **is saying**, as well as listening to what the client **“is not saying”** are both very important to build as well as carry forward the counsellor-client relationship. The figure elaborates on different levels of listening.

Counselling techniques

Some of the specific techniques used in counselling situation are:

- ◆ Clarification
- ◆ Para-phrasing
- ◆ Reflection
- ◆ Confrontation
- ◆ Probing
- ◆ Silence
- ◆ Interpretation
- ◆ Empathic response
- ◆ Self-disclosure
- ◆ Identifying alternatives

Clarification

This is intended to clarify the meaning of what the client has said. It also helps the client to see ambiguities or confusions in his thinking.

Client: I don't like my wife and so I take injections.

Counsellor: I did not get it. Please elaborate on how not liking your wife is related to your taking the injections.

Client: I got married against my wishes... she is always nagging... whenever I go home, she is shouting at me... So I prefer staying outdoors... When I am out and I see my other friends taking injections, I am unable to resist myself... it also helps me forget her nagging.

Paraphrasing

It consist of repeating what the client has said using the client's words and phrase arrangements.

Client: I don't know why my family has brought me here. I don't think I have a problem.

Counsellor: It sounds like that you don't think that you have a problem. And you don't know why your family has brought you here.

Reflection

It consists of bringing to the surface and expressing in the counsellor's words those feelings and attitudes that lie behind what client has said. This technique reflects empathy. The counsellor needs to make sure that his/her judgment is not expressed in the reflective statement.

Client: I am trying to kick a habit of 10 years, my wife has threatened to leave me, I don't have a stable job and my HIV test results are pending. Sometimes, I feel like giving up.

Counsellor: You seem to be feeling low and overwhelmed with all the problems that are going on in your life... all at once.

Confrontation

It involves challenging the discrepancies and distortions that client uses to hide both from self-understanding as well as constructive changes. However, this technique should be used responsibly and only when very necessary as it can be perturbing for the client and may hamper rapport-formation. The counsellor should refrain from using this technique in the initial sessions.

Client: I know my life is a mess because of taking injections... and all the wrong decisions that I have taken... but it's ok.

Counsellor: Really?

Client: Yes... it's OK. I have no regrets...

Counsellor: Don't you think something is missing here. You are here to seek treatment because you feel that you have made a mess of your life by taking injections and you also tell me that there are no regrets. Denial always defends you against feeling that you have failed ... right?

Probing

The counsellor uses questions to encourage the client to express in greater depth and to develop a personal awareness of deeper understanding and self-insight. The counsellor needs to make sure that the probe is not too overwhelming for the client.

Client: I had left injections for 2 months but then I started using it again.

Counsellor: What happened? After such a long abstinent period, what made you go back to the injections?

Client: I was passing by the market and I saw my friends using it and I also used it.

Counsellor: What were you thinking at that time?

Client: I had a strong craving and I thought, "How does it make a difference if I use it once. I will not get used to it."

Silence

It is one of the most helpful techniques that the counsellor needs to learn and practice. It is useful in certain situations, like, when the client is trying to understand his/her own behaviour or if the client is doing catharsis.

Client: I knew that I would get HIV if I share the needle with my friend, but then why do I still do it?

Counsellor: Hmm... (silence).

Client: I guess when that craving to use takes over you, all your senses get lost, you cannot tell right from wrong. And when friends pressurise, I give in easily. I guess I need to learn how to say NO.

Counsellor: (Nods head encouragingly).

Client: ... But I am scared now.

Interpretation

In simple, words, it means that that the counsellor explains to the client, the hidden meaning behind his statements or actions. To use this technique, the counsellor needs to point out discrepancies in what the client says and what he/she actually does. It should be delivered in a non-confronting manner and not as a final verdict. It should be done only when the counsellor is sure of what client's behaviour could be indicating.

Client: I am sorry I keep missing appointments, even though I really want to stop taking drugs. But something or the other keeps coming up and I am not able to come.

Counsellor: Perhaps it is really a feeling of anger for being sent here for treatment by your wife and maybe we need to re-think about your motivation to change.

Empathic response

It indicates that the counsellor accepts and understands emotionally what the client is trying to communicate. Empathic response is verbal and non-verbal communication of the understanding of what the client says, which can have both stated and unstated meaning. It is important that the counsellor should be able to differentiate between “sympathy” and “empathy”. The word “empathy” usually means a capability or action of “putting oneself in the client’s shoes”, that is, trying to understand what the client is thinking or feeling from their perspective. ‘Sympathy’, on the other hand, is an expression of pity or sorrow for the distress of others.

Client: I feel so miserable... such a failure. I sometimes get confused about what I want to do in life. I feel I would never be able to leave drugs.

Counsellor: I can understand that you are feeling low and hopeless. You come for all sessions which indicates that you are making efforts to leave, but still it is hard to change – and that makes you feel confused.

Self-disclosure

There are contradictory views regarding how much should the counsellor disclose about himself/herself to the client. At times, self-disclosure may help in strengthening the counsellor-client relationship, however, at other times, it may interfere with the therapeutic process. Thus, the counsellor needs to be careful about how much to disclose and when.

Client: It is terrible... Each morning I am determined not to take injections or use smack, but I am unable to stop.

Counsellor: I guess I can understand how you feel. I used to think that I could leave cigarettes anytime, but when I started trying, it was so awful... Even today, whenever I am under stress, I feel like smoking... So it must be so difficult for you to give up on these harder drugs.

Investigating alternatives

The purpose is to make the client aware of the choices they have – in terms of leaving drugs, finding meaningful employment, improving relationships etc.

Client: I have reduced my injections, but I am not able to stop because my friends use them and even if I refuse, they force me to use it.

Counsellor: Hmm... I am just wondering what all possibilities may be considered here.

Client: If I don't see them for some time, I may be better able to control my feelings.

Counsellor: That is one possibility... you can stay at a relative's house in another locality. Another option is that I can teach you more effective refusal skills and the third option can be to bring your friends for treatment too.

Client: I can probably try to get my friends to treatment centre.

Characteristics of an effective counsellor

Certain core characteristics of the counsellor can prove to be effective in the therapy process. They are as discussed below:

Non-judgmental

It is important for the counsellor to understand that the client sitting in front of him has already faced lot of stigma and discrimination because of his addiction and other problematic behaviours. He may be feeling sceptical and unsure of how the counsellor would react. By being objective and non-judgmental, the counsellor can evoke trust in the client and facilitate the rapport-building process.

For example: Instead of asking, "why did you take injections when you knew it would lead to infections?"... the counsellor can ask, "What made you use injections despite knowing that these could be harmful?"

Genuine

The client may have been involved with antisocial people to support his drug habit and thus is sensitive to manipulations and lies. Thus, it is necessary that the counsellor shows genuine concern and empathic understanding of the client's life circumstances and problems.

For example: The counsellor may say, "I understand your need to take injections right now, what I am more concerned about it that you should at least practice safe injection measures."

Calm and supportive

As therapy progresses, the client catches the mood of the counsellor and thus, no matter what the situation is, the counsellor needs to remain calm.

For example: "When in doubt, take a deep breath". If the client is getting agitated or is being stubborn, it is important that the counsellor does not start getting angry too (as these are the kind of reactions he has been getting from everyone around him). He/she calms down and then gives appropriate and firm reactions.

Self-aware

The counsellor need to first honestly explore his feelings regarding these clients. It is important for him/her to empathetically understand what made the client use

substances, take injections or indulge in high-risk sexual behaviours. And most importantly, the counsellor needs to separate objective information from values and cultural stereotypes. For example, if the counsellor comes from a culture where having multiple sexual partners is considered 'bad', then the counsellor has to make sure not to weigh this behaviour as 'right' or 'wrong' but just understand it from the client's perspective.

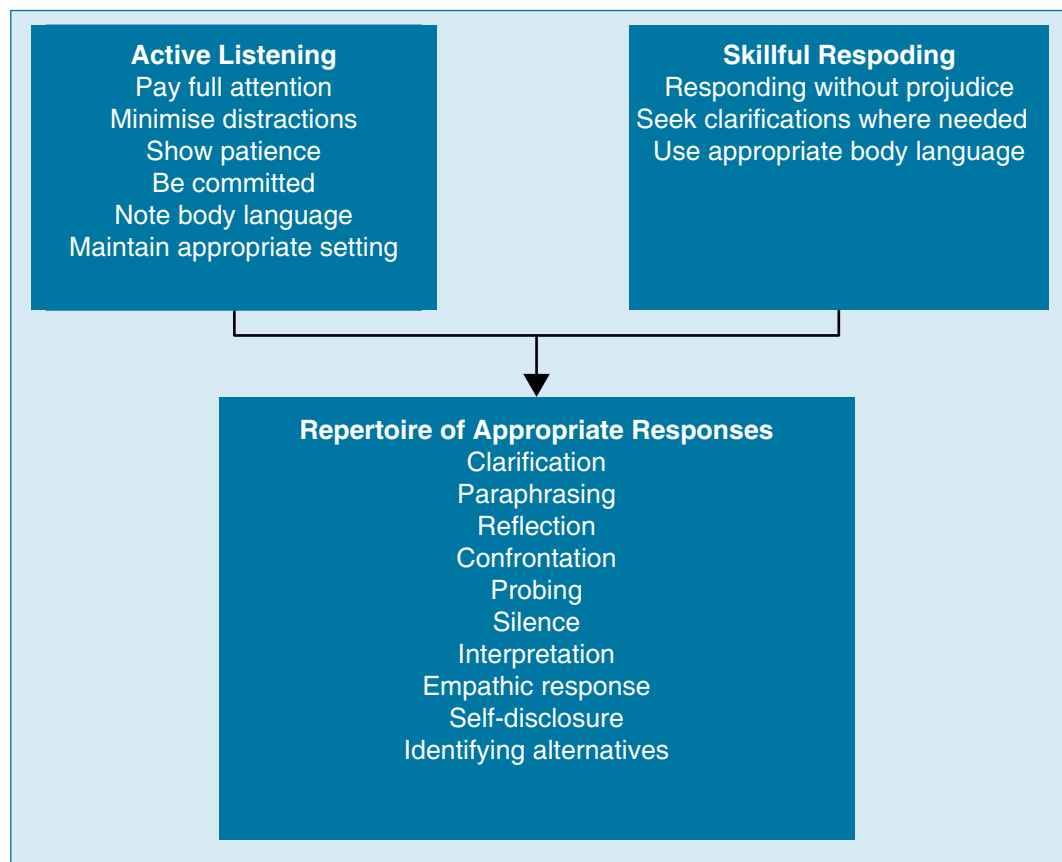
For example: The counsellor can ask him/her self – “How do I feel about this client?” “Does he/she makes me angry” “Is he/she evoking too much pity in me?” “Am I judging the client with respect to my value-system?” “Does the client remind me of anyone in my past (maybe a father who was always drunk). If the answer is YES, the counsellor needs to re-evaluate his/her approach and if possible, speak to a fellow counsellor or supervisor.

Objective

The counsellor needs to learn to “stand back” and observe what is happening from a neutral frame of reference. That is, the counsellor has to understand things “as they are happening” and free himself/herself from preconceived biases and expectations from a model client.

For example: Despite telling the client that he/she should not share injections, he/she still continues to do so. Without getting angry or losing hope, the counsellor should try and understand the situations leading to this behaviour objectively, so that appropriate solutions can be provided.

Box 15: Summary of a counsellor's role



Counselling IDUs: Injection-related risk-reduction

Introduction

An IDU faces a number of risks during his injection intake, which are manifested in multiple domains – physical, psychological, social, legal, etc. This chapter describes mainly the physical risks faced by IDUs during injecting, and the ways and means to reduce the same. The role of the counsellor is to help the IDU understand the risks that he/she faces, and counsel him/her in reducing those risks.

Risks faced by IDUs

A drug dependent individual faces multiple risks during his drug-using life. The risks are encountered at multiple stages:

- ◆ Procurement of illicit drugs
- ◆ Obtaining money for procurement of drugs
- ◆ Drug intake through injecting route
- ◆ Intoxications and withdrawals faced by an IDU as an effect of using the drug

The risks are encountered across multiple domains of an individual's life. This includes – physical, psychological, marital, financial, legal and social. In addition to the risks faced by a non-injecting drug user, an IDU also faces risks due to the injecting route used for drug intake. The chapter focuses on the injecting risks and counselling issues related to the injecting risks.

Why do IDUs face risks?

An IDU faces injecting risks due a number of reasons. The reasons may vary from the injecting practices itself or due to the circumstances around injecting:

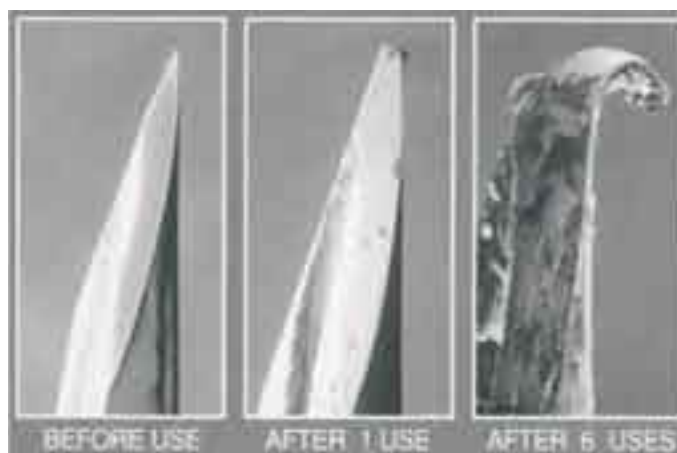
- ◆ **Lack of knowledge:** Injecting is a group behaviour, and often a new injector is initiated into the practice of injecting by older users. The practices followed by these older users are often passed on to younger injectors, who may resort to the same practices due to lack of knowledge.
- ◆ **Lack of adequate time for injecting:** IDUs have to be injected hurriedly due to the fear of being caught by police officials. In such cases, the IDU cannot afford to follow all the usual practices required to be followed for injecting safely.
- ◆ **Injecting in hazardous places:** The IDU often has to inject in places which are not suitable for injecting. These places are unhygienic and hence the chances of contracting infections at these places are higher.

- ◆ **Non-availability of injectable drugs:** Drug peddlers often mix impurities in white heroin to increase the quantity of heroin powder. This impure form is called brown sugar and is not dissolvable in water. If an IDU injects this impure form, there is greater risk due to the presence of non-dissolved particulate matter. In some parts of India, dextropropoxyphene capsules are mixed with water or other liquids and then injected. This is more hazardous than brown sugar injection.



- ◆ **Non availability of adequate needles/syringes and other injecting paraphernalia:** IDUs may not have an easy access to clean needles and syringes due to either non-availability of needles/syringes or difficulty in procuring them due to financial reasons. In such cases, they may either:
 - ▲ **Share needles/syringes or other paraphernalia used by other IDUs:** If an IDU uses a needle/syringe which has been used by an IDU already infected with HIV or Viral Hepatitis (Hepatitis B or C), he/she is at greater risk of contracting the blood-borne infections.
 - ▲ **Reuse the needles and syringes used by themselves earlier:** The IDU may repeatedly use the needle/syringes used by him earlier. Re-using the same needle over and over again results in blunting the tip of the needle. A photograph of the reused needle tip is shown alongside. The blunting of the tip results in damage to the vein into which it is injected.

Figure 9: Magnified view of injection needle



In addition to this, an IDU may also be using unclean water for rinsing the needle/syringe after using it or before the next injecting episode. In such cases, the injecting equipment would be infected with organisms causing infection.

- ◆ Non-availability of needles/syringes of the appropriate size also results in IDUs using needles with wide bore (i.e. large sized needles). This also results in greater damage to the vein.

- ◆ **Non-availability of materials for clean injecting:** Many a times, an IDU is not able to access materials such as cotton swab, spirit or other antiseptics, tourniquet, etc. In such cases, the IDU is at greater risk of getting infected with bacteria or other micro-organisms residing on the surface of the skin.
- ◆ **Non-availability of veins:** Due to repeated injections at the same site, the veins at the particular site may collapse, resulting in non-availability of veins which are safe. In such cases, an IDU may inject in unsafe sites or in arteries. This leads to complications also.

What are the risks of injecting?

It is usually presumed that the risks of injecting are limited to acquiring HIV infection due to sharing of needles and syringes, thereby resulting in HIV infection. However, this is just one of the risks. The following complications additionally occur due to faulty injecting practices:

- ◆ **Blood-borne infections:** HIV, Hepatitis B, Hepatitis C, Syphilis, etc.
- ◆ **Local infections:** Skin infections with bacteria/fungus resulting in swelling, or in severe cases pus collection into the swelling and finally the formation of a wound. These are called as 'abscesses and 'ulcers' respectively. If enough care and time is not given for healing, the ulcer becomes chronic, leading to non-healing ulcer.
- ◆ **Loss of veins (Sclerosis of veins):** Repeated injury to the vein by repeated injections leads to scarring in the vein with subsequent sclerosis. This leads to blockage of the vein. If large veins are blocked in this manner, then this leads to swelling of the limb in which the veins are sclerosed.
- ◆ **Scarring of tissue due to repeated injections at one site:** Repeated injections and seepage outside the vein due to faulty injection leads to scarring of tissue.
- ◆ **Septicaemia:** Infection spreading into the blood stream causing generalised infection of the body.
- ◆ **Injection into artery:** Leading to severe pain, swelling, spasm of arteries leading to loss of blood flow into the limb where the artery supplies blood. This leads to gangrene of the tissue.
- ◆ **Infection of internal organs:** Passage of micro-organisms to other organs in the body such as the heart, brain, lungs, etc. causes infection in the particular organ. This is especially true if unsafe veins such as the veins of neck, thighs, breast, etc. are used for injections.
- ◆ **Overdose:** Sometimes, IDUs miscalculate the amount of opioid required by them, and inject more than what their body can withstand. Additionally, because the effect of the drugs start after injection, and one cannot stop the drug from having an effect on the body after injection, IDUs are more prone to getting overdoses from opioids. Opioid overdoses are also fatal, and is one the most common reason for deaths among IDUs. A case of overdose has to promptly treated in an emergency setting.

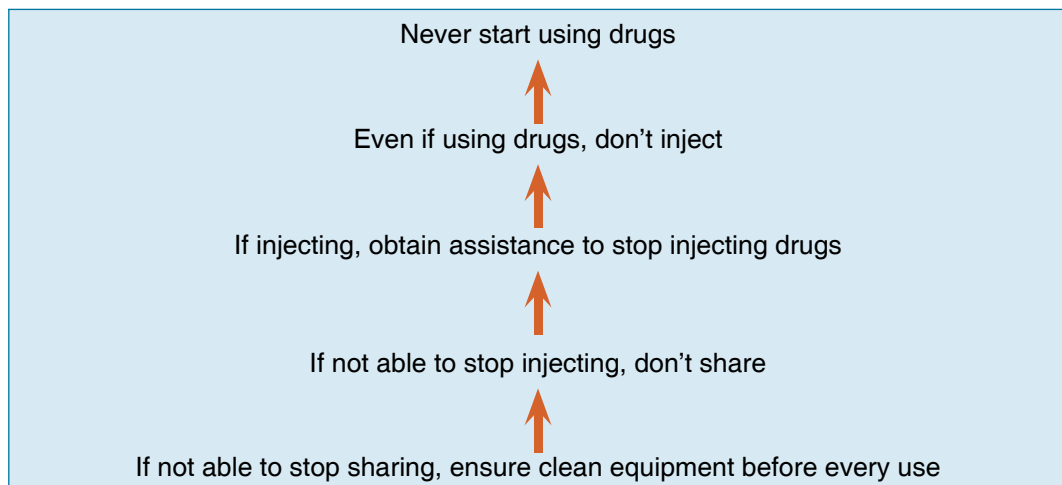


Risk-reduction counselling

As described in the chapter on harm-reduction, not every IDU is ready to give up drugs as soon as he/she comes in contact with the health-care provider. This may be because he/she has no motivation to give up drugs, or that he/she is not able to stop drug use despite being motivated due to cravings and withdrawals suffered by him/her on stopping drugs.

In such cases, the health-care provider needs to keep the IDU productive and healthy till he/she is motivated and appropriate help is available for the IDU to stop drugs. This is the approach adopted in harm-reduction. Harm-reduction follows a hierarchal approach to deal with clients injecting drugs, which is depicted in the box below.

Box 16: Hierarchal approach of harm-reduction



The counsellor should accept and internalise the following facts with regards to injecting drug use:

- ◆ It is not possible in a practical world to eradicate drug/intoxicant use
- ◆ It is not required for the drug user to be abstinent before getting help
- ◆ Not every drug user responds to counselling in the same manner and degree
- ◆ It is possible to offer help at each and every stage of drug use

The following section deals with the type of help and counselling which can be provided at different stages of drug use:

1. The IDU is not able to stop sharing

It is sometimes possible that an IDU may not be able to access clean needles and syringes every time he/she wants to inject. The IDU may then resort to reusing his/her own needles and syringes or sharing needles and syringes used by someone else. In such a scenario:

- ◆ The best way is to ask the client to be prepared for such an eventuality and carry one set of new needle/syringes all the time.
- ◆ In situations where there is no provision for getting clean injecting equipment, cleaning the needle/syringe before injecting is better than doing nothing. However, it should be emphasised to the client that there is **no foolproof**

method of cleaning needles, syringes and drug paraphernalia **that will guarantee no risk**. Cleaning can be done by using clean tap water, alcohol or bleach. Of these three, bleach is the best disinfectant. However, it is emphasised once again that as per the available literature, bleach also does not guarantee 100% disinfection of the needle/syringe. The recommended method to clean the needle/syringes are:

1. Pour bleach into one cup or bottle and water into another
2. Draw up freshly prepared bleach solution into dirty needle and syringe
3. Expel bleach away down the sink (not back into the cup or bottle)
4. Repeat steps 2 and 3
5. To remove the bleach, draw up cold water into the needle and syringe
6. Expel water down the sink
7. Repeat steps 5 and 6 two or three times

However, it should be remembered that:

- ◆ The above cleaning method does not guarantee protection
- ◆ Cleaning previously used equipment with bleach should only be a last resort option
- ◆ Always clean equipment both before and after use
- ◆ Boiling plastic syringes melts them
- ◆ Cold water is recommended as warm water may encourage blood to coagulate and hence will be harder to expel through the needle
- ◆ Thick bleach is impossible to draw up through a needle
- ◆ Diluted and old bleach may not be effective
- ◆ ***Using new/clean injecting equipment (from a needle exchange) is the safest option***

2. The IDU is not able to stop injecting, but is in a position to avoid sharing

In many instances, the client may not be in a position to stop injecting drugs due to the following possible reasons:

- ◆ He/she is not motivated to stop injections
- ◆ He/she is not able to afford non-injectable drugs (e.g. heroin) and hence continues with injections
- ◆ He/she is suffering from cravings and withdrawals due to dependence on injections as a result of which he/she is afraid to stop injections

In such cases, the counsellor should provide counselling on the following issues:

- ◆ Educate the client on the risks of sharing needles/syringes during injecting.
- ◆ Inform the client regarding the needle syringe programme and link the IDU with the concerned PE and ORW.
- ◆ Educate the client on the need to return the used needle/syringes. A guideline on safe disposal of used needles and syringes in the context of targeted interventions for IDUs has been prepared by NACO and is available online at www.nacoonline.org

- ◆ Educate the client on the risks associated with the reuse of used needles/ syringes.
- ◆ Educate the client on how to inject safely and prevent abscesses and other complications.
- ◆ Educate on overdose prevention and management.
- ◆ In case, the client is motivated and ready to stop injecting but is not able to do so due to cravings and withdrawals, OST, if available, should be offered to the client.
- ◆ In case the client is not motivated, specific techniques such as Motivation Enhancement Therapy should be used to enhance the motivation of the client. Motivation Enhancement Therapy is covered in other chapter.

The individual issues are covered in detail later in the chapter.

3. The IDU has stopped injecting

If the IDU has been able to stop injecting, he/she should be motivated to remain away from injecting drug use. Also specific strategies such as relapse prevention should be taught to the client. Relapse prevention is covered in another chapter.

Safe injection

Before counselling on safe injecting, an interview should be conducted on the current practices followed by the client for injection. Knowing the current injecting practices helps in understanding the risky and the safe techniques followed by the client, which should be noted down. As with any other assessment procedures, the interview should be conducted in a closed setting, making the client comfortable. In addition, the counsellor should exhibit warmth in his/her attitude towards the client. The questions asked should be open-ended, allowing the client to express his points, rather than close-ended questions. At the end of the interview, a summary of the important practices should be provided to the client as a feedback mechanism. This is also to ensure that the information captured by the counsellor is the same as provided by the client, thereby avoiding misinformation.

While addressing the risks, it is important to emphasise and praise the safe/correct techniques used by the client for injecting. This boosts the confidence of the client and makes him/her more responsive to the rest of the counselling session. When educating the client on the risks, examples should be drawn on what has been learnt during the assessment session, so that the client is able to relate his own practices with what is being discussed.

1. Before injecting

Precautions and safe injecting processes begin even before the client is attempting to inject. During this stage, the following points should be emphasised:

- ◆ Choose a safe environment, where the client is not anxious and is able to relax.
- ◆ Do not inject alone, inject in the presence of other peers, so that if one overdoses, peers can arrange for help.
- ◆ The immediate surroundings should be clean. Use a clean paper (such as clean newspaper or magazine) to lay down the injecting equipment to avoid infections.

- ◆ Choose the smallest bore needle possible. This would prevent greater injury to veins. However, intramuscular injection requires a larger bore needle.
- ◆ Use sterile water if possible. If this is not possible, use cooled freshly boiled water. Do not share water, as this may also lead to blood-borne infections.
- ◆ Impure forms of heroin, such as brown sugar, need to be dissolved before it is suitable for injecting. In such cases, an acidifier has to be used. Small doses of acidifier (such as vitamin c tablets, citric acid, etc.) should be used; using a large dose would lead to injury of the vein.
- ◆ The drug should not be heated too much, or for a long period of time; doing so will cause injury to the tissue.
- ◆ Filters are often used to block the impurities from entering into the injections. The commonly used filters are cotton swabs or cigarette butts. Of the two, cigarette butts are preferable as the cotton swabs have more loose fibres which may enter the injection. Do not reuse the filters, as doing so may cause infection.
- ◆ Do not touch the (metal cap/spoon used for heating the drug) with the needle tip, as this may make the needle tip blunt.



2. While injecting

- ◆ The intravenous route is preferable to the subcutaneous route (as subcutaneous route results in slow absorption of the drug and increases the possibility of more tissue injury and infection locally).
- ◆ The area where the drug is to be injected has to be cleaned first. The best way to clean is with soap and plenty of water. However, if this is not possible, alcohol swabs may be used. However, care should be taken that the alcohol has dried off before the initiation of the injection, as otherwise, the site will not be sterile.
- ◆ For injecting, the best site is the front of elbow (cubital fossa). There are some sites in the body where injecting is hazardous/dangerous. Such **dangerous injecting sites** should be avoided. These sites include:
 - i. **Groin veins (femoral veins):** Risk of injecting into artery.
 - ii. **Veins of the neck (jugular veins):** Risk of injecting into artery.
 - iii. **Veins of the hand and legs:** Risk of missed veins.
 - iv. **Breast veins:** Risk of infection of the breast (mastitis), blockage of milk ducts and breast abscesses.
 - v. Veins of the penis.

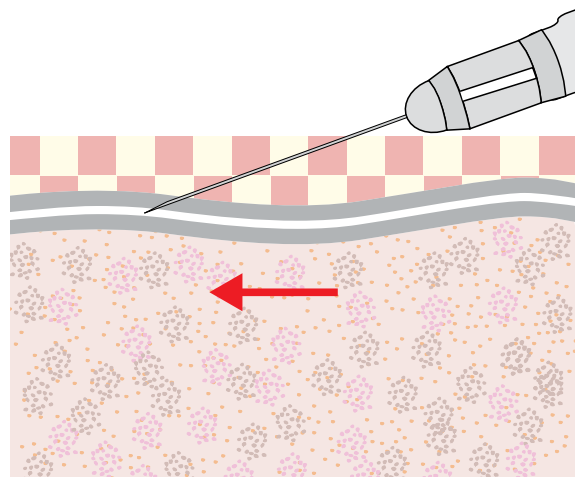


- ◆ Differentiate an artery from a vein:
 - i. A pulsating blood vessel is an artery; a vein does not pulsate.
 - ii. Arteries do not have valves which can be felt; veins have valves which can be felt.
 - iii. Soon after the needle hits an artery, bright red blood would enter into the syringe; in case of a vein, dark red blood would enter the syringe.

In case, you hit an artery, there would be excruciating pain. In such a scenario, immediately withdraw the needle from the artery and apply firm pressure. If blood does not stop oozing out, go to a medical doctor/hospital emergency immediately.

- ◆ Use the smallest bore needle possible. This will prevent more damage to the veins.
- ◆ If you use a tourniquet to make the veins prominent, use one that is easy to release. Do not tie the tourniquet very tightly. Once the needle has entered the vein, release the tourniquet to allow for drugs to enter the vein.
- ◆ Hold the needle at a 45 degree angle to the vein. The sharpest point of the needle should pierce the skin first with the hole facing upwards. Needle should not be pointed at 90 degree angle to the skin surface, as there is a great chance of puncturing the skin.

Figure 10: The correct angle for injecting



- ◆ Once you hit a vein, stop further puncture and draw some blood in the syringe to confirm that you have hit the vein.
- ◆ Administer the drug slowly; administering the drug in a fast manner would cause more damage to the vein.
- ◆ Do not repeatedly push down the blood and draw it back. Some injectors draw more than 1–2 ml of blood into the syringe and allow the blood to mix with the drug and then inject. This is a very dangerous method, as it may lead to clotting of blood outside the vein and lead to blood clot entering the body and lodging in any vital organ of the body.

3. After injecting

- ◆ Slowly remove the needle from the vein. Following this, immediately apply pressure on the injected site with a dry cotton swab. Apply pressure for at least one minute for stopping the blood from oozing out. Do not use alcohol swabs for stopping the blood.
- ◆ Safely dispose of the used needles and syringes. Do not throw away your used needles/syringes in the open, as this is liable to be used by others.
- ◆ Allow time for the injected vein to heal. Hence, use alternate sites for injection. You should rotate the injecting sites; otherwise there is a greater risk of abscess formation.

Opioid overdose

Overdosing from the opioid drugs being used by clients is very common and can be fatal. The clients should be explained about the risk factors for overdose, what are the early warning symptoms and what to do in case of overdose. Teaching the client on first aid for overdose may also lead to the client helping his/her friends out during an overdose episode.

Risk factors for opioid overdose

- ◆ **Periods of abstinence/staying away from drugs:** The client resumes the previous dose of opioid that he was using just before stopping the drugs.
- ◆ Change in purity of the heroin sample available from the streets.
- ◆ Poor or ill health or recent infections.
- ◆ Mixing different types of drugs together for injecting – e.g. heroin and benzodiazepines together.

Symptoms of overdose

- ◆ Seemingly awake, but no response elicited on giving any stimulus (such as calling out name).
- ◆ Skin becomes pale in colour.
- ◆ The body goes limp.
- ◆ Slow pulse/no pulse.
- ◆ Bluish coloration of fingernails.
- ◆ Vomiting.
- ◆ Choking noise.
- ◆ Shallow breathing.

Counselling for preventing overdose

- ◆ The client should be **educated** on what are the risk factors for overdose. The client should be made aware that reusing just after a period of abstinence of more than 3 days would put him/her at greatest risk of overdose. During abstinence, the client has lost the tolerance to drugs, and using the same dose as before would place him at risk of overdose.
- ◆ The client should be warned that though he/she is buying the heroin from the same dealer, the purity of the sample may not be the same.
- ◆ The client should be told to take a small dose first before taking the full dose to test for the purity.
- ◆ The client should be told to take injections in the presence of someone else, so that help is readily available, if something goes wrong.
- ◆ The client should be educated that mixing drugs especially other brain-depressing drugs such as alcohol, sedatives/hypnotics, along with heroin or other opioids would place him/her at a greater risk of overdose.
- ◆ The client should also be educated about some myths associated with treating overdose that would not help: Inducing vomiting, drinking water, drinking coffee/tea, taking cold showers, etc.

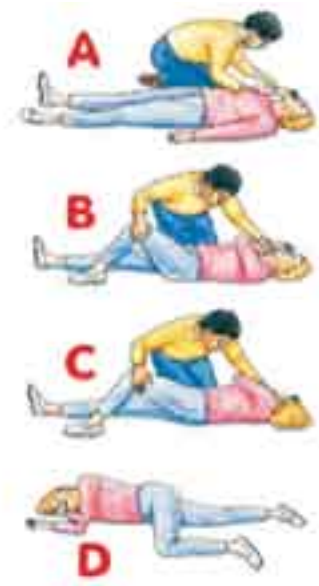
Overdose management

The first thing to do in case of overdose management is to call the ambulance and take the client to emergency. In the time the ambulance arrives, mouth-to-mouth breathing should be given and the client should be placed in recovery position to avoid choking.

Conclusion

Risk-reduction counselling is the most important aspect of counselling in a TI-related setting. The benefits of risk-reduction counselling goes beyond prevention of HIV and other blood-borne diseases; it helps the individual IDU to stay healthy, productive and, more importantly, alive till he/she is ready to wean away from drugs.

Figure 11: How to deal with an overdosed person



Counselling IDUs: Safer sexual practices

The sexual route is the most important route of HIV transmission in India. It is estimated that 87.1 percent of HIV infections are attributed to heterosexual and 1.5 percent to homosexual (men having sex with men) routes of transmission. Injecting drug users are doubly at risk of being infected with HIV. Apart from the risks of being infected through shared needles, syringes, and other paraphernalia, they are also vulnerable to infection through the sexual route. Contrary to popular beliefs, IDUs are often sexually active as most of them are within the reproductive age. In addition, IDUs are also a potential source (if already infected) for transmitting the infection onto others making it important to identify their high risk sexual practices and address them at the earliest possibility.

Understanding sex, sexuality and sexual orientation

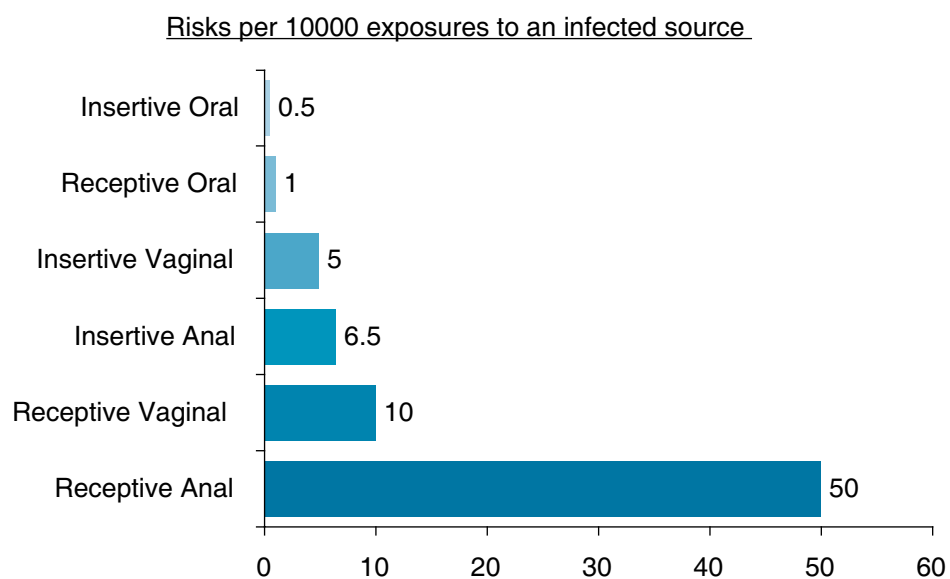
Before a detailed discussion on the counselling aspects related to the issue, we need to clarify – sex, sexuality and sexual orientation, as these are the guiding factors in understanding sexual practices and associated risks:

- A. The word '**sex**' has two meanings attached to it: 1) biological sex i.e. male, female and transgender and 2) the act of sex. Sex as an act may be penetrative or non penetrative. Penetrative – when the penis–the male genital organ, is inserted into the mouth (peno-oral), vagina (peno-vaginal) or anus (peno-anal) and non penetrative, when there is no penetration of the penis involved e.g. masturbation, rubbing, petting, fondling, thigh sex etc.
- B. **Sexuality** is the expression of one's sexual feelings. This can be through words and actions which may or may not be overtly related to sex. It is often guided by cultural norms varying from one community to another and changing with gender, age and socio-economic position of the individual. The degree of expression is often controlled by the degree of permissiveness allowed by the society. Sexuality is the result of interplay of biological (genetic and hormonal), psychological, socio-economic, cultural, ethical and religious/spiritual factors. It encompasses sex, gender, sexual and gender identity, and reproduction and all related aspects of human life. Sexuality is expressed through sexual orientation, eroticism, emotional attachment/love and various other behaviours and practices that go beyond the mere sexual acts.
- C. **Sexual orientation** is an individual's personal eroticism and/or emotional attachment with reference to the sex and gender of the partner involved in sexual activity. Sexual orientation guides the preference of sex partner (male, female, transgender), type of sexual act (peno-oral, peno-vaginal etc.).

While many prefer the opposite sex (male-female) and are termed **heterosexuals**, some are attracted to the same sex (male-male or female-female) and are referred to as **homosexuals**. There are others who choose partners from the same sex, as well as from the opposite sex and are referred to as **bisexuals**.

Sexual risks vary with the choice of partners as well as by the type of sex an individual is engaged in, i.e. whether peno-anal or peno-oral etc. The type of sexual act also determines the level of risk as they vary with the type of act and needs to be considered when counselling for sexual risk-reduction. As shown in the figure below, receptive peno-anal sex poses the maximum risk of transmission (50 in 10,000 exposures) if the insertive partner is infected. This is followed by receptive vaginal, insertive anal with an infected receptive partner and insertive vaginal. Oral sex poses the least risk with individuals engaging in receptive oral sex being at greater risk than the insertive partner.

Figure 12: Risks from infected partners during sex



Sexually Transmitted Infections

Sexually transmitted infections (STIs) are infections that are spread primarily through sexual contact from one person to another. Though a person has STI, he/she may or may not show any signs and symptoms. A majority of men and women can remain without experiencing any symptoms. But even during this asymptomatic phase, they may be able to transmit the infection to others through sexual contact and so are important to be considered for treatment. As penis, vagina, mouth (tongue and lips) and anus are the commonly used sexual organs, signs and symptoms appear in any of these organs.

High-risk sexual practices

Irrespective of the sex of the partner and the type of the act, all penetrative sex, if not protected, can lead to STIs. There are other factors, apart from condom use/non-use, that add to the risk of transmissions and need to be considered during sexual risk assessment and counselling.

Factors that are considered to be high-risk can be categorised as:

- a. **Personal risks:** Issues directly related to the client and may be altered by direct action of the individual.
- b. **Partner’s risk:** Issues that may be modified only by the partner through indirect action of the client that includes notifying the partner bringing him/her for counselling and subsequent services as necessary.
- c. **Situational or positional risks:** Issues originating due to situations or positions the individuals are in that will need the involvement of people beyond the individual and the partner e.g.– in case of sex workers – the pimp, madam and the other power-brokers and gatekeepers etc. will need to be involved for successful risk-reduction.

Box 17: Types of high-risk activities

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

IDUs and sex

Similar to other HRGs, IDUs have a high possibility of being infected through the sexual route. Contrary to popular belief, IDUs (both male and female) are actively engaged in sex. As per the report of the Behaviour Surveillance Survey published by National AIDS Control Organisation, India in 2006, the proportion of IDU respondents who had sex with any commercial partner in the last 12 months was reported to range from 7.0% (Kerala) to 55.6% (Punjab). Thus, the notion that IDUs do not engage in sexual acts should be removed forthwith from the minds of the staff engaged in working with drug-using populations, including IDUs.

There are many factors, which make the IDUs more vulnerable to transmission of infections through the sexual route than the general population:

- ◆ Drugs usually injected by IDUs ‘cloud’ their brain, affecting their thoughts and actions, and also lowering their inhibitions. This leads to a “loss of judgement” resulting in IDUs taking greater risks in many of their actions, including sexual acts. One easily related example is an intoxicated person thinking that he is in control and driving a vehicle, resulting in drunken driving-related accidents. Under the influence of drugs, IDUs similarly misjudge and take similar risks in sexual activities.
- ◆ Drug use affects their power of working with the hands and fingers (effect of drugs on nervous system) – making it difficult for them to wear and take off a condom correctly.

- ◆ Drug use often leads to disruption of relationships and broken families, which leads the IDUs to engage in sex with casual partners and/or commercial partners.
- ◆ IDUs may be compromised to sell sex to procure drugs. This is especially true for the women population, which adds to their vulnerability of contracting HIV infection.

Counselling for sexual risk-reduction

Counselling for reducing the risk of sexual transmission among IDUs should begin with conducting a thorough sexual risk assessment. While the general issues of assessment have been covered in the chapter on Assessment and Diagnosis, the following section details with the various issues to be considered for assessment of sexual risk.

Sexual risk assessment

Sexual risk assessment should be conducted periodically to enable the care-givers, especially the counsellors, to understand the client's sexual practices and help provide an appropriate intervention strategy. Sex is a private matter and the client may not be able to share all the details during the first assessment session. Thus, it may be necessary to revisit the sexual health assessment once rapport is built and the client has the trust in the counsellor to be able to share details of his/her intimate sexual life. It may need more than one session to complete the entire assessment, and the details may also change with improvement in rapport and confidence-building with the client. Confidentiality needs to be strictly maintained at all stages.

Apart from assessment in the initial stage, sexual risk assessment must be revisited in the following cases when the client:

- ◆ Has been diagnosed with STIs including HIV, Hepatitis B and Hepatitis C.
- ◆ Reports/complaints of symptoms of STIs.
- ◆ Needs to be screened for STIs.
- ◆ Needs to be referred for Voluntary Counselling and testing for VCT.

The objectives of sexual risk assessment are as follows:

- ◆ To assess the client's risk of transmitting and contracting STIs.
- ◆ To help the client recognise the behaviour/s as harmful to self and partner.
- ◆ To help the client understand that alternatives are available.
- ◆ To ascertain the course of further action and requisite services.
- ◆ To help the client seek treatment and allied services needed for changing the high risk behaviour.

During assessment, the following issues need to be covered:

- ◆ Sexually active or not (in the last one year)?
- ◆ Number of sex partners (in the last one year):
 - ▲ Regular (spouse/girlfriend/boyfriend).

- ▲ Non regular (other than spouse/girlfriend).
- ▲ Commercial (paid for sex).
- ◆ Condom use with:
 - ▲ Regular (spouse/girlfriend/boyfriend) – how often and last time.
 - ▲ Non-regular (other than spouse/girlfriend) – how often and last time.
 - ▲ Commercial (paid for sex) – how often and last time.
- ◆ History of STIs – treated, untreated?
- ◆ Signs and symptoms of STIs present?
- ◆ Drug/alcohol use before sex.
- ◆ (In case of male client) History of sex with a male.
- ◆ In case of history of male to male sex:
 - ▲ Nos. of male partners.
 - ▲ Type of act.
 - ▲ Frequency/consistency of condom use.

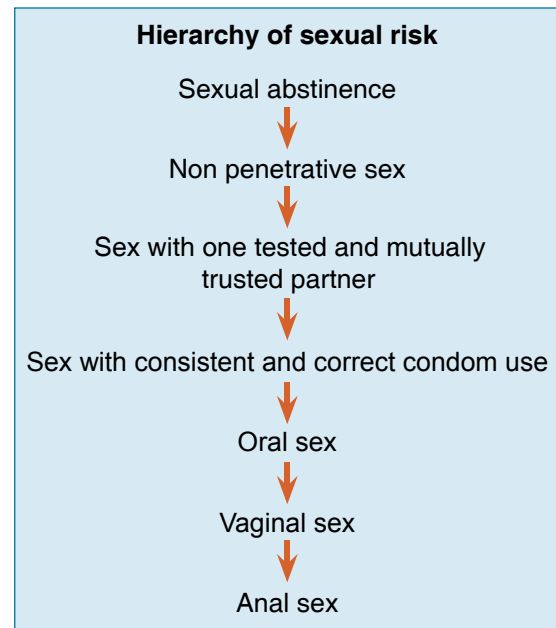
Once the sexual risk assessments are carried out and the client is identified to have risks that make him/her vulnerable to STIs and HIV, the risk-reduction counselling begins. The steps to be followed in the sexual risk-reduction counselling are:

- ◆ Share the level of risk of the client based on his/her current sexual practices (derived from assessment findings).
- ◆ Educate client on the risks and their complications, both current and future.
- ◆ Explore client's feelings about the risk/s.
- ◆ Refer for STI screening, if the client reports/complains of signs and symptoms of STIs of self or the partner.
- ◆ Assess level of risk perception by the client.
- ◆ Educate the client in case of incorrect perception and/or misconceptions, if any.
- ◆ Check for the client's level of concern and actions already being taken by him/her, if any.
- ◆ Appreciate efforts already in place, if any.
- ◆ Correct the ideas and practices that will not help in risk-reduction.
- ◆ Educate the client on alternatives that may help in reducing risks.
- ◆ Help the client set achievable goals and plan practicable steps towards it.
- ◆ Educate on importance of condom use, demonstrate correct steps for using and also provide condoms.
- ◆ Discuss potential barriers to the risk-reduction strategy planned by the client and possible support.
- ◆ Agree on the final strategy and timeline.
- ◆ Endorse a follow-up plan.

In case of multiple risk factors, the counsellor must target, in consultation with the client, the greatest risk that can be altered by personal efforts first, and then approach the other practices with reducing risk and where greater effort is required. This will also enable the client to take one step at a time and save him/her from being overwhelmed with “too many changes too soon”.

More than one session will be required to help the client change his/her high-risk behaviour/s. The counsellor should also motivate the client for follow up visits until the risks are reduced significantly and the new (safer) behaviours are sustained.

Box 18: Hierarchy of sexual risks



On follow up visit

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

STI counselling

STIs are important from public health point of view because, if left untreated, they may be transmitted to others and also to the new born babies from parents with untreated infections. Besides, they can cause serious complications like infertility among both men and women affected. Moreover the presence of STIs increases the chances of HIV transmission. Counsellors should note that presence of HIV also increases the chances of STI infections with lower level of immunity like any other Opportunistic Infection. Since STIs are caused through the same sexual practices that also cause HIV, addressing them will also help in educating the client on risk-reduction, screening for infection and subsequent services and ultimately add to the prevention of transmission of these infections too.

The level of risk of the client with regards to STIs the client may be categorised as one with:

1. Signs and symptoms of STIs.
2. History of STIs that were not treated or partially treated but presently not showing any signs or symptoms.

3. History of unprotected sex or sex with HRG partner.
4. HIV positive status.

Box 19: Common symptoms of STIs in males and females

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

The objective of STI counselling is to help the client:

1. Seek and complete treatment, if infected with STIs
2. Be screened for STIs, if showing signs and symptoms of STIs or with history of unprotected sex or sex with HRG and receive subsequent services as required
3. Complete the treatment with partner identification and screening/treatment of partner
4. Reduce high risk sexual practices that may infect/re infect the client

The client will need to be prepared and motivated for screening before the clinical examination of the genital area and insertion of equipment into the vagina and anus. The steps for motivation for screening will include:

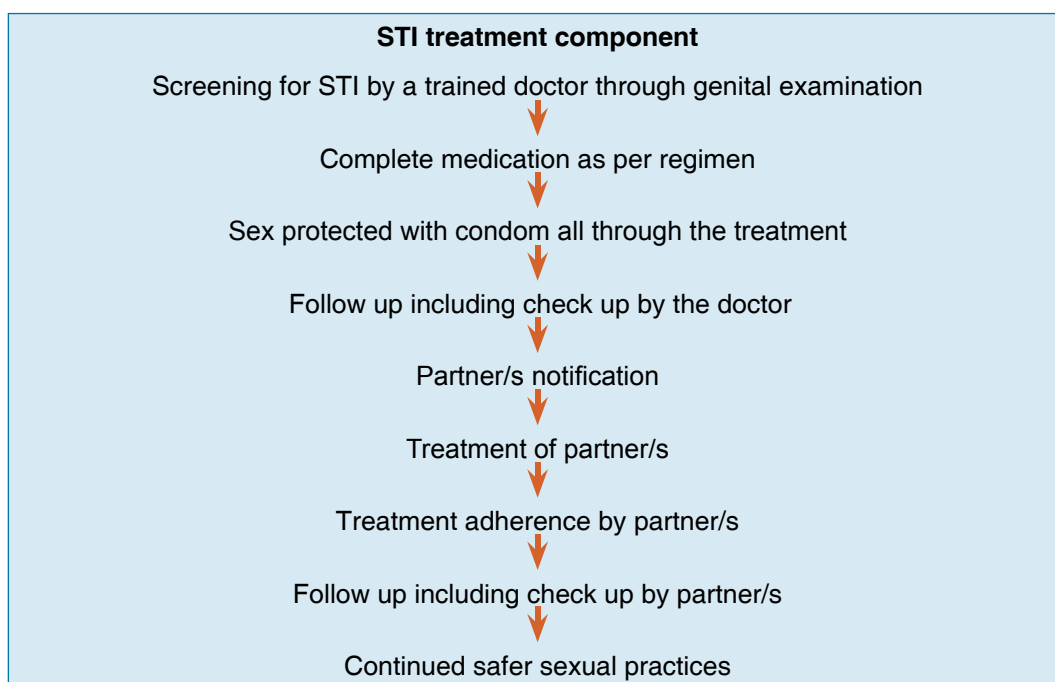
- ◆ Sharing the level of risk of the client based on his/her sexual practices
- ◆ Educate client on STIs (based on the signs and symptoms reported by the client) their complications both present and future
- ◆ Explore client's feelings about the risk/s
- ◆ Educate the client on the need for screening
- ◆ Explain the components of STI treatment
- ◆ Motivate for the screening procedure by helping the client to evaluate the pros and cons of seeking treatment
- ◆ Refer for STI screening
- ◆ Endorse a follow-up plan

If the client is identified as infected, STI counselling will be needed and the steps to be followed are:

- ◆ Educate the client on the diagnosis based on the syndromic approach, cause of infection and the treatment

- ◆ Help the client take the medicines as prescribed by the doctor.
- ◆ Educate the client on the importance of completing the medication by taking all the medicines correctly and completely.
- ◆ Explain the need for contacting the doctor, in case of side effects.
- ◆ Educate the client on the immediate and long term effect of not completing the treatment.
- ◆ Explain the interaction of some of the medicines (metronidazole, if prescribed) with alcohol.
- ◆ Plan strategies to avoid alcohol use, if the client is a regular user.
- ◆ Explain the importance of condom use as part of the treatment adherence. Demonstrate proper condom use and provide condoms.
- ◆ Educate on the importance of partner notification and treatment of partner.
- ◆ Explore alternative sexual practices for risk-reductions.
- ◆ Reinforce importance of treatment completion.
- ◆ Endorse plan for follow-up.

Box 20: STI treatment component



Treatment of STIs requires time and may vary from one syndrome to another. It is important to complete the entire treatment and this includes:

- a. Completing the entire regimen of medication even after the signs and symptoms disappear. Otherwise the infection remains in the body though it does not show symptoms and may lead to a relapse in the client's body and may also be transmitted to others.
- b. Notification of the sex partner/s (especially with whom condom was not used) and their counselling, screening and subsequent services so that he/she may also be treated and freed from the infection. This will ensure no re-transmission of the infection between partners.
- c. Condom use during the STI treatment for all sexual acts is a must to ensure that no new infection/s occur/s and no onward transmission is caused.

Some STIs cause ulcerations on the genital area. These ulcers become gateways to other infections, especially HIV. Condom use during this period also prevents such infection/s.

Partner notification and treatment

Since, STIs are transmitted from one individual to another through sexual acts between two persons, there are more than one person exposed to the infection, either as the source or as the one/s who (may have) received onward transmissions. When the client is only treated, the sex partner is left exposed to the infection untreated. This may lead to re-infection of the client despite him/her being treated for STI. Thus, partner notification should be conducted in which the sex partners of the client diagnosed with STIs are informed of their exposure to the infection and made aware about the need for screening and treatment (for the same infection if required).

Box 21: Benefits and barriers of partner notification

Benefits of partner notification

1. Prevents re-infection in the client initially reporting for screening/treatment.
2. Prevents morbidity and long term effects of untreated STIs in identified partners (if infected).
3. Prevents transmission to others, including children yet to be born.
4. Provides an opportunity to make the client as well as his/her partner/s aware of risks and introduce risk-reduction strategies for avoiding further infection/re-infection.

Barriers of partner notification

1. Chances of abuse and domestic violence.
2. Fear of embarrassment, rejection, accusation (of being unfaithful, of being the source of the infection) damaged relationship, break up, divorce, stigma associated with STIs.
3. Locating casual partners and commercial partners difficult.

Box 22: Issues to be considered by the counsellor

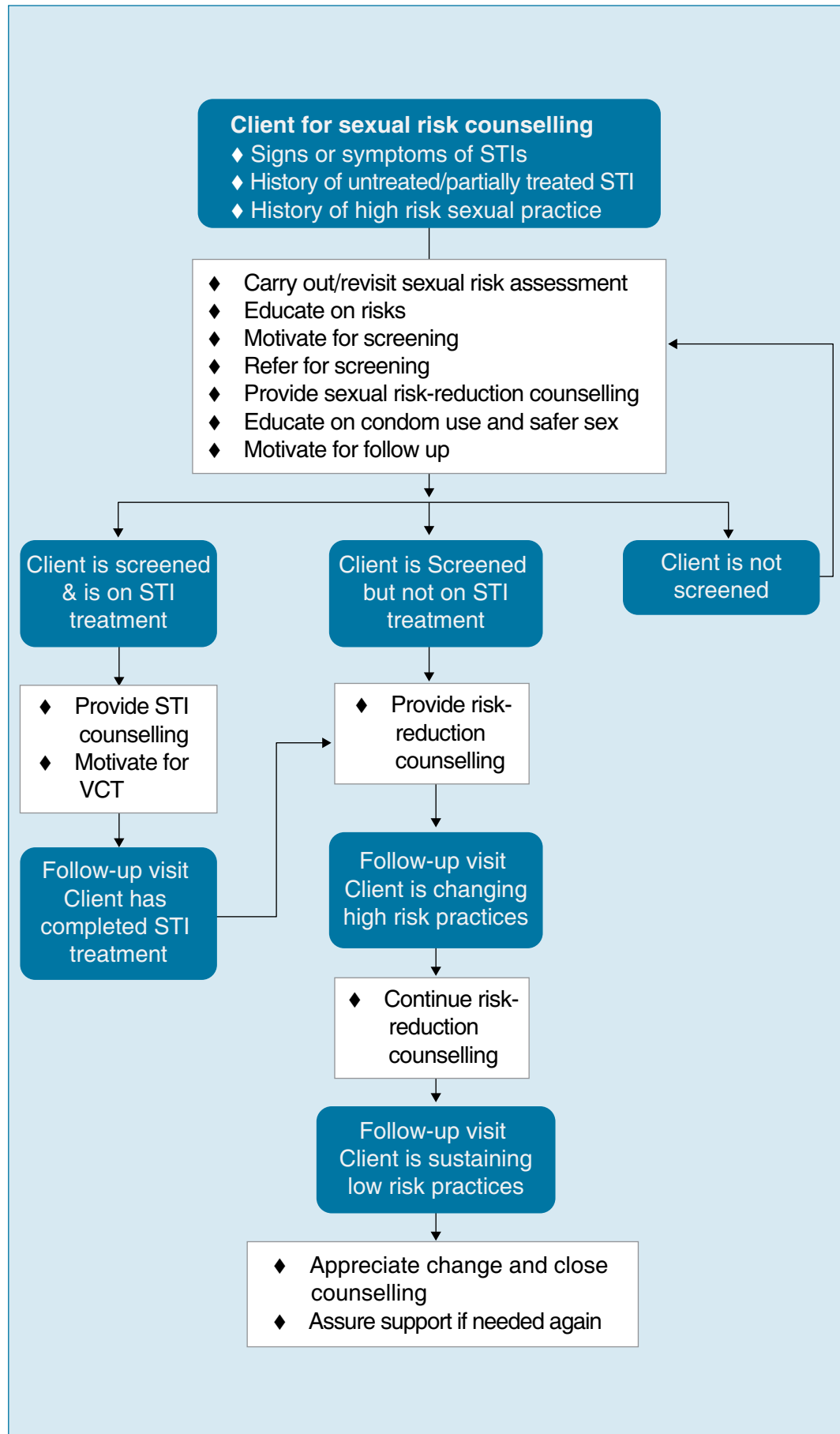
As it is often difficult to tell the partner about an STI infection since revealing it may lead to conflicts and distrust in a relationship – sometimes leading to verbal and physical abuse, the counsellor needs to take special care to see that the client is convinced that:

- ◆ The benefits of partner notification are far greater than the possible costs.
- ◆ Partner notification and treatment is needed even if the partner does not show any symptoms.
- ◆ Partner notification is always voluntary.

Once the client agrees to inform his/her partner the counsellor will need to discuss with the client the best possible way to do so and the different ways a client can make sure that the partner gets treatment. The counsellor should discuss how the partner may react to the news and what the client can do to reduce chances of rejection, conflict and abuse. The counsellor should also inform that the partner notification and STI diagnosis and treatment shall be confidential. The partner shall be treated for same infection/s as client.

Adapted from – Training manual for counsellors at STI/RTI clinics-NACO.

Box 23: Flow chart of sexual risk-reduction counselling



STIs and IDUs

Though IDUs are equally vulnerable to transmission of STIs, they may not always report/complain about the signs and symptoms even if they have STI. Some of the reasons are:

1. As the drugs injected by the IDUs are opioids, which have analgesic properties, IDUs may not feel the pain associated with some of the STIs.
2. IDUs may be on antibiotics for their abscesses; these antibiotics may partly treat the infection, resulting in partial improvement of the signs/symptoms of STIs, without complete cure.
3. Due to the injecting practices of IDUs in groin or penis, genital ulcers due to STIs may be misinterpreted for ulcers caused due to the injections.
4. Due to the injecting practices of an IDU, all signs/symptoms may be attributed to injections and the drugs that he/she is taking, and missing out the STI related symptoms.
5. Due to unhygienic living conditions of an IDU, femoral lymphadenopathy (swelling of the lymph nodes of groins) that occurs may be due to infections from blisters/abscesses in the foot, rather than STI.
6. The stigma attached to STIs may also bar the IDUs from reporting the signs and symptoms.
7. As the life of the IDU is focused on drug intake, procurement or recovering from the effect of drugs, IDUs may not be bothered about the STIs from which they are suffering.

The counsellor needs to be aware of these issues related to IDU and hence, during any visit to the DIC, relevant signs/symptoms of STI should be enquired about, and also a medical check-up with the doctor/nurse should be encouraged and insisted upon.

Counselling for condom use

Using a condom is the most consistent and safe means of having sex without being infected with STIs, HIV, Hep-B and C. It also prevents unwanted pregnancy and enhances pleasure by delaying ejaculation.

IDUs and condom use

Like any other HRG, IDUs also have the same myths and misconceptions about condom use. Moreover, since they are often pre-occupied with their drug use-related issues, the care-givers may undermine their need for sexual health services. Educating IDUs on sexual health and importance of condom use often take a back seat. Taking drugs or alcohol, especially before sex makes it difficult for the IDUs to use the condom correctly – both when putting it on and taking it off. The use of opioid drugs may delay ejaculation for long periods. Added lubrication may be needed in such cases to avoid condom tear and tissue damage of both partners.

Box 24: Common facts about condoms

Condoms

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

Uses of condom

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

Reasons for not using condoms

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

Myths about condoms

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

Counsellor's role in condom promotion

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

Frequently Asked Questions

What can damage condoms?

Oil-based lubricants, Vaseline.

What are the different brands of condoms available in India?

Male- Nirodh (free), Deluxe Nirodh, Kamasutra, Fiesta, Kohinoor, and many others

Female- Velvet, Confidom, Femidom.

Are condoms marketed socially?

Yes, there are social marketing organisations (SMO) that market condoms, they sell condoms at a price lower than market rate.

Are free condoms of poor quality?

No every batch of condoms are tested the same way whether supplied free or sold for a price.

Can an HIV infected person have sex using a condom?

Yes.

Are there condoms for women?

Yes! Called Femidom, it is costly and is marketed in India.

Figure 13: Condom demonstration – Male

① Check the expiry date of condom. Never use condom AFTER EXPIRY DATE.

② Open the condom packet by tearing it from one side. Roll out the condom by pressing on one side of the packet.

③ Press teat of the condom BEFORE putting it on tip of the fully erect Penis. Fix the condom on the tip with hand.

④ Start unrolling the condom on penis. Unroll it right up to the base of penis.

⑤ ... for SAFER SEX.

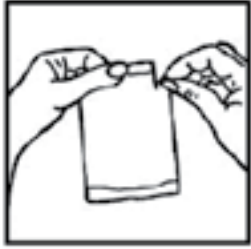









⑥ After intercourse, withdraw the penis form the vagina, while the penis is semi-erect.

⑦ Hold onto the rim of the condom while withdrawing to prevent it from slipping off and the semen spilling into the vagina.

⑧ Tie knot at base of condom without spilling semen before disposing.

Adapted from: Pathfinder International Mukta Project.

Figure 14: Condom demonstration – Female

	<p>1</p> <p>Open the female condom package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.</p>		<p>2</p> <p>The outer ring of the female condom covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.</p>
	<p>3</p> <p>While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.</p>		<p>4</p> <p>Choose a position that is comfortable for insertion; squat, raise one leg, sit or lie down.</p>
	<p>5</p> <p>Gently insert the inner ring of the Female Condom into the vagina. Feel the inner ring go up and move into place.</p>		<p>6</p> <p>Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure that sheath is not twisted. The outer ring should remain on the outside of the vagina.</p>
	<p>7</p> <p>The female condom is now in place and ready for use with your partner.</p>		<p>8</p> <p>When you are ready, gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly; be sure that the penis is not entering on the side, between the sheath and the vaginal wall.</p>
	<p>9</p> <p>To remove the female condom, twist the outer ring and gently pull the condom out.</p>		<p>10</p> <p>Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.</p>

Adapted from: www.condomdepot.com

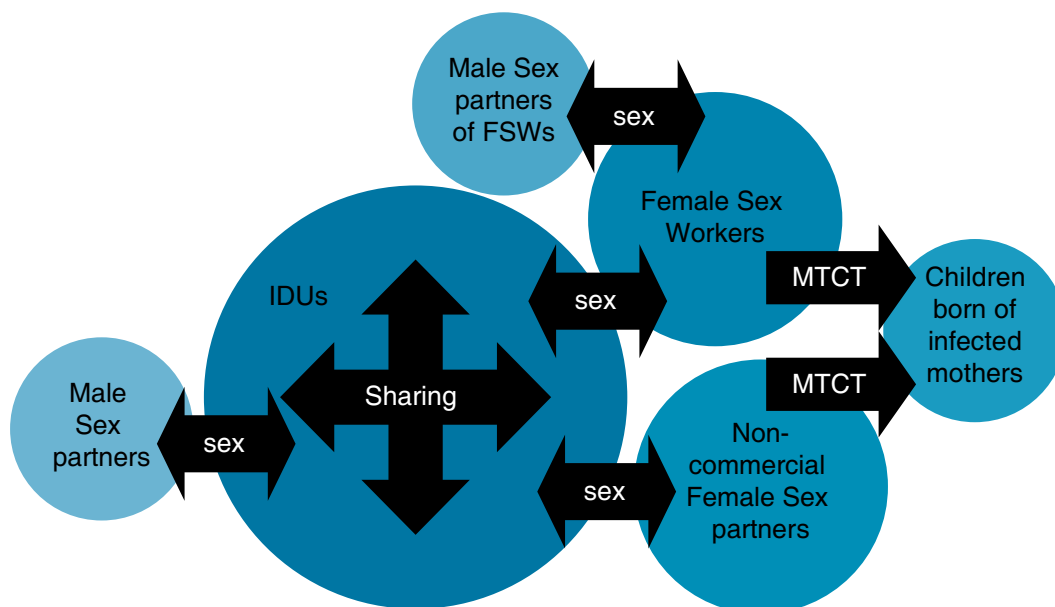
(From Training Manual for counsellors at STI/RTI clinic, National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India)

Counselling IDUs: HIV-related issues

Introduction

HIV is transmitted among and from IDUs through both the injecting route as well as the sexual route. As outlined in the earlier chapter, IDUs are also sexually active, and hence the sexual route also becomes an important transmission route, especially in the context of transmission to the non-injecting partner. While initial transmission may occur among IDUs through sharing needles, syringes and paraphernalia, transmission soon takes the sexual route and also by the vertical route of mother to child (MTCT) transmission from the infected female partners. Being sexually active while injecting makes them doubly vulnerable to receiving infection through the injecting route as well as through the sexual one. Their female partners and subsequently 'children to be born' become vulnerable to infection.

Figure 15: Transmission of HIV infection in IDUs



Sex-work and IDUs are closely linked in many settings. Studies from India show that over 50% of men who inject drugs have visited a commercial sex worker in the past year. Moreover, in some cases, women who use drugs are also involved in sex work. This IDU-FSW network with strong sexual links with the general community creates a very high-risk environment that has the potential to explode from a concentrated epidemic into a generalised epidemic affecting the entire population.

IDUs and HIV-related services

IDUs often fall behind when it comes to receiving services for prevention and treatment of HIV. Lack of proper nutrition and their lifestyle makes them prone to TB and STIs. Untreated mental illnesses are also common among IDUs.

Box 24: Common health problems of IDUs

Common health problems among IDUs

- ◆ Hepatitis B, C (HBV and HCV) infections, which may lead to liver diseases including cirrhosis and hepatocellular carcinoma.
- ◆ Injection-related bacterial infections, including septicaemia, bacterial endocarditis and osteomyelitis.
- ◆ Local soft tissue and vascular injury, including skin abscesses and thrombophlebitis.
- ◆ TB, both pulmonary and extra-pulmonary.
- ◆ Psychiatric co-morbidity including depression.
- ◆ Overdose.
- ◆ Poly-substance dependence, including alcohol.

There is also a misconception among service providers that IDUs are more likely to become resistant to ART medicines than others. However, studies have shown that resistance to ART among IDUs is similar to that among other population groups. It has also been evidenced that when comprehensive services that include harm-reduction, detoxification, opioid maintenance treatment and psycho-social support are provided in a non-threatening and non-judgemental manner, and are made easily accessible to them, retention and compliance to treatment is high.

HIV testing

It is true that an individual infected with HIV will progress through the various stages of the infection towards the AIDS stage ultimately. If the infection is detected early, the rate of progression of the disease can definitely be slowed down through regular testing and timely introduction of Anti-retroviral Therapy (ART) and regular check-up. Moreover, detection can also help prevent Opportunistic Infections (OIs) by taking necessary precautions and proper treatment for the OIs (if infections occur), reduce related sufferings (morbidity) and prevent progression to AIDS. Detection of HIV infection also helps in the prevention of onward transmission to uninfected partners and future children, and also re-infection or infection with a newer strain of HIV. Detection and subsequent psycho-social support helps deal with associated problems, better planning, coping with eventualities and help enhance the overall quality of life. Even if tested and found to be HIV negative, the client may identify the high risk practices that may lead to HIV infection and modify them to ensure prevention of infection.

Box 25: Reasons for undergoing tests for HIV

Getting tested for HIV		
	Advantages	Disadvantages
Detected as HIV-positive	<ul style="list-style-type: none"> ◆ Early identification. ◆ Psycho-social support. ◆ Regular monitoring of CD4 counts. ◆ Timely introduction of ART. ◆ Prevention of OIs. ◆ Faster identification of OIs–proper treatment of OIs. ◆ Onward transmission prevented. Through partner notification and subsequent services. ◆ Improved quality of life. 	<ul style="list-style-type: none"> ◆ Fear of: <ul style="list-style-type: none"> ▲ Abandonment ▲ Violence ▲ Loss of job ▲ Loss of family support. ▲ Community rejection. ▲ Illness/death. ◆ Denial of engaging in behaviours that have put them at risk. ◆ Stress
Detected as HIV-negative	<ul style="list-style-type: none"> ◆ Psycho-social support. ◆ Reduced risks of being infected. ◆ Regular check up for further reduction of risks. ◆ Lowered level of stress. ◆ Improved quality of life. 	<ul style="list-style-type: none"> ◆ Can make the client. Overconfident (“nothing will happen to me”) leading to continued high-risk practice.

HIV risk assessment

The first step to HIV counselling is HIV risk assessment. Assessment of HIV risks should be done for all clients with a history of high risk activities, as well as for those who come to seek for HIV testing specifically. An IDU client may be referred for HIV testing and counselling if he/she has a history of high risk activities – sharing of needles, syringes and injecting paraphernalia and/or sex without condoms. However, as per NACO’s guidelines on referral, it is recommended that every IDU accessing services must be motivated for HIV testing.

In order to carry out a proper assessment, scales such as High Risk Behaviour Scale (HRBS) may be used (annex-1). The counsellor may also use the Individual risk assessment for the purpose (annex-2). The counsellor should also verify whether the client is in the ‘window period’ for the test to show correct results.

Box 26: HIV tests and the “window period”

The regular tests (ELISA and Western Blot) conducted for HIV infection in the human body are based on detection of antibodies produced in response to the presence of the virus in the body. These antibodies take time to be produced in enough quantity to be detectable. It can take up to 12 weeks after infection with HIV for antibodies to be produced in detectable quantities. This means that an **HIV test cannot guarantee a person’s HIV status as negative if they have had any risk for HIV infection in the 12 weeks immediately before the test.** This time period of 12 weeks before the test is called the ‘window period’ when the antibody level is too low for detection but the infected individual can still have a high viral load and can transmit the infection to others.

It is important to consider the time since the '*last episode of reported high-risk activity*' by the client. If it is within the window period of 12 weeks, the test may not be able to detect HIV infection. In case the test is conducted within the window period, the client should be advised to repeat the test on completion of the window period. During this period, the client should be advised not to indulge in any high-risk behaviour and should use condoms for every sexual act.

Pre-test counselling

Before referring the client for a pre-test counselling session, the counsellor should prepare the client for the test, by educating the client about its significance and implications. When recommending HIV testing and counselling to the IDU, the counsellor needs to provide the client with the following information:

- ◆ Reasons for recommending the test (symptoms or history of risk behaviour).
- ◆ Advantages (access to ART and related services) and disadvantages (risk of discrimination and abandonment) of testing.
- ◆ Services available for both negative and positive results.
- ◆ Confidentiality of the test results.
- ◆ The test is **strictly voluntary**, and the client has the right to decline and declining the test will not affect access to other services.
- ◆ In case of positive results, disclosure to intimate partners and contacts may be encouraged.
- ◆ The clients should be informed that the test is only for HIV and does not screen for other infections related to injecting (hepatitis B, C or syphilis).

IDUs often take alcohol and other drugs over and above the drugs used for injection. It is important for the counsellor to have an overall idea of the drugs used by the client, the pattern of use, frequency and route of use. The implications of all these in enhancing the client's risks, interference with treatments and behaviour change attempts need to be considered. The client may need additional services like drug treatment, OST to help improve his/her quality of life and/or bring the required stability in life for HIV testing, counselling and subsequent HIV treatment. The counsellor should prepare the client appropriately and arrange for referral as required. In case of a female IDU client, there are special issues to be considered:

Box 27: Special issues to be considered during counselling for female clients

- ◆ Risk of HIV transmission to infants.
- ◆ Risks of acquiring HIV during pregnancy.
- ◆ Measures to reduce MTCT, including ARV prophylaxis.
- ◆ Infant-feeding counselling.
- ◆ Benefits of early HIV diagnosis to infants.
- ◆ Advice on contraception if deciding not to become pregnant.

Once the client is aware of what to expect at the ICTC, and is ready for testing, the client should be referred to ICTC. An appropriate referral form should be filled by the TI counsellor for referral to the ICTC counsellor. The chances of IDU client getting tested increases, if the referral is accompanied by a PE or an ORW.

In case a client declines a test, extra care should be taken to see that he/she is not denied access to other services. Helping the client to contemplate on the costs and benefits of testing as opposed to not testing for HIV should be facilitated with continued education and support to overcome the barriers and fears. The client should never feel threatened at any point of time.

At ICTC, a formal pre-test counselling for the client is done by the ICTC counsellor.

Box 28: The contents of a pre-test counselling session will include

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

Preparation for results

The client should be motivated to come back for the results on the given date and time. Facing HIV test results can be very stressful for clients and some may resort to alcohol or drugs before receiving reports.

Post test counselling

All clients, irrespective of test results, should be provided with a post test counselling. Such sessions are mandatorily held at the ICTC centres by specialised counsellors trained for the purpose. Salient features of a post-test counselling are as follows:

- ◆ Results should be provided to the client in person individually by the counsellor who provided the pre test counselling.
- ◆ Strict confidentiality is to be maintained.
- ◆ IDUs have lower capacity of dealing with stress, whether positive or negative. Care should be taken to ensure that the IDU is not at risk of self harm by overdosing on drugs or suicide upon receiving the result. Negative results may also lead to overdose when the client tries to celebrate the relief. Peer support mechanism is usually helpful in such cases.
- ◆ The client is within his or her rights in not receiving the results of the test but the counsellor should make reasonable attempts to ensure that the client receives his/her results and is able to understand the entire significance of it.

In case the result is negative, the counsellor should provide the following:

- ◆ Explain the result and its significance.
- ◆ Educate on window period and recommend for re-test in case of recent exposure.

- ◆ Educate on prevention of HIV transmission, especially based on the high-risk practices of the client.
- ◆ Educate on risk-reduction (safer injecting and safer sex with condom use).
- ◆ Motivate for drug treatment services, especially OST where it is available.
- ◆ Provide condoms, and sterile needles and syringes.
- ◆ Endorse plan for follow up with defined time for re-test, if needed.

In case the result is positive, the counsellor should provide the following:

- ◆ Inform the client simply and clearly: provide time for the client to internalise the result.
- ◆ Explain the significance of the result clearly and in the language understandable by the client.
- ◆ Assist in coping with the stress and emotions of the result.
- ◆ Discuss immediate concerns of the client and their implications.
- ◆ Discuss available social support from where the client may seek immediate support.
- ◆ Educate on services available, their accessibility and their advantages.
- ◆ Educate on the need for preventing onward transmission, re-infection and infection from newer strains of HIV.
- ◆ Educate on prevention of common infections.
- ◆ Explore disclosure of results, especially to the intimate partners (when, how and to whom of it).
- ◆ Motivate for testing and counselling of intimate partners and children.
- ◆ Advise on other pathological tests (like liver function, hepatitis B and C, pregnancy, TB).
- ◆ Advise on referrals to treatment, care, counselling, support and other services, as required (e.g. screening and treatment of TB, prophylaxis for OIs, STI treatment, contraception, antenatal care, OST, hepatitis B and C screening, and access to supplies of condoms and sterile needles/ syringes).
- ◆ Assess risk of violence, drug overdose or suicide, and discuss possible measures to ensure the physical safety of clients.

Box 29: Additional measures during post-test counselling for HIV positive pregnant women

Post-test counselling for **pregnant women** who are **HIV-positive** should also address the following measures:

- ◆ Childbirth plans.
- ◆ The use of ART drugs for the client's own health when indicated, and for PPTCT.
- ◆ Maternal nutrition, including iron and folic acid supplements.
- ◆ Infant-feeding options and support options to facilitate the mother's infant feeding choice.
- ◆ HIV testing for the infant and the follow up that will be necessary.
- ◆ Partner testing.
- ◆ Referral to drug treatment centres, particularly those providing OST.

Disclosure of positive HIV test results to partners

The need for disclosure to partners, injecting or sexual, is important to prevent onward transmission, re-infection and infection from newer strains of HIV. This requires a very sensitive approach.

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

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

Box 30: Protocol for partner notification in case the client does not agree to voluntarily share the HIV status with the spouse/partner

- ◆ The HIV-positive person has been thoroughly counselled as to the need for partner notification and encouraged to voluntarily inform the partner or bring the partner to the VCTC for joint counselling.
- ◆ The HIV-positive person is given advance notice of the intention to notify.
- ◆ The identity of the source from where the client acquired HIV is concealed from the partner if that is possible in practice.
- ◆ Post-notification follow-up counselling, information and support is provided to the partner and the HIV-positive person to prevent violence, family disruption, etc.

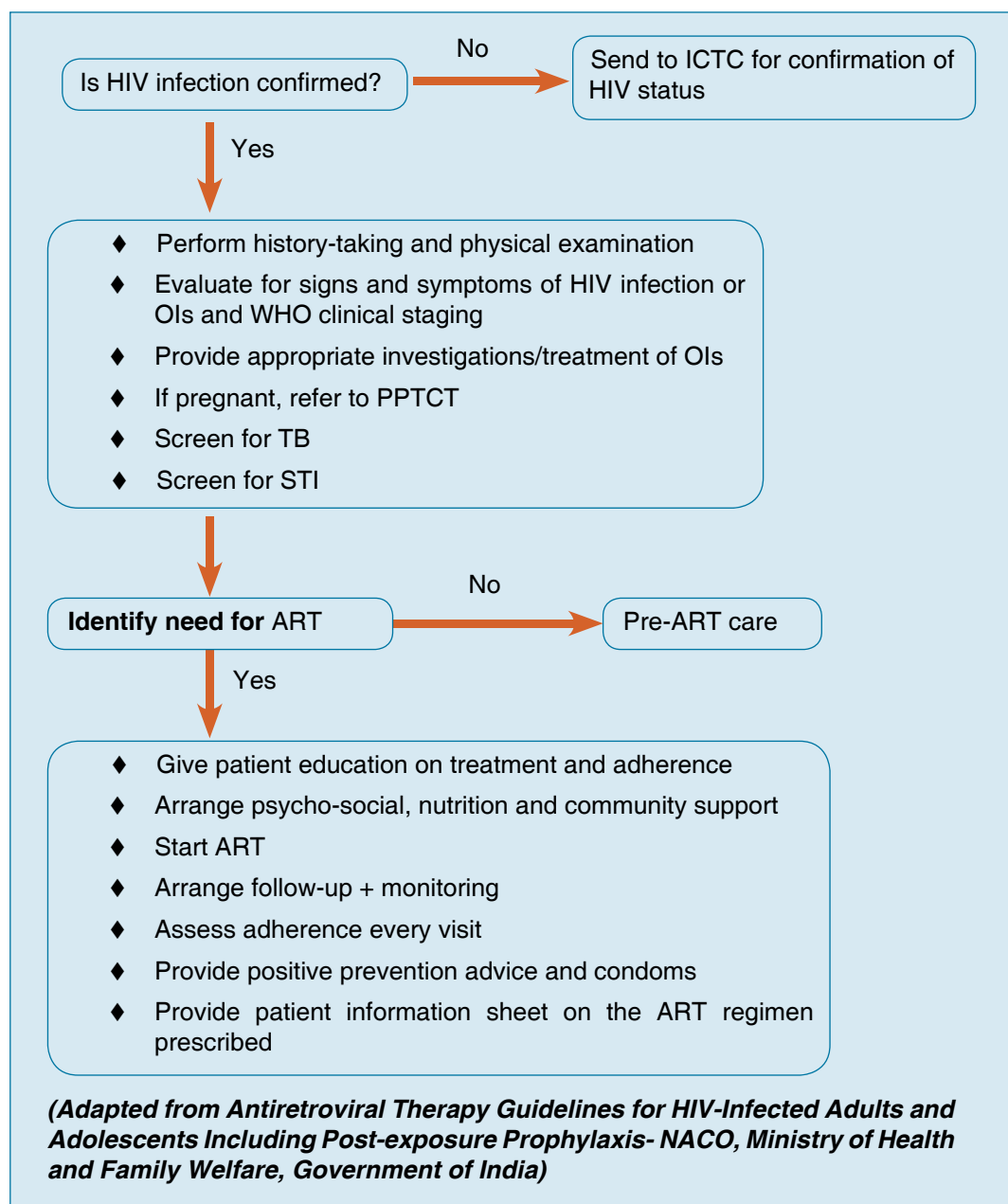
Pre- ART phase

Once tested positive for HIV, the client should be regularly monitored and supported at every stage. Depending on the CD4 count, viral load and opportunistic infections, the client may or may not need ART immediately. Till the time they require ART, the clients will need an array of services including treatment and care. This is referred to as the Pre-ART care phase. If provided correctly and adhered to properly by the client, it can delay the initiation of ART, subsequent development of resistance to ART medication and help delay the progression of the disease, thereby reducing AIDS-related mortality.

PLHA who do not need ART (or are not medically eligible for the initiation of ART) should be counselled to maintain healthy/positive living and should be linked to care and support services. The recommended activities of the counsellor during this phase are as follows:

- ◆ Educate on the treatment aspects and allied services available.
- ◆ Educate on the need for these services and their accessibility at ART/ICT centres.
- ◆ Educate on the need for regular check-ups and follow-ups.
- ◆ Educate on ART medication and need for adherence.
- ◆ Motivate for family screening and testing (if not done already).
- ◆ Educate on the issues related to continued drug use and their implications in the HIV treatment.
- ◆ Motivate the client to seek drug treatment services (OST if available, detoxification, etc as required).
- ◆ Motivate and support the client to register in the NACO Pre-ART Register for continued services.

Box 31: Assessment and Management of HIV-infected Person



Anti-retroviral Therapy

ART drugs cannot eradicate HIV infection from the human body but can delay the progress of the disease, prolong lifespan, and improve the overall quality of life.

Goals of ART

Box 32: Goals of ARV therapy

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

When to start ART

The initiation of ART is based on the clinical stage of the disease and the client's CD4 count. CD4 count results guide treatment and follow-up. However, lack of a CD4 result should not lead to delay in initiation of ART if the patient is clinically eligible according to the WHO clinical staging. However, it is advisable that a CD4 test should be done as soon as possible.

The optimum time to start ART is before the patient becomes unwell or presents with the first OI. The progression of the disease is faster in patients who commence ART when the CD4 count falls below 250 cells/mm³ than in those who start ART before the count drops to this level.

Adherence to ART

It is imperative to ensure good adherence to ART. Non-adherence leads to drug resistance requiring the client to be moved from one regimen to another thus limiting future treatment options. The TI counsellor in collaboration with the ART/ICTC counsellor plays a crucial role in this matter. NACO recommends at least two counselling sessions before the initiation of ART. The primary objective of these sessions is to prepare the client for ART and its adherence.

ART for IDUs

The issues described above for testing as well as ART is the same for IDUs as well as the non-IDU population. However, it is often seen that IDUs are often excluded from ART services, or even if initiated into ART services, are done so quite late into the stage of HIV illness. Even in India, studies have documented that fewer IDUs have access to ART due to a number of barriers.

It is also seen that there are some misconceptions and barriers among the service providers on the provision of ART. These include:

- ◆ IDUs are poor candidates for ART treatment due to poor adherence.
- ◆ IDUs do not do as well as non-IDUs on ART.
- ◆ IDUs must be clean of drugs before initiating ART treatment.
- ◆ IDUs are seen as being non-compliant with the instructions given by the ART team, and hence it is a waste to start ART for them.

- ◆ Medical complications associated with IDU such as Hepatitis B and C makes it difficult to initiate ART in IDUs.
- ◆ Stigma and discrimination against the IDUs by the service providers are also seen among ART providers.

Studies across the world have proven the misconceptions stated above as false. It should be remembered that:

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

Thus, it should be remembered that:

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

Role of the IDU TI counsellor in improving ART adherence

As the IDU TI counsellor has established rapport with the IDU client, he/she can play a major role in improving ART adherence among IDUs. To improve adherence to ART, the following steps can be taken by the counsellor:

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

- ◆ Make sure the IDU is accompanied for the initial phase by a staff of the IDU TI. This will build the motivation of the client, and ensure that the referral is completed.
- ◆ When conducting one-to-one counselling, address the following issues:
 - ▲ Specific factors that may affect the timing of initiation and the choice of ART, (social instability, active use of illicit drugs and the presence of co-morbidities, such as mental problems and co-infection with hepatitis viruses) and refer for appropriate treatment prior to initiation.
 - ▲ Spend adequate time on preparing patients for ART, and helping them understand the treatment goals, need for adherence and lifelong nature of ART will maximise treatment outcomes.
 - ▲ Enquire about the adherence and factors related to adherence/non-adherence to ART medications.
 - ▲ Clarify any myths/misconceptions related to ART treatment.
 - ▲ Encourage the client to involve family members in the treatment process.
 - ▲ Assess the suitability and willingness of the client for drug treatment, e.g. detoxification-cum-rehabilitation, and opioid substitution therapy. Refer the client to these services, if they are available and the client is motivated enough.
- ◆ Visit the ART clinic regularly and follow-up with the counsellor to enquire about any issues regarding adherence. In addition, ensure that the ART counsellor informs the IDU TI counsellor/other staff on any drop-outs from the treatment, so that the clients can be motivated to re-initiate treatment.

Some IDUs may need special care and services due to co-morbidities. If identified or recorded in the history of the client, the TI counsellor should refer for specialised care and inform the ART/ICTC counsellor.

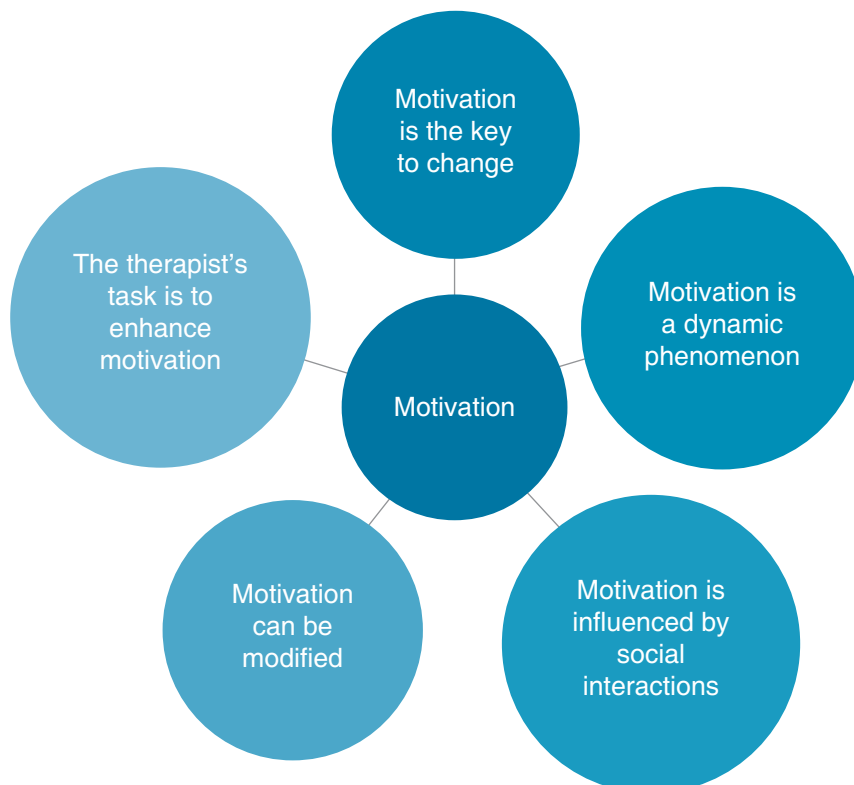
Motivation enhancement

Many people harbour the myth that drug users do not want to stop taking drugs. Nothing can be farther than truth. Indeed, one of the criteria of drug dependence is “unsuccessful efforts to reduce or cut down drug use.” The fact that despite wanting to quit, people are unable to do so, makes drug dependence the disorder it is.

On the other hand, another widely held myth is that just by a strong desire and “will-power” people should be able to change their behaviours, including drug use. This is also incorrect. The fact is that motivation is a very important aspect of any kind of behaviour change. Whether it is dieting to lose weight, studying regularly to pass tests, quitting drugs, or adopting safer injecting practices, motivation plays a key role. However, while motivation is necessary for behaviour change, it alone is rarely sufficient to result in behaviour change.

The important point to remember about motivation is that it is dynamic, keeps changing, and the change in desired direction can be brought about by a social interaction (such as an interaction between an IDU client and a counsellor). The adjoining figure highlights some important aspects of motivation.

Figure 16: Important aspects of motivation



Stages of change

Before discussing about motivation we must understand the concept of “stages of change” involved in changing any kind of behaviour. Simply telling people that “*you must stop sharing injections*” may not work. For achieving any kind of behaviour change, it must be remembered that:

- ◆ An individual needs to pass through certain stages (described below).
- ◆ The pace with which people progress through each stage varies from individual to individual.
- ◆ Each of the stages involves dealing with its own set of issues and challenges.
- ◆ The change is cyclic in nature and the movement can happen in any direction.

Thus, an individual in contemplation stage can move to action stage or someone from maintenance stage can slip back to contemplation stage.

Box 33: Stages of change

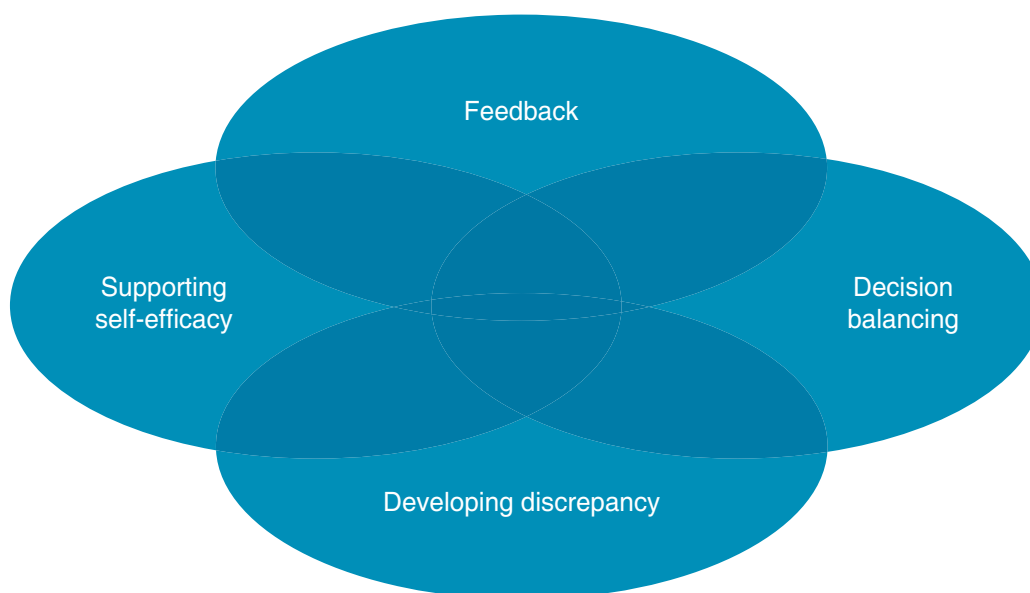
Stage	Description	Example
Pre-contemplation	Not yet acknowledging that there is a problem behaviour that needs to be changed.	Arun, an IDU, does not think that he has a problem with injecting/sharing.
Contemplation	Acknowledging that there is a problem but not yet ready or sure of wanting to make a change.	Arun understands that his injecting is causing him various problems but does not know how to reduce/stop.
Preparation	Preparing for change.	Arun has talked to a peer educator about where to find help regarding his injecting.
Action/Willpower	Changing behaviour.	Arun has enrolled in the TI for NSEP.
Maintenance	Maintaining the behaviour change.	Arun has stopped sharing injections now, and injects with full precautions.
Relapse	Returning to older behaviours and abandoning the new changes.	Arun has stopped visiting the DIC, has again started injecting and sharing in the same pattern as before.

With motivation enhancement, the task of a counsellor is to help the patient move from one stage to another (i.e. from pre-contemplation to contemplation, from contemplation to action and so on) Thus, a counsellor working with IDUs, needs to be familiar with the strategies, which may enhance the motivation of a client to adopt safer behaviours or even to quit taking drugs. To enhance the motivation, the counsellor needs to interview the client using certain specific strategies.

Strategies for motivation enhancement

The following strategies are distinct, yet overlap with each other:

Figure 17: Strategies for motivation enhancement



Feedback

As the name suggests, feedback involves giving feedback to the client regarding the ACTUAL negative consequences the client has faced in the past due to his behaviour. Any 'preaching' about possible or potential consequences that the client may suffer in the future is avoided. An example of feedback is provided in the box.

Box 34: Feedback

During interviewing a client, the counsellor elicits information about all the negative consequences the client has actually suffered. Suppose, during the course of the interview, it was discovered that the client has suffered blocked veins in both hands on many occasions, had an abscess in his left forearm once and once injected such a large amount that he became unconscious. The counsellor then, in her own words, provides feedback about exactly these three negative consequences "So, you are telling me that because of your injecting drug use, not only you have experienced blocked veins but even abscess and fever too. And once you had experienced an overdose, which was a life-threatening situation." While there are obviously many more likely consequences of injecting (like HIV etc.), the counsellor at this moment just focuses on consequences actually experienced by the client.

Decision balancing

Yet another strategy to enhance motivation is, "decision balancing". In this strategy, the client is helped to compare ('weigh') two different situations: the benefits of change vis a vis benefits of staying the same and compare it with cost of staying the same vis a vis cost of change. Thereafter the client is encouraged to take the decision whether to change or stay the same. Sounds complicated? See example in the box, next page.

Box 35: Decision balancing

The counsellor is trying to increase the motivation of an IDU client to get enrolled in the NSEP. The client expresses that enrolling in the NSEP would mean that he has to contact the DIC daily in order to obtain the needles and syringes. This may also mean some inconvenience, spending time and possibly losing some money, through loss of earnings (i.e. cost of change). If he gets enrolled however, he will be able to protect himself from the consequences of injecting with an old needle and will also receive other services (i.e. benefits of change). On the other hand if he decides not to enrol in the NSEP, then he may save himself some inconvenience, time and money (i.e. benefits of staying the same). However, in this situation, he will be at risk of experiencing even more harms due to unsafe injecting (i.e. cost of staying the same). In this way the counsellor can help the client weigh, for himself, both the options and decide the best course of action for him.

Such cost-benefit analysis can be done typically by using a cost-benefit table as shown below:

Box 36: Issue: Whether the client should get enrolled in the NSEP?

	Benefits	Costs
Short term	Access to sterile needles free-of-cost, access to other services.	Inconvenience and possibly losing some money
Long term	Better health, safety from diseases	Inconvenience and possibly losing some money

Developing discrepancy

Another strategy that counsellors may employ to increase the motivation is developing discrepancy. Here, the client is helped to compare his life with his non drug-using friends and relatives or with those who have successfully changed their behaviours. Additionally, a comparison can also be made between the status of the client as it stands today and his likely status had he not been taking drugs. Yet another way to increase motivation through this technique would be to encourage the client to compare his status in the future in two imagined situations – if he succeeds in changing his behaviour vis-à-vis he does not change his behaviour.

Box 37: Developing discrepancy

Here the counsellor asks the client about his other friends – those who are either non-drug users or those who have changed their behaviours successfully. Who is doing better in life? The client or they? The counsellor may also ask the client to imagine himself five years down the line. How does client visualise himself five years from now, if he continues to take drugs in a similar fashion? And how does he appear if he succeeds in changing his behaviour? In this way client can be helped to see and decide for himself.

Supporting self-efficacy

Many drug users hold this notion that it is impossible for them to change their behaviours; “You know, I have been injecting in this manner for so many years now. Now it is impossible for me to change myself.” In such situations the important thing for the counsellor to do is to instil the hope in the client (“change is possible”) and confidence (“you can bring about that change”). Examples of others who have succeeded in changing their behaviours can be cited. Indeed, if the client has live examples of people who have been able to change their behaviours (such as peer

educators), it can go a long way in increasing the optimism and confidence of clients and enhance their motivation to change.

Box 38: Supporting self-efficacy

The client expresses pessimism and doubts regarding his ability to be able to change his behaviour. The counsellor attempts to increase his self-efficacy by making statements like, *“I understand that at this moment, you are not sure whether you will be able to do it. However, many others have done this before you and they have achieved success. If others can do it, so can you.”*

Summary and conclusion

Any kind of behaviour change, include change in drug-related behaviour occurs through various stages. **Motivation enhancement** of an individual for behaviour change can be achieved by the counsellor through employing specific strategies. These include, **Feedback** (i.e. giving feedback to the client about actual negative consequences experienced by him), **Decision balancing** (helping the client to compare pros and cons of changing and not changing the behaviour and arrive at a decision), **Developing discrepancy** (comparing status of drug-using client with the status of other with safer behaviours) and **Supporting self-efficacy** (instilling hope and self confidence in the client).

Counselling IDUs: Drug-use related issues

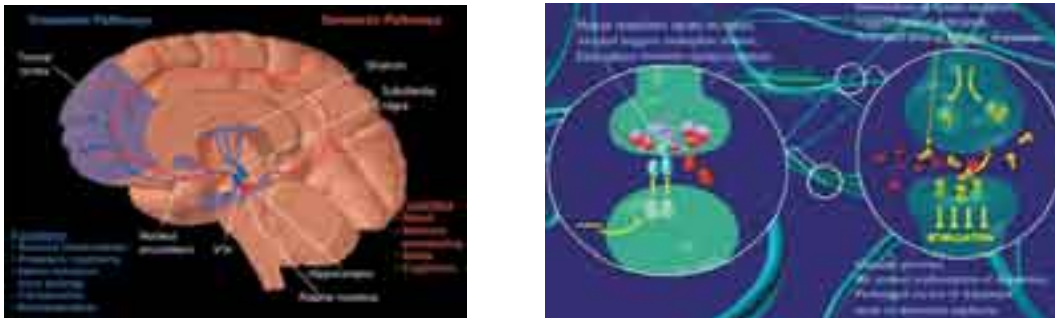
A. Drug detoxification

As may be recalled from the initial chapters on the various features of drug dependence, there are two important phenomena that are a feature of physical aspects of drug dependence. This includes: tolerance and withdrawal.

Tolerance

When a particular drug is taken over a long period of time, the body requires progressively increased amounts of the drug to have the same effect as that experienced by the individual during his initial intake days. This is because there are physical changes at the microscopic level in the body, when a particular drug enters the body. In case of psycho-active drugs, the micro-level changes are produced in the brain receptors. As a result of these changes, the body gradually requires additional amounts of the substance to get 'high'.

Figure 18: Neuronal pathways associated with drug use in the brain



Withdrawals

As a result of the above changes at the receptor level of the brain neurons, when the drug intake is stopped or decreased as compared to the previous levels, the balance between the drug and the changes in the neuro-receptors is disturbed. This results in the appearance of symptoms which are called as 'withdrawals'.

The mechanism of withdrawal has been compared to the 'spring'. As the weight goes on increasing, the spring is pushed down; similarly, when the amount of drugs are increased, the changes in the brain (produced due to drugs) increase. When the weight is suddenly removed, the spring recoils; similarly, when the drug is suddenly stopped, the brain changes recoil, resulting in withdrawal symptoms.

What are withdrawal symptoms?

Withdrawal symptoms are not the same for all the drugs. Different drugs produce different withdrawal symptoms. However, these can be divided into two broad categories: physical and psychological. While the psychological symptoms are similar for most of the drugs, the physical symptoms of withdrawal are different for different drugs.

The following tables show the withdrawal symptoms associated with the three most commonly encountered drugs in IDU TI setting:

Box 39: Withdrawal symptoms seen with alcohol, opioid and cannabis

Alcohol withdrawal symptoms	Opioid withdrawal symptoms
<p>Mild-to-moderate psychological symptoms</p> <ul style="list-style-type: none"> ◆ Anxiety or nervousness ◆ Depression ◆ Difficulty thinking clearly ◆ Fatigue ◆ Irritability ◆ Nightmares <p>Mild-to-moderate physical symptoms</p> <ul style="list-style-type: none"> ◆ Clammy skin ◆ Enlarged (dilated) pupils ◆ Headache ◆ Insomnia (sleeping difficulty) ◆ Loss of appetite ◆ Nausea and vomiting ◆ Rapid heart rate ◆ Sweating ◆ Tremor of the hands or other body parts <p>Severe symptoms</p> <ul style="list-style-type: none"> ◆ Agitation ◆ Delirium tremens – a state of severe confusion and visual hallucinations ◆ Fever ◆ Seizures 	<p>Mild – moderate symptoms</p> <ul style="list-style-type: none"> ◆ Anxiety ◆ Restlessness ◆ Yawning ◆ Nausea ◆ Sweating ◆ Rhinorrhea (running nose) ◆ Lacrimation (running eyes, tears) ◆ Dilated pupils ◆ Abdominal cramps <p>Severe symptoms</p> <ul style="list-style-type: none"> ◆ Severe anxiety ◆ Restlessness ◆ Diarrhea (loose motions) ◆ Vomiting ◆ Piloerection (goose bumps) ◆ Muscular pain ◆ Chills ◆ Increased heart rate, ◆ Increased blood pressure ◆ Increased temperature
<p style="text-align: center;">Cannabis withdrawal</p> <p>There are no major physical symptoms of cannabis withdrawal. Cannabis withdrawal is associated with psychological symptoms:</p> <ul style="list-style-type: none"> ◆ Irritability ◆ Sleeplessness ◆ Decreased appetite ◆ Anxiety ◆ Drug craving 	

Some points that should be remembered in case of withdrawals from psychoactive drugs:

- ◆ Different drugs produce different types of withdrawals, as well as different timings for withdrawals; for e.g. alcohol withdrawals may start within 4–6 hours, while withdrawal symptoms from some opioids (e.g. methadone) may appear after more than one day.
- ◆ The severity of withdrawals depends on the amount of drugs consumed in the recent period before stopping the drugs, as well as the severity of dependence.
- ◆ The severity of withdrawals also depend on a number of individual related factors – physical status, presence of other illness, and psychological status.
- ◆ Withdrawals of some drugs, especially alcohol, can also result in death.
- ◆ Withdrawal symptoms of opioids are not often life-threatening and rarely result in deaths, unless due to some other complications. For e.g. severe loss of body fluids due to vomiting and diarrhoea as opioid withdrawal symptoms result in salt imbalance in the body and may cause death. However, the withdrawal symptoms are very painful for the user and may be the worst period of time in the life of the opioid user.

How are withdrawals managed?

Withdrawal management is also called as **drug detoxification**. Detoxification is the process by which assistance is provided to the body to clear itself of the effects of drugs. A drug user undergoes detoxification with the aim of stopping drugs altogether either for a short period of time or for forever (complete abstinence).

The process of detoxification, often, is managed with medications that are administered by a physician in an inpatient or outpatient setting; therefore, it is referred to as “medically managed withdrawal.” Specific medicines are used for specific drugs; for e.g. benzodiazepines (diazepam, lorazepam, chlordiazepoxide) for alcohol withdrawal, opioids (such as buprenorphine, methadone), and clonidine for opioid withdrawal.

In addition to specific medications, a lot of supportive treatment is also required to be provided to avoid untoward effects. This include, for e.g., thiamine replacement during alcohol withdrawal, analgesics and benzodiazepine for opioid withdrawals.

Detoxification can be carried out in both outpatients as well as inpatient settings. The decision as to which of the two is preferred depends on the degree of dependence and the complications associated. The decision is taken by the treating physician after a thorough clinical examination.

What happens after detoxification

It is important to remember that detoxification alone does not address the psychological, social, and behavioural problems associated with addiction. Hence detoxification alone does not lead to the long term behavioural changes necessary for complete abstinence. Detoxification should be considered as the first step of treatment as it takes care of the acute phase of drug withdrawals. Well-researched studies have documented that detoxification alone leads to almost 95-98% relapse. Hence, it is of utmost importance for the client to remain under treatment even after the detoxification phase is over.

After detoxification, the long and gradual process of recovery begins. During this post-detoxification phase, an individual is maximally vulnerable to relapse i.e. going back to drug use. Hence, maximum support is required to be provided to the individual during this phase. Post-detoxification, a number of measures can be employed: periodic counselling, relapse prevention, psycho-social rehabilitation, occupational rehabilitation, etc.

Counselling issues in detoxification

A TI counsellor would encounter a number of clients who would want to leave drugs altogether. In such cases, the counsellor has to counsel the client before he/she is referred for undergoing detoxification. For inpatient detoxification, the client has to be referred to a detoxification-cum rehabilitation-centre located at the nearest distance. In India, these centres are usually run by NGOs and funded by the Social Welfare department. In most of these centres, while the stay, cost of the treatment and the staff charges are borne by the centre, the client has to pay for the food expenses incurred. In some cases, the client is also required to be admitted accompanied by his/her family members. Apart from the NGOs funded by the Ministry of Social Justice and Empowerment, there are a number of private-funded ones as well as charitable trust/faith-based organisations/funded centres which run detoxification-cum-rehabilitation centres. The counsellor should visit these centres and try to establish a working relationship with the staff of the centre and also understand the procedural issues involved in availing of their services.

The following issues should be borne in mind and the client counselled during this phase:

- ◆ **Understand the factors** that have led him/her to take this decision; an individual may have multiple reasons that may compel him to think **about stopping drugs** altogether – totally fed up of using drugs, realisation of multiple complications that the drug has caused in his/her life, threat of being thrown out of job/home, impending divorce/separation, etc.
- ◆ **Assess** whether these motivating factors are temporary or more pervasive. Whatever the factor, build on the crisis and explain to the client about other areas of his life where drugs have caused problems. By exploring the other areas, build the motivation of the client through **motivation enhancement therapy**. This technique to build the client's motivation has been dealt with in the previous chapter.
- ◆ **Educate** the client on what is **to be expected during detoxification**. Make the client understand that he/she will experience some amount of discomfort when undergoing detoxification.
- ◆ **Educate** the client that **detoxification is the first step** towards abstinence, and that the process of recovery is a long one. Also that the client has to continue treatment with the centre even after he/she has completed detoxification.
- ◆ **Explain the administrative issues** associated with detoxification, for e.g. user-fees, staying with a family member, fixed number of days of compulsory inpatient stay, etc.
- ◆ **Caution** the client, that in case he/she relapses after detoxification, the dose of the initial few doses of opioid which he/she may use must be very small, as the body has lost tolerance to the drug. That this is the period when he/she is going to be at maximum **risk of overdose** and should

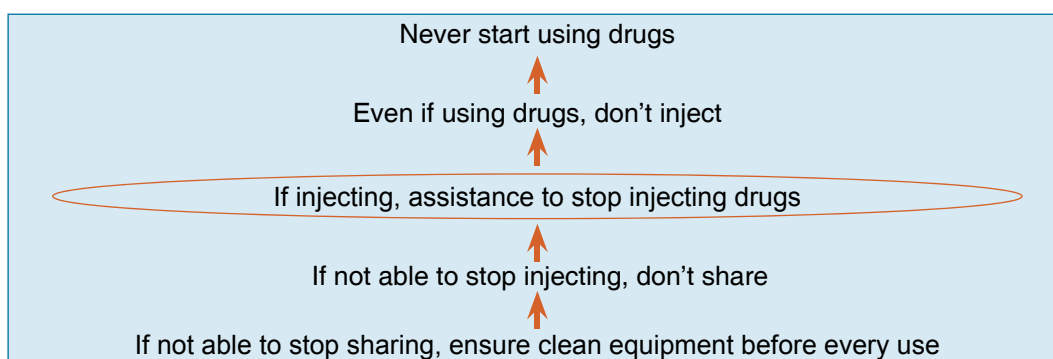
be extremely cautious (the issue of overdose is covered under the risk-reduction chapter).

- ◆ **Explain** to the client that if he/she **relapses** after detoxification, he/she should **get in touch** with either the TI staff or the detoxification centre staff once again. The client should not feel that he/she is a failure and stop seeking help. Explain to the client that even a few days of abstinence achieved is better than not trying at all.

B. Opioid Substitution Therapy

As may be recalled in the previous chapters on basics of harm-reduction as well as risk-reduction counselling, there is a hierarchy of harm-reduction, and services can be offered to an IDU client depending on his/her stage of injecting drug use.

Box 40: Hierarchy of harm-reduction



The third hierarchy of harm-reduction is about providing assistance to stop injecting and later on to stop illicit drug use altogether. There are two ways of providing assistance:

- ◆ For those clients, who are completely motivated and want to stop drugs altogether → **Detoxification/rehabilitation**
- ◆ For those clients who are motivated, but are not able/willing to stop drugs altogether → **Opioid Substitution Therapy**

What is Opioid Substitution Therapy (OST)?

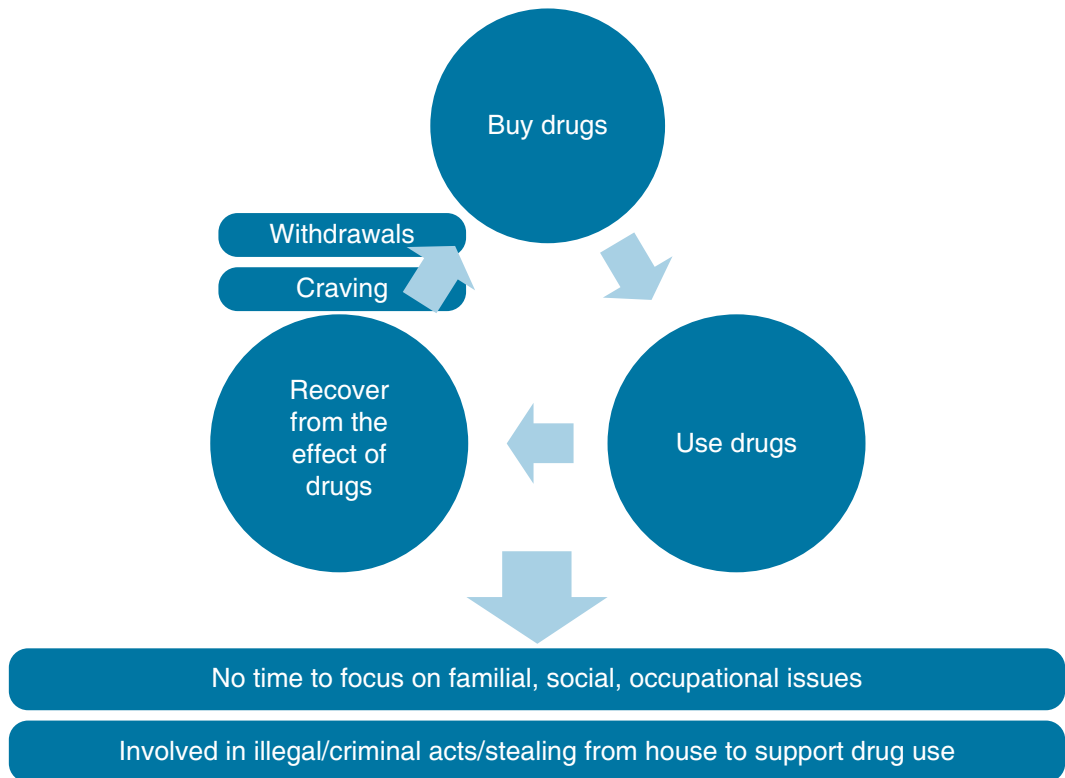
OST is defined as the administration of a prescribed daily dosage of opioid medicines with long-lasting effects to patients with opioid dependence, under medical supervision. Though the opioid medicines are similar in action to the opioid drugs which the client is using, there are important differences between an OST medicine and the illegal opioid:

Box 41: Comparison between opioid drugs and OST medicine

Opioid drugs	OST medicine
◆ Medically unsafe	◆ Medically safe and prescribed by a doctor
◆ Unknown purity	◆ Purity and strength known
◆ Used by unsafe route (injection/inhalation)	◆ Used by oral route, which is safe

Opioid drugs	OST medicine
◆ Has short duration of action → has to be administered repeatedly in a day	◆ Has a long duration of action → can be administered once a day
◆ Illegal and hence hazards involved in procurement	◆ Legally prescribed
◆ Higher chances of overdose, as the potency of the drug is not known and varies	◆ Less chances of overdose, as the potency of the drug is known and constant

Figure 19: The life of a drug user



It should be remembered that the life of an opioid dependent drug user is chaotic.

The life of the drug user, including IDUs, revolves around the opioids on which he is dependent, as can be seen from the adjoining flow chart. The IDU is constantly either in search of the next dose or uses drugs or to recover from the intoxication effect of the drugs. As a result, he is not able to focus on any other aspects of his life, both personal and social. In addition, he is also involved in illegal activities to support his drug-using habit.

As the medicines used in OST have a longer period of action, they help break the cycle depicted in the flow chart, and as a result stabilise the client. The dose of the medicines is maintained in such a manner that he/she does not suffer from either withdrawals or intoxications. As a result of this stabilisation, the client is able to focus on other aspects of his/her life, and he/she can be amenable to counselling and other psychosocial interventions.

The most commonly used medicines in OST are methadone and buprenorphine. Methadone was the first medicine to be used as OST. Currently, it is being used in more than 70 countries in the world. Buprenorphine is another medicine which is being used in more than 50 countries in the world, including India. India has more

than 17 years of experience with buprenorphine and it has been found to be a safe medicine, which can be used in Indian settings.

It should be remembered that OST is given only to those clients who are dependent on opioids. Clients who are dependent on other drugs and not on opioids do not benefit from OST and are not given OST. There are specific inclusion and exclusion criteria for enrolling a client on OST. The majority of the centres follow a regime in which the clients have to visit the centre daily for receiving the medicines. The treatment duration is considerably longer – for at least one to two years. In addition, taking OST medicine alone does not guarantee complete recovery; the client also has to be counselled on structuring other areas of his/her life, which increases the chances of abstinence from drugs.

Benefits of substitution therapy

The benefits of substitution therapy are both at the individual level as well as at the community level.

Box 42: Benefits of substitution therapy

Individual level benefits	Community level benefits
<ul style="list-style-type: none"> ◆ Reduction and finally stopping the use of illicit drugs, including injecting. ◆ Reduction in high-risk behaviour. ◆ Improved treatment adherence for co-morbid conditions involving long term treatment such as TB, HIV, Hepatitis B and C. ◆ Increased availability for social and psychological support. ◆ Reduced overdose mortality. ◆ Improved physical and mental health. 	<ul style="list-style-type: none"> ◆ Significant reduction in criminal activities in the community, as the client is stabilised on OST. ◆ Reduced risks of blood-borne infections in the community – HIV, Hepatitis B and C. ◆ Decreased domestic violence and abuse against family members. ◆ Increased productivity in the society.

OST under NACP III

- ◆ OST has been recognized as a harm-reduction intervention under NACP III.
- ◆ OST has been approved for use in NACP III phase.
- ◆ OST is a medical intervention, initiated by a doctor and administered by a nurse.
- ◆ OST is given on a ‘DOT’: i.e. daily observed treatment basis.
- ◆ Both buprenorphine and methadone are to be given as OST under NACP III.
- ◆ About 20% of the total population of IDUs will be provided OST.
- ◆ OST is currently available through TI settings. Some of the TIs which have been accredited by NACO (through an independent process) have been implementing OST using buprenorphine. There are a total of about 50 OST centres in the country.
- ◆ OST using buprenorphine is also being made available through some Government district hospitals or medical colleges.

Role of TI counsellor in OST

This section deals only with the scenario in which the TI does not have OST services within its TI setting (which is the case in majority of the TIs). In such a scenario, the counsellor would receive clients who would be desirous of enrolling into OST services which may be available in the nearby locations of the TI/area. The following issues should be addressed by the counsellor towards supporting the OST treatment initiative:

- ◆ **Assess** the client and determine the exact reasons for his/her desire of initiating OST. These factors should be used to **build the motivation** of the client.
- ◆ **Educate** the clients on the **benefits of OST**.
- ◆ **Assess** whether the client has **understood the implications** of being in OST programme. For e.g. this may mean that the client would have to travel to the OST centre daily to receive his/her dose of medicine, etc.
- ◆ **Break the myths** surrounding OST among the clients. For e.g.,
 - ⤴ Taking OST is enough, psycho-social counselling is not required.
 - ⤴ OST can be used to treat other drug dependence also.

C. Relapse prevention

The natural course of drug use is characterised by relapses and remissions. ‘Relapse’ is broadly defined as an act or instance of backsliding, worsening or subsiding. It is encountered in a number of health-related conditions, especially chronic diseases. This is also especially true in case of chronic mental illness, including drug use-related disorders. Thus, for example, an individual attempting weight loss will have slips on occasions, as well as at times have his condition worsen i.e. gain weight. Relapse is however, commonly associated with addictive disorders, and sometimes, it is presumed that this occurs only in those who use drugs.

The most difficult part in the path to recovery from substance use disorder is continuing to remain abstinent. During this stage, a number of factors – both intrinsic and extrinsic, play a role in determining whether the individual continues to remain abstinent or relapses back to drug use. In addition to these intrinsic and extrinsic factors, the most important determining factor is the way in which the individual client handles or deals and reacts to the intrinsic and extrinsic factors.

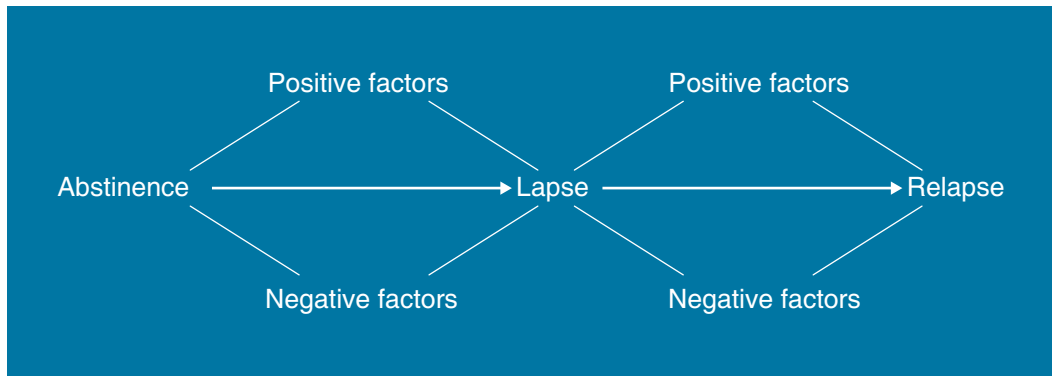
Relapse prevention therapy (RPT) is based on the cognitive-behavioural approaches to addressing the issue of relapse among drug users, including injecting drug users. According to the cognitive-behavioural approach:

- ◆ The initiation, continuation as well as slipping back into drugs are based on a number of factors, including those associated with cognition and behaviour of an individual. Individuals indulge in drug-taking behaviour, as drugs either produce ‘happiness’ or decrease pain.
- ◆ When individuals take drugs every time, they are rewarded with either happiness or a decrease in pain. This reward compels the individual to continue to take drugs.
- ◆ Addiction is a behaviour that is learned, with a cognitive and behaviour process involved in drug intake and continuation.
- ◆ When the individual has stopped drug use, similar processes play a part in relapses.

Lapse – relapse

It is important to distinguish between lapse and relapse in the context of drug use. An abstinent individual, who restarts drug use, does not go back to a full blown pattern of drug dependence/addiction immediately. There are a number of factors which determine the intake of the first dose of drug. Similarly, both negative and positive factors play a role in determining whether the individual continues to take drug after his first slip.

Figure 20: The relation between lapse, relapse and abstinence

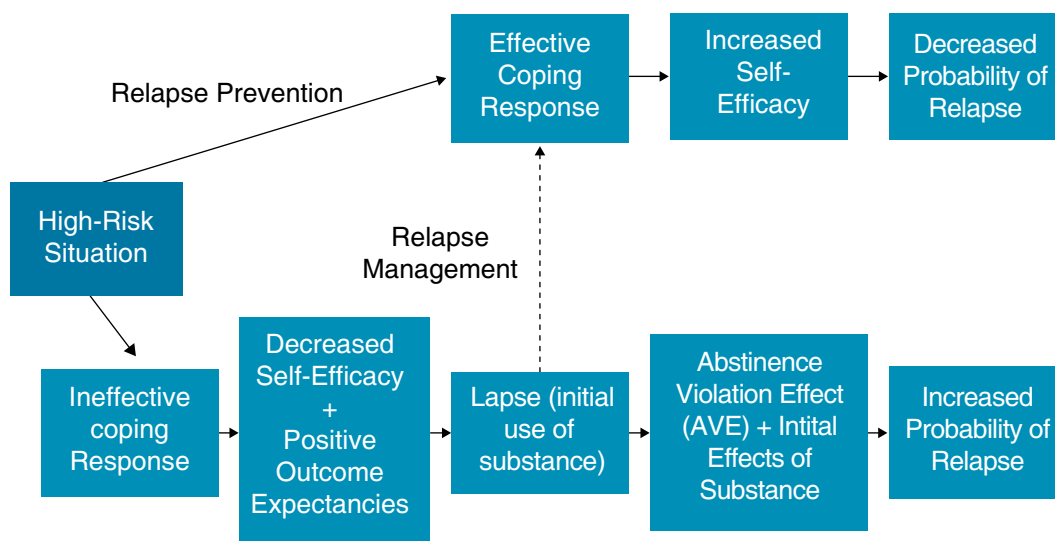


The first episode of drug intake after a period of abstinence is called as ‘**lapse**’ or slip. When the previous pattern of drug use is resumed, the individual is said to have a full blown ‘**relapse**’. As the lapse and relapse stages are determined by the positive and negative factors, these positive and negative factors can be modified to bring about positive changes in the behaviour of an individual in terms of drug use.

Relapse prevention therapy model

The following diagram, reproduced from Marlatt’s article on relapse prevention, summarises the contextual factors and processes involved in lapse and relapse:

Figure 21: Factors and processes involved in relapse prevention and relapse management



◆ **High-risk situations**

These are situations, which make an individual vulnerable to lapse and relapse. High-risk situations can be of various types:

1. Coping with **negative emotional states** such as frustration, anger, fear, anxiety loneliness, boredom, worry.
2. Coping with **negative physical states**, such as pain, fatigue, illness, injury.
3. Enhanced **positive emotional states** such as feeling of pleasure, joy, freedom, celebration, etc.
4. Wanting to test one's personal control, for e.g. wanting to see what happens, or wanting to see one's commitment to stay abstinent, or simply 'wanting to try it once'.
5. Giving into urges/temptations or cravings. This can happen in response to external 'cues' or the drug itself, or in the absence of the cues or the drugs. For e.g., the individual may see a bar or a peddling site, and then have the urge to use the drug, which they are not able to resist.
6. Coping with inter-personal conflicts, such as marital relationships, relationships with other family members, friends, etc.
7. Influence of other person/s to use drug – peer pressure.

When the client is faced with one or more of the above high-risk situations, he becomes vulnerable to restart drug use (lapse). How the client responds to the situations, determines whether he takes the drug or not. The response of the individual is **coping**.

◆ **Outcome expectancies**

This refers to what an individual expects as an outcome out of a certain event. In case of drug/alcohol use, because the individual relies on his earlier experience and the biological effect of the drug on his brain, the expectancy of using the drug tends to be positive. Though the individual may have suffered the negative consequence of drug use, yet the positive outcome from using drugs far outweighs the negative outcome. As a result, the individual is very vulnerable to using drugs.

◆ **Self efficacy**

With every day of abstinence, the client increasingly feels that he/she can manage to remain abstinent. This is not only because of increased time spent in remaining abstinent, but also because the client during his abstinent days has used effective coping strategies to deal with drug use. Self efficacy is defined as the belief of a given individual that he/she is able to handle a given situation, and will have a positive outcome.

The initial drug use, i.e. lapse, is determined by the three above phenomena – coping abilities, outcome expectancy with regard to drug use, and his/her self efficacy. Based on the interplay between these three phenomena in the face of a high-risk situation, the individual may or may not lapse/slip and use the drug once again.

Once a lapse occurs, the chances of an individual continuing to use drugs depends on the following:

- ◆ Continued exposure to high risk situations.
- ◆ Initial experience with the drug: the individual's experience with using the drug during lapse determines whether he would use the drug once again or

not. Due to the intoxicant effect of the drug, the individual feels pleasurable effects, which increases his chances of continuing drug use.

- ◆ **Abstinence violation effect (AVE):** after a lapse, the client may feel loss of control (he can't control), guilt, shame, self-blame, that he is a 'failure'. All of this leads to a decreased self-efficacy, and motivates him/her to continue using drugs.

By understanding the phenomena behind the lapses and relapses, as well as the fact that it is possible to intervene at both the stages, the counsellor is able to use specific techniques to carry out relapse prevention therapy. The techniques used can be divided into the following categories:

- ◆ **Assessment procedures:** Through exploration of the risk situations and coping skills, the counsellor makes the client understand the nature of their addictive behavioural problems, and also uses motivation enhancement therapy to increase the client's motivation to remain abstinent.
- ◆ **Handling high-risk situations:** In this, the high risk situations likely to be encountered by the client is listed down, and then the counsellor works with the client on detailing how he/she would deal with the specific high risk situation.
A way of handling high-risk situations is to avoid it altogether. While this may be possible in some instances, in some other instances, it may not be possible. In such cases, the client may try to escape the situations. However, it is to be remembered that these strategies may not allow the client to develop effective coping skills. For developing coping skills, the counsellor may use **direct instruction** – guide the client on preparing a specific strategy to each high-risk situation, and the client is asked to practise it. Alternatively, the client can be exposed to the situation through imagery or in controlled situations and be asked to practise the behaviour to be adopted. This is called as **behavioural rehearsal**. This can also take place in a group setting, and the other *group* members may guide the client and suggest how to handle the particular situation.
- ◆ **Coping skills techniques:** Apart from the above methods, the counsellor can also use the problem solving method to help the client in handling situations:
 - ▲ Identify the problem.
 - ▲ Elicit different responses on how the problem can be solved.
 - ▲ Weigh the pros and cons of each of the solution.
 - ▲ Ask the client to choose the best solution based on the exercise of weighing the pros and cons.
- ◆ **Stress management:** Relaxation training such as deep-breathing, progressive muscular relaxation may be given and also encourage clients to use yoga, exercise, meditation.

Box 43: Breathing techniques

Breathing techniques: e.g. Benson's technique:

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

- ◆ **Dealing with lapse:** Ask the client to stop, and assess the reasons for the lapse. Make the client understand that the lapse is a warning sign. Ask the client to carry out a lapse management plan by carrying out a situational assessment leading to the lapse and develop specific strategies to deal with the same.
- ◆ **Dealing with AVE:** Teach clients to view lapse as a process for recovery rather than failure on the part of the patient, make the clients aware of the AVE and help the client in catharsis by venting out their feelings and emotions in front of the counsellor.
- ◆ **Lifestyle modification:** During active drug use, the client's life revolved around drug procurement and drug use. After stopping drug use, the counsellor should work with the client on structuring the daily life of the client and modify the life-style in accordance with the socio-economic and cultural background of the client.
- ◆ **Dealing with urges and cravings:** As craving is associated with cues and external stimulus, strategies such as stimulus control techniques, behavioural rehearsals can be used to teach the client on how to deal with urges and cravings. In addition, **urge surfing** is used to help the client to deal with urges. An individual experiencing a craving usually feels that pressure is building up inside him/her, under which the resolve to remain abstinent and resistance to drug use, will collapse under this overwhelming balloon. The individual is asked to imagine the craving or urge as a wave and that he/she is surfing over these cravings or that the imagined balloon of the urge is floating away.

The various techniques mentioned above under the RPT can be used alone or in conjunction with each other.

Co-morbidity among IDUs

An IDU faces risks not only related to injecting and associated infections related to injections, but also faces a number of other physical and mental problems due to drug use. The IDU is more vulnerable to the physical and mental problems due to a number of factors, including the effect of drugs on the brain system and accompanying risk factors associated with psycho-social complications arising from drug use. The TI counselling staff should be able to detect the symptoms and signs of such problems at the earliest and offer them appropriate help including referral services, if needed.

Co-morbidity

Co-morbidity, simply means, the presence of two or more conditions together in an individual. The conditions can start together (simultaneously), or one condition may precede the occurrence of the other one (sequentially).

If the drug use problem and mental illness co-occur together, the condition is also referred to as dual diagnosis. The same is also known by a number of other terms – Mentally Ill Substance Users, Substance Use Mentally Ill, Chemical Abuse Mentally Ill, etc.

Co-morbid conditions associated with drug use

◆ Physical illness

- ▲ Tuberculosis
- ▲ HIV
- ▲ Hepatitis B and Hepatitis C
- ▲ Abscess
- ▲ Other infections.

◆ Mental illness

Common mental illnesses associated with chronic drug use include:

- ▲ Depressive disorder
- ▲ Generalised anxiety disorder
- ▲ Schizophrenia
- ▲ Bipolar disorder
- ▲ Attention Deficit Hyperactivity Disorder (ADHD)
- ▲ Obsessive-compulsive disorder

- ▲ Post-traumatic stress disorder
- ▲ Panic disorder
- ▲ Antisocial personality disorder.

Is co-morbidity more common among IDUs as compared to others?

Both physical and mental illnesses have been seen to occur more commonly among IDUs as compared to those who do not use drugs. The sentinel surveillance conducted by NACO routinely every year shows that the rates of HIV among IDUs are 10-20 times more than the rates among the general population. In a study conducted on IDUs in Chennai, it was seen that IDUs have more rates of co-morbidities such as tuberculosis, overdoses, and also deaths as compared to those who are not injecting drug users.

The rates of mental illness among those who use drugs have been studied systematically in the USA. The study conducted by National Institute of Mental Health shows that the rates of mental illness is more among those who have used/ are using drugs as compared to those who do not. The following table shows the various rates of mental illnesses among drug using population:

Table 3: Rates of mental illnesses among drug users

Disorder	Risk
Antisocial personality disorder	15.5%
Manic episode	14.5%
Schizophrenia	10.1%
Panic disorder	04. 3%
Major depressive episode	04.1%
Obsessive-compulsive disorder	03.4%
Phobias	02.1%

There are three different scenarios considered and explored to explain the relationship between drug use and co-morbidity. This is especially true for mental illness:

- ◆ Drug use itself may cause mental illness: e.g. using cannabis for a long time has been seen to develop psychosis in some individuals. In case of physical illnesses, a drug user may make himself/herself prone to physical illnesses due to social complications resulting from drug use – for e.g. unhygienic living conditions, poverty, poor nutrition, etc.
- ◆ Individuals suffering from mental illness may use drugs to decrease their symptoms. This is also called as “self-medication hypotheses”. For example, some patients suffering from schizophrenia increase their consumption of tobacco/cigarettes to reverse the slowing in thought processes developed due to schizophrenia and also due to antipsychotics used to treat schizophrenia. This is also true in case of some physical illnesses such as intractable pain conditions, in which the patient may try to self-medicate opioids to relieve pain and thus become dependent on opioids.
- ◆ Both drug use and mental illness may be caused by some overlapping factors already present in the individual making the individual develop both drug use as well as mental illness. These factors include genetic factors, stress-related factors, exposure to traumatic events in early childhood, etc. This is also true for some physical illnesses such as tuberculosis, wherein the individual due to societal factors such as poverty, homelessness, may resort to both drug use as well as contract tuberculosis due to unhygienic living conditions.

Common co-morbid physical conditions

A. Hepatitis C

Hepatitis C infection is a major concern among IDUs in India as well as other parts of the world. It is estimated that in some parts of the country, more than 80-90% of the IDUs are infected with Hep C. Following are some of the related facts:

- ◆ The liver is a vital organ of the body. Some of its main functions include processing food to convert it into energy, neutralising toxins and other drugs entering the body, storing iron and other important vitamins, processing hormones produced elsewhere, fighting infections and also producing important proteins in the body. The liver can re-grow if it is injured.
- ◆ Hepatitis is inflammation of the liver, a vital organ of the body. The liver is inflamed if it is affected by toxins or attacked by organisms from outside. Some causes of hepatitis include alcohol, other chemicals, and viruses.
- ◆ When the liver is inflamed chronically (i.e. over a long period of time), it causes scarring called as fibrosis. Extensive scarring leads to cirrhosis of the liver, which is scarring alongwith uneven liver growth.
- ◆ There are 5 types of viruses causing hepatitis – A, B, C, D and E.

Box 44: Various forms of Hepatitis and how it is contracted

Virus	Mode of transmission
Hepatitis A	Eating unhygienic food
Hepatitis B	Sexual and injecting
Hepatitis C	Sexual and injecting
Hepatitis D	Sexual and injecting: occurs along with hepatitis B; worsens prognosis of hepatitis B
Hepatitis E	Eating unhygienic food

◆ Transmission of Hepatitis C

- ▲ In majority of the cases, transmission is due to sharing of contaminated injecting equipment. Apart from sharing of contaminated needles and syringes, transmission can also occur during the process of drug preparation and injecting, through the sharing or re-using of other contaminated injecting items such as mixing spoons, swabs, water, needles, syringes, syringe plungers and tourniquets. Hands and surfaces used for mixing can also become contaminated during preparation and injecting.
- ▲ Hepatitis C virus is also transmitted through transfusion of infected blood or blood products when a person undergoes blood transfusion. Additionally, invasive procedures such as tattooing, body piercing, and acupuncture can cause Hepatitis C, if contaminated equipment is used in the procedure.
- ▲ Though the Hepatitis C virus is also found in other body fluids, the concentration of the virus is too low for it to be transmitted through these body fluids.
- ▲ Hepatitis C can also be transmitted from infected mothers to their babies, though the risk is only 5%.
- ▲ The chance of transmission of Hepatitis C through the sexual route is very low, though the possibility still exists.

◆ **Stages of Hepatitis C infection**

- ▲ **Acute infection:** soon after the individuals are infected with Hepatitis C virus, some of them experience symptoms of a liver infection called “acute hepatitis”. In 25% of the patients, the virus is cleared from the body without medical intervention within 2–6 months of infection.
- ▲ **The remaining 75% of the patients will move into the next stage of infection called “chronic hepatitis”.** It is estimated that among those with chronic hepatitis C: about 45% do not develop liver damage; 30-40% develop mild liver damage; 10-20% develop liver cirrhosis and 1-5% develop liver failure or liver cancer.

- ◆ **Treatment of hepatitis C:** not everybody requires treatment for Hepatitis C infection. Currently, the treatment is very costly, and the success rate is only 30-40%.

Issues for the TI counsellor

The TI counsellor should discuss with each IDU about Hepatitis C and help the IDU client by providing accurate information about the disease condition, and ways and means of preventing the infection. More specifically, the counsellor should:

- ◆ Educate the clients about the transmission dynamics of Hepatitis C as described above.
- ◆ Stress on the importance of using clean needles and syringes every time the client injects. Not only the needles and syringes, but all the injecting equipment should be clean and sterile, as there is a great chance of Hepatitis C transmission through the injecting equipment also.
- ◆ Teach the client on how to inject safely. The issue on safe injection is discussed in the chapter on risk-reduction.

For those clients with Hepatitis C infection, it is important for the counsellor to not only refer him/her to the doctor, but also provide hope and support throughout this period. The counsellor should:

- ◆ Instil hope in the client that not every case of hepatitis C is fatal.
- ◆ There is no special diet required for Hepatitis C. However, it is beneficial for the client, especially if obese, to decrease the fat content in his/her dietary intake.
- ◆ Educate the client that alcohol intake will hasten the progress of liver cirrhosis, and should be avoided at all costs.
- ◆ Treatment for Hepatitis C is available in India, but is very costly. The response for treatment is also about 40%.

B. Hepatitis B

◆ **Disease facts**

- ▲ Hepatitis B is transmitted through contact with infected blood or body fluids including saliva, semen, vaginal secretions, and breast milk. Transmission examples include: sexual activity; unsafe injecting practices; sharing contaminated objects that pierce the skin such as needles, tattoo equipment, body-piercing equipment, acupuncture equipment and razor blades; sharing razors or toothbrushes; and from infected mother to baby.

- ⤴ The acute illness usually lasts from 1 to 3 weeks, but it may also continue for several weeks.
- ⤴ Most adults (95%) recover completely from hepatitis B, and only 5% develop “Chronic Hepatitis B”
 - ✦ About 25% develop serious liver disease, including cirrhosis and liver cancer.

◆ **Counselling for Hepatitis – the counsellor should**

- ⤴ Provide information to the client regarding the disease.
- ⤴ Educate the client on the preventive means: practice safer sex; avoid sharing injecting equipment (including needles, syringes, water, tourniquets, filters and spoons); use new and sterile injecting equipment to ensure that there is no blood contamination during injecting practices (e.g. on hands, tourniquets and surfaces).
- ⤴ A vaccine is available for Hepatitis B, and immunisation is the most effective way to protect against hepatitis.
- ⤴ For those with the disease, the use of alcohol should be stopped, and a balanced diet should be followed.
- ⤴ People who have been able to clear the virus and have normal liver function tests do not need any treatment.
- ⤴ People with chronic Hepatitis B who have no liver damage or no active viral replication may not require treatment. However, if there is liver damage, antiviral medicines can be used.

C. Tuberculosis

◆ **Disease facts**

- ⤴ Tuberculosis is caused by microscopic organisms – bacteria named “Mycobacterium tuberculosis”.
- ⤴ Tuberculosis usually affects the lungs, but it can affect any organ system of the body, including lymph nodes, genitor-urinary tract, bone, brain, spinal cord, skin, etc.
- ⤴ TB is contagious and **spreads through the air**. If not treated, each person with active TB infects on average 10 to 15 people every year.



- All cases of TB are transmitted from one person to another through droplets. When someone with TB infection coughs, sneezes, or talks, tiny droplets of saliva or mucus are expelled into the air, which can be inhaled by another person. TB is not transmitted by only touching the clothes or shaking the hands of someone who is infected.
- ⤴ People who have inhaled the TB bacteria, but in whom the disease is controlled, are referred to as infected. The body’s immune (defence) system, however, can fight off the infection and stop the bacteria from spreading. The immune system does so ultimately by forming scar tissue around the TB bacteria and isolating it from the rest of the body. If the body is able to form scar tissue (fibrosis) around the TB bacteria, then the infection is contained in an inactive state. Such an individual has no symptoms and cannot spread TB to other people.

Sometimes, however, the body's immune system becomes weakened, and the TB bacteria break through the scar tissue and can cause active disease, referred to as secondary TB. For example, the immune system can be weakened by old age, the development of another infection or a cancer, or certain medications such as cortisone, anti-cancer drugs, or certain medications.

▲ **In India, almost everybody is at risk of getting TB, but certain people are at higher risk as compared to others:**

- ✦ People who live with individuals who have an active TB infection.
- ✦ People living in poverty.
- ✦ Homeless people.
- ✦ Nursing-home residents and prison inmates.
- ✦ Alcohol-dependent clients and injecting drug users.
- ✦ Diabetics.
- ✦ People suffering from certain cancers.
- ✦ People with HIV infection.
- ✦ Health-care workers.



▲ **The usual symptoms that occur with an active TB infection are:**

- ✦ A generalised tiredness or weakness
- ✦ Weightloss.
- ✦ Fever.
- ✦ Night sweats.
- ✦ Persistent cough.
- ✦ Chest pain.
- ✦ Coughing up of sputum (material from the lungs) and/or blood.
- ✦ Shortness of breath.

If the infection spreads beyond the lungs, the symptoms will depend upon the organs involved.

- ▲ Diagnosis of TB is based on symptoms, along with investigations—chest X-ray, skin test (Mantoux skin test), and sputum examination under microscope (for detecting the presence of TB bacteria).
- ▲ Treatment is prescribed by the doctor and is to be continued for at least 9-12 months duration. The duration of the treatment also depends on the organ system being involved, as well as resistance to the medicines prescribed for the disease. Soon after treatment, the patient becomes non-infectious (i.e. not able to transmit the disease to others) in 3 weeks.
- ▲ **TB is a leading killer of people with HIV.** People who are HIV-positive and infected with TB are 20 to 40 times more likely to develop active TB than people not infected with HIV. TB and HIV are frequently referred to as co- or dual-epidemics due to their high rate of co-infection. HIV weakens the immune system, increasing the likelihood that an individual will become infected and develop active TB. Though the problem of TB

had decreased in the past, nevertheless, since the 1980s, with the rise of HIV epidemic, TB has also resurged among the population.

- ⤴ **Multidrug-resistant TB** (MDR-TB) is a form of TB that is difficult and expensive to treat and fails to respond to standard first-line drugs (such as isoniazid and rifampicin).
- ⤴ **Extensively drug-resistant TB** (XDR-TB) occurs when resistance to second-line drugs develops on top of MDR-TB.
- ⤴ DOTS, “Directly Observed Treatment, Short-course” is the internationally recommended strategy to control TB. DOTS aims to decrease TB-related morbidity, prevent TB deaths, and decrease TB transmission. These efforts have shown some promising signs: TB incidence, prevalence, and mortality rates appear to have declined in recent years while case detection and treatment rates have increased (the number of people living with TB has increased, but it is largely due to population growth).
- ◆ **Counselling issues in TB management with regard to IDU in TI setting:**
 - ⤴ There is higher prevalence of TB among IDUs, as discussed before. There are a number of reasons for this high prevalence – poverty, homelessness, poor living conditions, low immunity, poor nutrition, high prevalence of HIV.
 - ⤴ Many of the early symptoms of TB can be mistaken for other conditions associated with IDUs.

For e.g., weight loss, weakness or tiredness can be associated with general debility associated with poor nutrition among IDUs; cough and chest pain can be associated with chronic bronchitis due to co-morbid smoking. However, in case where IDU presents with recent changes in weight and recent onset of cough, TB must be ruled out first before ascribing it to other conditions.
 - ⤴ Symptoms of TB must be positively enquired for periodically by the TI counsellor.
 - ⤴ A baseline screening for TB must be ensured by the counsellor during first contact with the IDU client.
 - ⤴ The clients must be educated on the basics of TB and signs and symptoms associated with tuberculosis.
 - ⤴ Clients presenting with symptoms of TB must be referred to the nearby diagnostic centre, preferably accompanied by an outreach worker or peer educator.
 - ⤴ For those clients who are diagnosed with TB and are on DOTS, the counselling must be on regular adherence to TB medications. The counsellor should also attempt to physically check on the adherence by verifying the number of tablets remaining.

Mental health conditions

As discussed above, the co-existence of mental illness with IDU/drug use is much more than what is seen in the general population. While a full discussion on the mental illnesses and their management is outside the purview of this module, the following section would deal with the basic understanding of the three most common mental illnesses – depression, anxiety, and psychosis, associated with

drug use, and the steps that a counsellor in a TI setting should take to ensure that the IDU suffering from any of the co-morbid mental illness gets treated properly. It is to be remembered, however, that treatment of mental illness is done best by a trained psychiatrist.

A. Depression

Depression is a common mental illness, but with great morbidity. While everyone occasionally feels sad or 'down', depression as a mental illness is a morbid state of sadness with significant effect on the productivity and normal functioning of the affected individual.

There are many types of depression; however, the signs and symptoms are similar across different types. Every individual does not have all the symptoms listed here. Depression is diagnosed, when many of the following signs and symptoms are exhibited in an individual for **at least a two week period leading to difficulty in work or personal suffering**:

- ◆ **Lowering of mood/sadness:** The mood varies little from day to day and is unresponsive to circumstances.
- ◆ Reduction of energy, with marked tiredness even after minimum effort.
- ◆ **Decrease in activity:** Both psychic (thinking ability) as well as motor (decreased physical activity). In some cases, there is agitation instead of retardation.
- ◆ Capacity for enjoyment, interest is reduced. The previously pleasurable activities are not pleasurable anymore.
- ◆ Concentration is reduced, and the thinking process gets muddled and hazy.
- ◆ **Sleep is usually disturbed:** Waking in the morning several hours before the usual time; the individual does not feel refreshed even after sleeping; frequent awakening during sleep.
- ◆ Decreased appetite.
- ◆ Self-esteem and self-confidence are decreased.
- ◆ Ideas of guilt or worthlessness – the individual feels that he has committed something wrong or that he does not have any worth.
- ◆ Ideas of hopelessness – the individual feels that there is no hope for him in the future.
- ◆ Ideas of helplessness – the individual feels that he cannot be helped out of his present condition.
- ◆ Wishes of dying or suicidal ideas and acts – the individual may feel that life is not worth living and may attempt to end his/her own life.

B. Anxiety disorders

- ◆ Anxiety disorders are a group of disorders, in which the predominant symptom is anxiety. Anxiety is irrational fear or fear which is out of proportion to what is expected.
- ◆ Almost everyone has experienced nervousness or fear at one time or the other in his/her life. This is usually in the presence or anticipation of a stimulus, such as exams, animals, darkness, etc. This fear helps the individual to marshal his resources to mount an effective response. Thus,

the fear helps an individual to fight with the feared animal or prepare for his exams. However, if this fear or nervousness occurs without any stimulus, or the fear is out of proportion and hinders the individual's performance, then it is labelled as a disorder.

- ◆ Anxiety disorders are of various types. The most common types of anxiety disorders are:
 - ▲ **Specific phobia:** Irrational fear of a specific object, animal or situation: for e.g. phobia for heights, water, exams, etc.
 - ▲ **Social phobia:** Irrational fear of being publically embarrassed or being negatively judged by other socially.
 - ▲ **Panic disorder:** A disorder in which repeated panic attacks occur. A panic attack is a state of extreme anxiety and fear occurs with a sense of dying without any external stimulus (i.e. spontaneous attack). This is accompanied by other physiological symptoms.
 - ▲ **Obsessive compulsive disorder:** A disorder characterised by obsessions and compulsions. Obsessions are anxiety-provoking thoughts which intrude into the patient's mind repeatedly and are most often irrational. Compulsions are irrational actions which the patient is compelled to perform repeatedly to relieve anxiety. For e.g. a patient may have irrational thoughts of being dirty and unclean (though he is not, he is not able to resist these thoughts, and though he knows this is not true), as a result of which he has compulsion of washing hands/ clothes repeatedly.
 - ▲ **Generalised anxiety disorder:** A chronic disorder in which the patient is worried about non-specific life events, objects and situations. The common anxieties are around one's own health or that of another family member, well-being, future, work, etc. The anxiety is out of proportion to what is normally expected, and interferes with the individual's functioning.
- ◆ **Signs and symptoms of anxiety disorders:** Apart from 'anxiety' as a symptom, the following symptoms are additionally reported by the patients:
 - ▲ Excessive, unrealistic worrying
 - ▲ Trembling
 - ▲ Churning stomach
 - ▲ Nausea
 - ▲ Diarrhoea
 - ▲ Headache
 - ▲ Backache
 - ▲ Heart palpitations
 - ▲ Numbness or "pins and needles" in arms, hands or legs
 - ▲ Sweating/flushing
 - ▲ Restlessness
 - ▲ Easily tired
 - ▲ Trouble concentrating
 - ▲ Irritability

- ▲ Muscle tension
- ▲ Frequent urination
- ▲ Trouble falling or staying asleep
- ▲ Being easily startled

C. Psychosis

Psychosis is a group of mental illness, in which there is a loss of contact with reality. In such cases, the patient's thought is disorganised, along with the presence of delusions and hallucinations. All of these lead to disorganised behaviour and impairment in the individual's functioning. Psychosis is seen in disorders such as schizophrenia, delusional disorder, bipolar disorder as well as in some cases of depression with psychotic features.

Symptoms of psychosis

- ◆ **Delusions:** false beliefs which are not part of the person's culture; these beliefs are not amenable to reasoning and are held steadfastly by the person despite providing evidences to the contrary. Some examples of delusions include that of being persecuted (persecutory delusions), being spoken about and referred to in a negative sense (referential delusions), of having superlative powers and worth (grandiose delusions). Sometimes delusions can also be bizarre and is seen in schizophrenia. For e.g., a patient may feel that his neighbours are controlling his mind and compelling him to perform actions by magnetic waves.
- ◆ **Hallucinations:** are sensory perceptions without any stimulus. This includes hearing (a person hearing, when in reality no sounds are being produced), smell, touch, seeing, etc. The most common type of hallucinations is auditory hallucinations, in which the patient hears voices talking to him or about him in a derogatory manner.
- ◆ **Thought disorders:** usually there is a logical connection between one idea to another, resulting in a clear understanding of what a person is thinking. In thought disorders, this connection is lost, with the result that one cannot understand what the patient is trying to say and think.
- ◆ **Negative symptoms:** these are found in chronic psychotic disorders such as schizophrenia. In this, there is disruption of one's normal emotions and behaviours. For e.g. there is loss of intonation of speech or loss of emotions when a person talks (loss of effect), not speaking even when required to do so, loss of feelings, loss of goals in life, not taking initiatives in life, etc.

Counselling for Mental illness in the context of IDU TI

- ◆ When the counselling staff of the IDU TI come in contact with an IDU who presents with symptoms suggestive of mental illness, the counsellor should look for the signs and symptoms listed above. There are some simple standardised scales for assessment of each of the mental illness, which can be used by the counsellor for assessment purpose. For e.g. for depression and anxiety, DASS 21 item scale can be used. The scale is provided in Annexure 3.
- ◆ In case the counsellor has suspicion that the client has some symptoms of mental illness, then the counsellor should promptly refer the client to a psychiatrist for further assessment and treatment.

- ◆ The counsellor should also educate the client that most of the mental illnesses, especially illnesses such as depression and anxiety, are treatable and taking treatment for adequate duration will enable him/her to deal with his condition much better.
- ◆ The counsellor should educate the client that having mental illness does not mean that the client has some 'character' defect or that the client has weak will-power. The client should be informed that there are several causes of depression, which includes a combination of genetic, environmental and psychological factors.
- ◆ The counsellor should build hope in the client regarding the outcome of mental illnesses such as depression and anxiety disorders which have a good outcome and prognosis.
- ◆ The counsellor should reinforce the risk-reduction messages at this time, as the client during periods of despair, may indulge in sharing or other high-risk behaviour.
- ◆ The counsellor should emphasise to the client about the possibility of overdose, and also rule out any suicidal ideas as the client can easily inject more quantities of the drugs to commit suicide.
- ◆ The counsellor should also seek the support of family during the occurrence of mental illnesses especially during crisis situations.

Crisis management

Introduction

The IDU may face numerous problems, like overdose, poor relationship with family, financial crisis and involvement with anti-social peers. Many of these may be solved by the client either alone or with the help of family or friends. However, certain situations come suddenly, unexpectedly and are of such an intensity to throw the client off-guard. These kinds of situations are called 'crisis situations', which are difficult to be solved by the client's usual problem-solving patterns. This chapter will tell the counsellor about the various crisis situations that an IDU may face and what the counsellor can do to help. The crisis situations requiring medical interventions e.g. overdose; injury/infection will not be discussed in this chapter.

Defining a crisis

A *crisis* can be defined as a temporary state of emotional turmoil and disorganisation following a very sudden and significant stressful situation. It can be regarded as a situation which is difficult to be solved without professional help. Crisis intervention is, thus, an immediate and active entry by the service provider into the client's life during the stressful situation.

Different crisis situations faced by the IDU

The IDU can face a crisis in any of the various spheres of his life as mentioned below.

Box 45: Different crisis situations

Situations	Examples of Types of Crisis
Personal	Separation/divorce; sudden homelessness; violence at home; sudden death in family; death of a friend with whom injections were used/shared
Financial	Sudden loss of money; accumulated debts leading to a crisis
Occupational	Being thrown out of the job; conflicts with colleagues/boss at work
Health-related	Becoming aware of HIV+ status; developing a physical illness
Legal	Facing legal action
Drug-related	Sudden decrease in availability of usual dose of drugs; overdose; injection-related injury/infection

The client facing a crisis situation usually goes through the following stages:

Box 46: Stages of a crisis situation as experienced by a client



For example:

The client comes home in the early hours of the morning and his brothers are standing at the door. They tell him that they have had enough of his behaviours and drug-using habits and don't want to do anything with him. He tries to reason with them initially that he would leave drugs as soon as possible but they tell him that they don't believe him.

He tries to appeal to his parents who also don't take his side. He begs the family to give him another chance and promises to do whatever they say. When they just don't pay any heed to his requests, he bargains to let him stay for the night as he has no money and nowhere to go. But they get adamant and refuse to let him enter.

He starts to lose his temper and gets abusive towards his family. Tempers rise and there is a physical altercation between his brothers and him. In anger, he throws household utensils, hurting his brother and walks away from the house and comes to the centre.

In the centre, the counsellor meets him and listens patiently to what he has to say. Once the client has ventilated his emotions, he calms down and even starts feeling somewhat sorry for his actions. The counsellor, using the counselling skills, helps the patient explore alternatives and find appropriate solutions for the problem-in-hand.

Role of the counsellor

The counsellor must remember that:

- ◆ The IDU is vulnerable to have a crisis at any point.
- ◆ Crisis is usually a temporary phase.
- ◆ Emotional distress is common in this stage and the client will stabilise once the crisis situation is over.

Thus, the role of the counsellor is:

- ◆ To be available to the client at the time of the crisis situation.
- ◆ Be supportive and accept the client's distress.
- ◆ To be flexible in her approach.
- ◆ Gather as much resources as possible for the client.
- ◆ Rather than focusing on "why it happened?" the focus should be on "how it can be resolved."
- ◆ Avoid blaming the client for "bringing in the crisis on himself". Help the client deal with the feelings of guilt.
- ◆ Actively listen to what the client has to say.
- ◆ Express empathy.
- ◆ Provide timely help – any crisis is of short-duration and usually may last for 4-6 weeks. It is important that the counsellor provides help during this critical period to prevent breakdown and restore normal functioning.
- ◆ Addressing unrealistic expectations that the client may have from the service providers.

Counselling techniques

During the crisis phase, the counsellor can make use of some techniques to help the client resolve his/her crisis.

Box 47: Crisis Intervention Counselling Entails:

- ◆ Providing support
- ◆ Facilitating expression of emotions
- ◆ Facilitating client's understanding of his/her problems and reactions
- ◆ Ensuring client's safety
- ◆ Defining the problem
- ◆ Facilitating problem-solving behaviour
- ◆ Providing guidance and education

Providing Support to the Client – The client facing crisis is under tremendous stress. Thus, it is important that the counsellor is empathic towards the client. The counsellor needs to be genuine and accept the client unconditionally. They should be willing to listen to the client even if he is expressing anger and instil hope for a positive resolution. By talking to the client in a reassuring and concerned manner, the counsellor can decrease the hyper-arousal that the crisis may have produced in the client.

Box 48: Some Don't s

- ◆ Don't probe the client to the point where he feels under attack.
- ◆ Don't criticise or embarrass the client.
- ◆ Don't "preach".
- ◆ Don't become impatient and appear rushed.
- ◆ Don't trivialise threats of suicide or homicide.
- ◆ Don't become too over-involved with the client's crisis.

Facilitating Emotional Expression – The client may experience various negative emotions, like sadness, rejection, anger, confusion, following a crisis. The counsellor needs to encourage the client to share his/her feelings and assure him/her that these emotions would be accepted non-judgmentally.

Facilitating Client's Understanding of their Problems and Reactions – Client may feel distressed and fail to comprehend why the particular situation has happened and how he/she is supposed to react or what he/she is supposed to do.

For example, *"How can I be HIV-positive? It is not possible. I only shared injection once."* Or *"How can they throw me out of the house like this? They did not even think once where will I stay tonight."*

The counsellor needs to help the client to understand what exactly happened and validate the client's experience.

For example, *"I understand that you feel dejected and rejected by your family. You must be feeling angry too. Right now it is more important to see what we can do to help you."*

Ensuring Client Safety – Apart from the crisis situation, negative emotions can also become a problem in their own right. In this state, the client is vulnerable to causing self-harm due to impulsiveness or despair. Thus, the counsellor needs to assess if the client may be having thoughts of self-harm.

For example, *"I can understand that you are feeling stressed out. I just don't want you to lose all hope. We will be able to work out a solution."* Or

"How do you feel about your life right now?"

Also, the client may be facing violence at home. In such a scenario, help should be sought from an appropriate agency to intervene.

Defining the Problem – The counsellor needs to understand and define the problem from the client's view-point. This step would also help the counsellor to reflect back this understanding to the client. Adequate conceptualisation of the problem can help both the counsellor as well as the client to get the right focus and plan accordingly. Some helpful strategies that the counsellor can keep in mind while trying to understand the problem are:

- ◆ Start with open-ended questions.
- ◆ Avoid using "Why"; instead use terms like, *"Tell me more about what exactly happened when you reached home."*
- ◆ Avoid asking too many questions at the same time- *"How do you think your family would take your joblessness? How will you manage your finances? How will you pay the kid's fees? How do you feel?"*

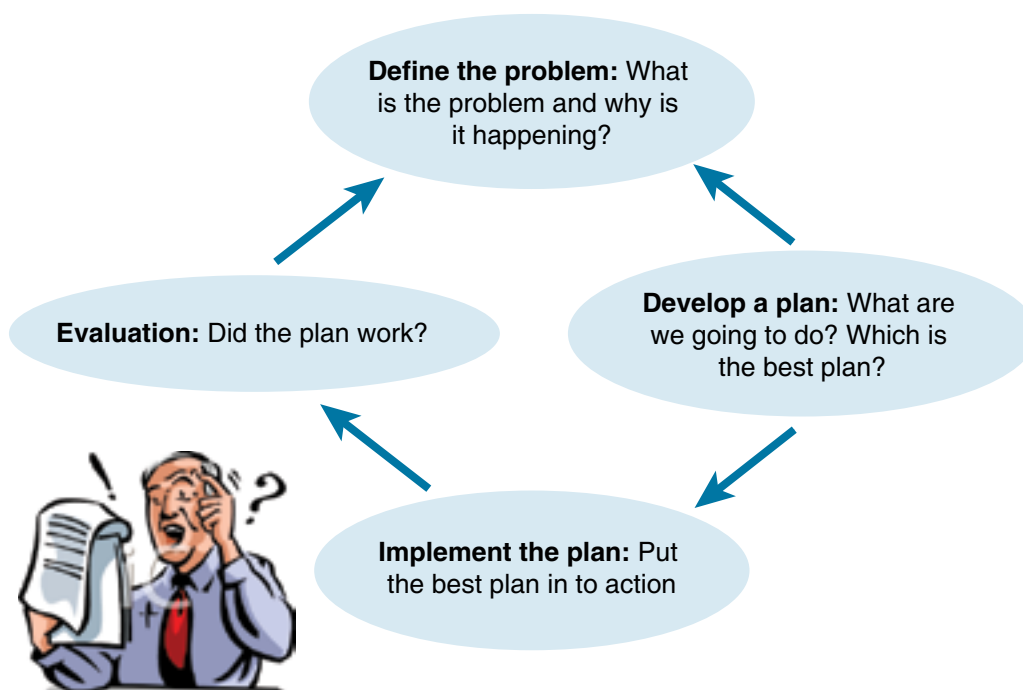
- ◆ Avoid questions that can inflict value on the client – “How could you not use condom when you knew it’s dangerous to have unprotected sex.”
- ◆ Avoid closed-ended questions- “Do you feel upset that you got involved with the police?”
- ◆ At times, passive listening with adequate non-verbal gestures, that is, eye-to-eye contact, simple comments like- “hmmm...”; “Go on” are very appropriate and effective.
- ◆ Active listening is a very important strategy for conceptualising the problem. Some possible active listening responses can be:
 - ▲ I understand the feeling...
 - ▲ It sounds to me like...
 - ▲ I would like to hear more...
 - ▲ I am wondering if you could tell me more...
 - ▲ Tell me more about...
 - ▲ I would like to understand...

Box 49: Areas to be explored for conceptualisation of the problem

What is the problem?	What made it happen?
Who is contributing to it?	How can it be handled?
When did it happen?	

Facilitating Problem-solving Behaviour – Clients who are drug users and are facing a crisis are not efficient at problem-solving, thus resorting to impulsive or aggressive strategies. The counsellor can use the *problem-solving* approach to facilitate the client’s understanding of the problem and to find solutions. The four stages of problem-solving strategy are:

Figure 22:



Once the problem has been adequately defined, the counsellor and client need to look for all possible solutions. Each solution is then evaluated for advantages, disadvantages and feasibility. After the evaluation, the best possible solution is picked up and implemented. Then both counsellor and client need to re-evaluate whether the solution actually worked or not.

Problem: I have been thrown out of the job. I have no source of income.

Solution (s): *I can take loan from my neighbour.
I can sell my wife's jewellery.
I can sell household items.
I can go with my friend who pick pockets and learn that skill.
I keep on waiting for a good job.
I ask my wife to work and take some money from her.
I start doing some menial job while searching for something better.
I take my counsellor's help in searching for job.
I reduce my expenses including my injection use.*

Evaluation: Counsellor and client look at each solution and discuss its advantages and disadvantages. Which of the available options appear feasible and likely to have good outcome?

Implementation: The decided solutions are implemented and re-evaluated after some time (usually a few days).

Apart from counselling the client, the counsellor also offers practical help to the client there and then. The counsellor should have a directory of referral services, which would include contact information of health-services, and legal aid. For example, the client is agitated as he has been tested HIV-positive. The counsellor needs to calm the client down using the counselling skills and then refer him to a nearby ART centre. Or if the client is involved in illegal activities and is in danger of being incarcerated, the counsellor should have the contact number of an agency which can provide legal aid. The counsellor also may need to contact the family or employer of the client to work out the best possible alternative for the client.

Always remember: *The primary task of the counsellor is to provide psychosocial help to the client. Providing actual logistic support – for any and every crisis–may be beyond the means of the setting in which the counsellor is working.*

Summary

Thus, the counsellor's role during crisis intervention is on acknowledging the crisis, stabilisation of the resources, mobilising available resources, preventing harmful responses and restoring the client's maximum functioning in the fastest possible period of time.

And once the crisis has stabilized, the counsellor can review the situation again to help the client strengthen his/her useful responses and change the unhealthy/unhelpful responses. This would make the client stronger and able to face future crisis in a better way.

Family counselling

Introduction

Family members of IDUs face a number of problems including violence, risk of HIV/AIDS, disruption of family structure, separation/divorce, financial problems and stigma. Drug abuse is often seen as “problem of the family” (poor parenting) and “problem for the family” (domestic violence). The family may serve as a “protective factor”, that is, the family may take the initiative to bring the IDU to the treatment centre and may extend logistic and emotional support during process of recovery. On the other hand the family may also serve as a “risk factor”; interpersonal problems in the family may be a source of stress which may be a reason behind initiation, maintenance or relapse into drug use. Indeed when family members are overcritical or suspicious of recovering drug users, the risk of relapse may be high. Thus a counsellor working with drug users must be fully familiar with various issues involved in family counselling. The chapter thus focuses on how the counsellor can involve family members in treatment process.

What is family?

Family has often been defined as a, “group of people with common ties of affection and responsibility who live in proximity to one another.” There is no single definition of family; however, certain broad categories encompass all families in our culture:

Joint Families: Multi-generational families, like, grandparents, uncles, aunts, cousins and other relatives staying together, pooling the family income and using the same kitchen.

Extended Families: Usually two-generational families including grand-parents.

Nuclear Families: Family of procreation including heterosexual couple and their two minor children or single parent family with minor children.

Elected Families: which are self-identified and by choice, for example, staying with other drug-using peers. For some IDUs, the elected families may be more important than the biological family.

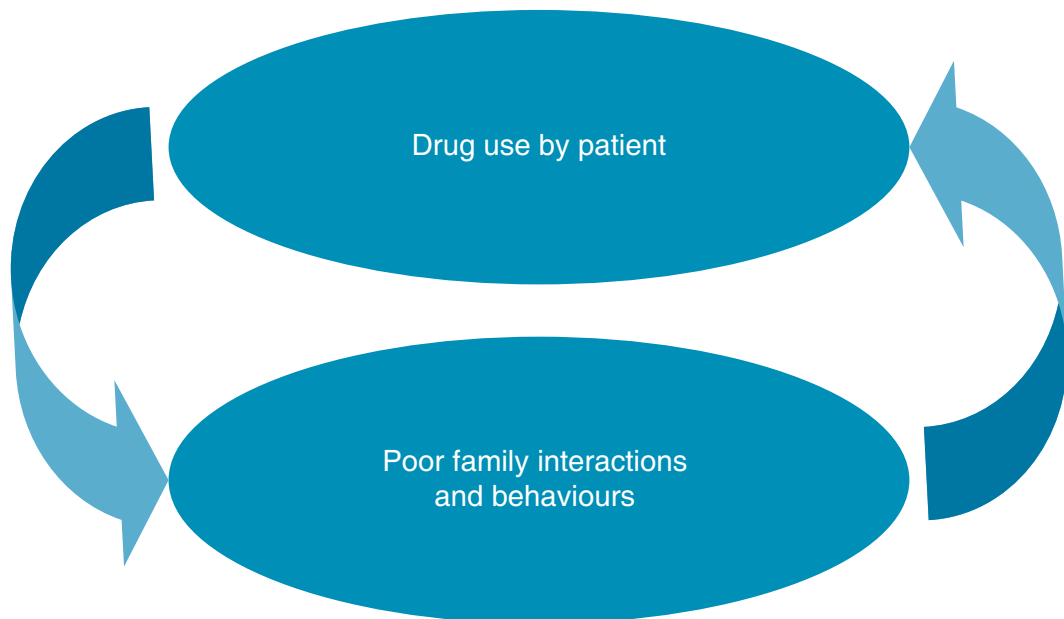
In family counselling, it is important to identify people who are important in the life of the IDUs and he/she should be allowed to identify which family member(s) he/she wants to involve in the intervention/treatment process.

Characteristics of a family

- ◆ The behaviour of family members is strongly inter-related, that is, if one family member changes his/her behaviour, the others will also change as a

consequence, which in turn causes subsequent changes in the member who changed initially. This shows how difficult it is to ascertain what came first—drug use or dysfunctional behaviours by one or more family members.

Figure 23:



- ◆ Each family has its own pattern of communication, which can be verbal or non-verbal, overt or subtle ways of expressing emotions, conflicts etc. For example, in one family, whenever the person threatens to run away, the family member get him injections that he can use; whereas, in another family, the IDU may be badly beaten up by family members to stop him from using injections.
- ◆ All families try to achieve homeostasis, that is, achieve and maintain a balance. The family may try to cover up and hide drug use and act as if everything is normal.

Impact of drug use on family

The impact of drug use on family can be multi-fold:

- ◆ **Economic:** Money is often spent on procuring drugs and injections, which often drains the family's financial structure. The other family members, usually the spouse or maybe the older parent, may have to take up the role of the provider.
- ◆ **Psychological:** Families go through a lot of psychological trauma due to drug use as well as related behaviours (for example, stealing, staying away from house for days, not taking care of personal hygiene, injuries related to injection use). They may experience hopelessness, helplessness, chronic anger, shame, isolation, stigma and blame one self or others. The spouse may need to act as both father and mother for the minor children, hence increasing the emotional work-load.
- ◆ **Health:** Health consequences are related to violence inflicted by the IDU in state of intoxication or in efforts to procure drugs. Additionally, due to chronic stress experienced on account of drug use by one family member, the health needs of other family members may be neglected. For instance, a family may remain so preoccupied with father's drug use that children's

vaccination may be forgotten. The most important consequence for the spouse however, is the risk of HIV transmission. Since the IDU may indulge in sharing of needles/syringes and multiple sexual relationships, which makes him/her prone to get infected with STI/STD/HIV, these may be transmitted to the spouse/partner.

- ◆ **Impact on minor children:** Even the children may feel guilty and responsible for their parent's drug-using habit. They are susceptible to develop low self-esteem, depression and other behavioural problems. They also become vulnerable to initiation into drug use and poor capacity to form healthy relationships.

What is family therapy?

Family therapy is a constellation of approaches that believe in assessment and intervention at the level of the family. It involves strengthening the family's protective role in reducing and preventing drug use. It also helps the family deal with the negative consequences of drug use suffered by family.

Box 50: Important Points for Family Counsellor

- ◆ Consider the "family" from the client's point of view.
- ◆ Assess the communication patterns, supportiveness/negativity, conflict management, and understanding of behaviour patterns of the IDUs.
- ◆ Many families have given up hope of recovery or are too negativistic towards the IDU and may resist participation in therapy process, but it is important not to give up.
- ◆ Be non-judgmental. Avoid taking sides. Especially, never breach the confidentiality of one family member by disclosing unwanted issues to another.
- ◆ When in doubt, remember, the IDU is your index client, not family members.

Important issues to be addressed in family therapy

- ◆ **Co-dependency:** It is described as being overly concerned with the problems of another to the extent of neglecting one's own wants and needs. Usually the co-dependent person has low self-esteem and is not sure of what he/she wants. Wives of many male IDUs may fall under this category.
- ◆ **Enabling:** It is the process of encouraging drug use by unintentional behaviours, for example, lying for the benefit of IDU or protecting him/her from consequences. This kind of behaviour tends to increase the risk of sexual and physical abuse by the IDU, diffuse the real impact of drug use and does not allow the IDU to understand the need for treatment. It is important that the family counsellor identifies and addresses these processes in the family members during the counselling.
- ◆ **Boundaries:** It delineates one family member from another and regulates the flow of information. Usually, IDUs have families with dysfunctional boundary patterns. The family members may be over-involved and interfering (enmeshment) or completely aloof (disengaged).
- ◆ **Sub-systems:** In a healthy family, the sub-systems are separated by clear boundaries that fulfil particular functions, e.g. parental sub-system used to discipline children or sibling subsystem acting as emotional pillow. However, in IDUs, there may be unhealthy sub-systems, like, father-son; the father who

is having an extra-marital affair about which the addicted son knows, hides son's drug use from mother so that the son would also keep his secret.

- ◆ **Adjusting to abstinence:** Families may react to abstinence in a variety of manners. There can be negative reactions when the hidden/suppressed conflicting issues start coming to the surface, for example, the IDU and his/her spouse never had a healthy communication. However, due to drug-use, that issue took a back-seat and the focus was only on getting the IDU to leave drugs. However, as IDU reduces his/her injection use, this lack of communication starts becoming obvious and creating further conflicts between client and his/her spouse. If the counsellor does not deal with these issues, they may become a potential trigger for relapse.
- ◆ **Triangulation:** It occurs when two family members prevent discussing about a sensitive issue and divert their energies on a third family member, who becomes a scapegoat. This reduces the emotional tension between family members but prevents the conflict from being resolved. For example, in a family where the parents share a relationship of conflict may shift all the blame on their son who has become an IDU.

Steps in family counselling

There are different steps in family therapy that the counsellor carries out with the client and his/her family. Although, the first step needs to be assessment, but families often come with their own needs and expectations and therefore the counsellor needs to be flexible in his/her approach. Before beginning, it is important to build a rapport with the family members just the way it is done with the client. Some of the important aspects of rapport building can be:

- ▲ Making the family member comfortable.
- ▲ Identify each family member by their name instead of just the patient's relative.
- ▲ Assure them of confidentiality.

Different sessions may address different issues and can be structured as per the needs of the family members. The issues to be addressed in family counselling are as delineated:

- ◆ **Ventilation:** Family members often feel angry, disappointed and frustrated because they feel that the person is taking injections deliberately and does not want to quit. They have often gone through phases of hope and then disappointment. They face a lot of stigma and isolation because of the behaviour of IDU. There is also a lot of hostility and bottled-up anger towards the person. Thus, one important task of the counsellor is to facilitate the "un-burdening" of family's emotions and feelings. The counsellor, using the skills discussed earlier (in basic skills of counselling) listens to the family member in a non-judgmental and empathic manner. During ventilation, the counsellor plays a passive and supportive role and allows the family member to determine what he/she wants to talk about.

The counsellor enquires about the problems that the family is facing and just allows them to talk. For example, the counsellor may say, "I understand that you have gone through a lot in the last few years... Would you want to talk about it?"

- ◆ **Assessment of the problem:** The counsellor needs to have a comprehensive understanding of the impact of addiction on the families and needs to assess various areas (listed in the box below).

Box 51: Family Assessment by a counsellor:

- ◆ Family member's knowledge about drugs and injections.
- ◆ Reactions and attitude of family members towards the IDU.
- ◆ Impact of drug use on client's and family's financial status.
- ◆ Available social-support to the family, for example, other relatives, friends, self-help groups etc.
- ◆ **Maintaining factors for drug use:** Craving, withdrawal, frequent conflict in family, poor coping with stress, peer pressure, availability of money.
- ◆ Health status of family member, for example, screening spouse for HIV/STIs.
- ◆ Relationship quality amongst different family members and client (whom client is close to, with whom does he have maximum conflicts).
- ◆ Communication patterns in family and conflict-resolution skills.
- ◆ Sub-systems in the family.

Family member's perception of these issues may be different from the IDUs perception. The counselling would also involve addressing these differences.

Box 52:

Counsellor to family members: *I want to know what do you understand by his drug use and how has it affected you?*

Mother: *My son was so good before he got into the company of those neighbourhood goons... they can't seem to leave him alone.*

Wife: *I just don't want to live with him. I think he is doing it deliberately. How can someone prick oneself again and again despite having injuries due to injections? He does not care about any of us. Every night, there is a fight in the family and all of us cry.*

Father: *All that I have earned – money, respect, name... he has put me to shame. I cannot face the world anymore. I have never so much as touched alcohol ever. And he steals, lies and uses drugs through injection. He is good for nothing and I don't think he will change.*

Counsellor: *Hmmm... I understand your concerns and emotions. We will be dealing with these issues. What I would like to know is that how do you usually react when he comes home after using injections?...*

- ◆ **Psycho-education:** As discussed earlier, family members usually believe drug use to be a consequence of lack of will-power or poor motivation on the part of the client. Some of the important areas that needs to be addressed in educating the family members are:
 - ▲ **Concepts of craving and withdrawals as maintaining factors:** It is important for family members to understand that lack of will-power is not the sole determinant of continued drug use. The counsellor makes the family understand the concept of craving, withdrawal symptoms, and poor coping ability to deal with stress as major blocks in abstaining from drug use.

Box 53:

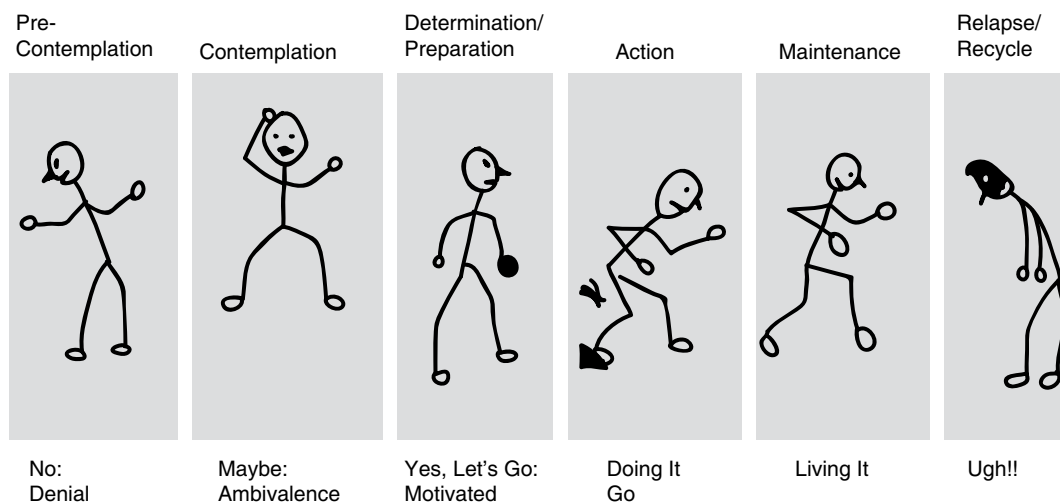
Family member: *He is just not trying enough to leave drugs. I have tried everything but the moment he opens his eyes, he goes out to meet his using-friends.*

Counsellor: *I understand that you think that he is not motivated enough. But I would like to share some facts about why we believe that drug use is maintained in a person. You need to understand that these drugs lead to certain changes in a person's body and mind... So whenever, the person does not get the drug that he is used to... the body starts demanding it. There may be significant pains and aches, disturbance in bowel/bladder movements, severe restlessness and anxiety. These symptoms get alleviated only when the person gets his drugs. Gradually, more and more quantities are required to achieve the same effect, making the person completely dependent on these drugs to get through the day. These drugs also influence the person's thinking and judgment, making him indulge in behaviours he would never think of doing when sober. ...*

- ⤴ **Risk associated with injection use:** The family needs to be aware of the risks associated with injecting drugs so that they can take action, that is, getting required medical/legal care for the patient on time. (The risks associated with injecting drugs are discussed in the chapter on Risk-reduction Counselling).
- ⤴ **Safe sexual practices:** IDUs are vulnerable to indulge in high risk behaviours, which increase the risk of acquiring and transmitting STIs. It is a very sensitive issue for both the client as well as for his/her spouse. Apart from counselling the client in this regard, the counsellor also need to educate the wife about safe sexual practices, like, using a condom (as a safe-sex device and not just as a birth-control device), taking care of hygiene and getting regular check-ups done.
- ⤴ **Reproductive health:** The spouse of a male IDU also requires education about maintaining reproductive health, contraception, spacing between children etc.
- ⤴ **Process of change:** The family goes through a cycle of hope (when client abstains from using drugs and injections) to despair (when he starts using again). They feel miserable and hopeless, *"He/she will never change. He/she lies when he/she talks about giving up"* or *"He does not even realize that he has a problem. I had to drag him here."*

It is useful if the counsellor can *explain the process of change to the family members.*

Figure 24: Six stages of change



Box 54:

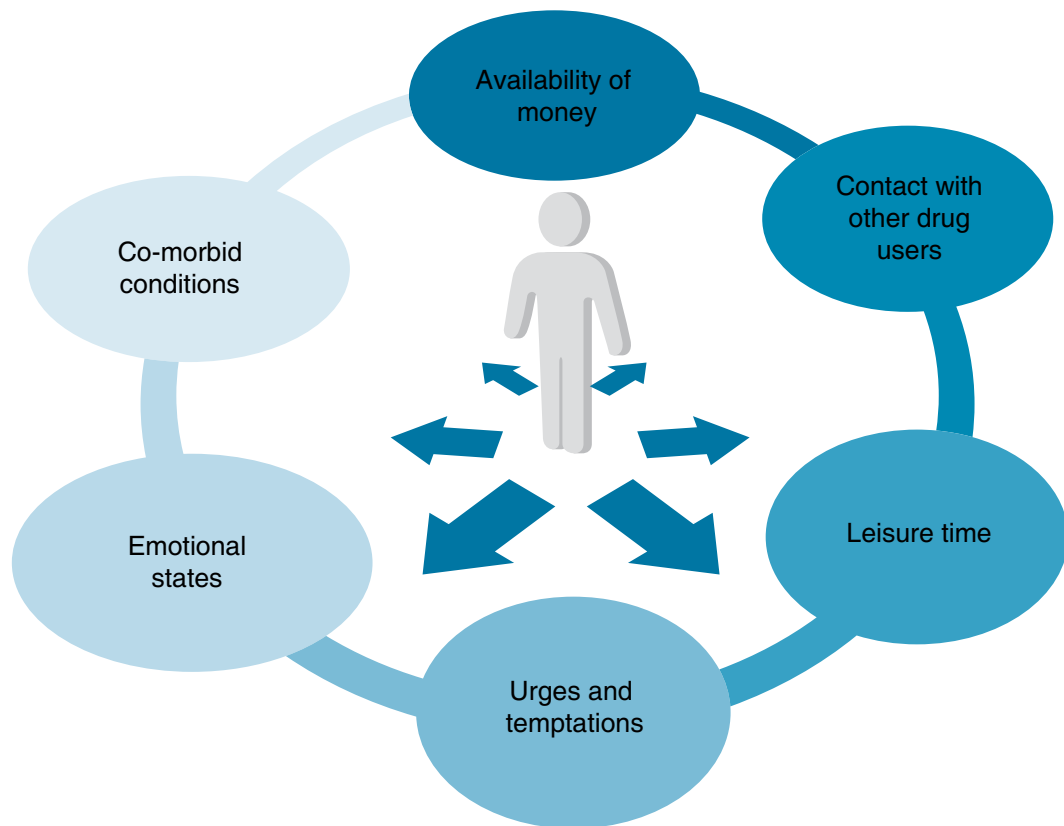
Counsellor: *The typical process of change consists of these 6 stages of change. The client may initially completely deny that he/she has a problem. As the consequences start surfacing, he may be confused what to do... Gradually, he is motivated to quit and comes to seek treatment. Once on treatment, he may reduce injection use or may completely stop it... however, he may relapse due to some stressful situation that he could not cope with e.g. loss of his job.*

The counsellor can use the following analogy here:

Even with the highly motivated client, relapse may occur. You can understand this as a wheel... when you apply brakes, the wheel does rotate a couple of times before stopping completely. It's the same with addiction. The person may have a few lapses or relapse, but that does not mean that he/she will not improve. Apart from his use of injections, you also need to focus on improvement in any other sphere of his and your life.

- ▲ **Treatment process:** *The counsellor needs to inform family members about the long-term nature of the treatment process. It can be compared with chronic physical illnesses, like hypertension or diabetes, which require life-long medication and significant life-style changes to prevent exaggeration. The family member should be told to keep motivating client for regular follow-ups and in case, the client is not being regular, they should come to understand how they can motivate the client to come to the centre.*
- ▲ **Harm-reduction:** *A counsellor working with the IDUs in a harm-reduction context (such as in a IDU TI), also needs to explain the family about the concept of harm-reduction. Very often the families may expect the service providers to 'cure' the person's drug addiction. Indeed, it is not uncommon for the family members to blame the agency providing needle syringe exchange for continued drug use by the client ("If you keep giving him syringes, why will he ever think about quitting drugs? You are further damaging his chances of recovery").*
- ▲ **Relapse Prevention:** *As discussed in the process of change that relapse is always a possibility especially if the IDU faces any stressor or high-risk situations (see adjoining picture), which may act as a trigger to use injections. At times, the trigger may be internal (e.g. craving, physical discomfort or negative emotions) and at other times, they may be external (e.g. being with drug-using peers, conflicts in the family environment). In case of IDUs, there may be certain triggers leading to high risk behaviours (e.g. non-availability of money, intoxication, going to red-light areas). The counsellor needs to help the client and family members understand and identify these triggers and teach coping methods. The counsellor can help family members to identify potential trigger situations with the use of a method known as A-B-C charting (that is, Antecedent-Behaviour-Consequences). The family member should also help client to make similar charting to identify the triggers.*

Figure 24:



Box 55: A-B-C Table

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

Counsellor: Tell me the last time you think that he used injections.

Wife: It was yesterday. He had joined work about 6 days back and was going there regularly and on time. However, yesterday he came late. As each minute was passing, I had this increasing fear that he must have gone to meet those other guys to use... I was so upset. The moment he entered the house, I started shouting at him that he didn't care about me or the kids and all that mattered to him was his injections. He also got upset and shouted at me... he said that he was working over-time today. He also said that this was the reason he used to stay away from home because I am always shouting... I still did not believe him and left the room to go in the kitchen... He yelled at me that if I can't trust him, he will do what he wants and went out. When he came back 2 hours later, all signs showed that he had used injections again. He needs to understand what I go through. He has promised me so many times he would leave, but did not... I don't trust him now.

Counsellor: I understand... now let's try and understand it again using the A-B-C chart.

Date	Antecedent	Behaviour	Consequence
24 th July 2010	He came home late at night. I kept on thinking that he must be using injections. I was getting anxious, angry and helpless.	I did not ask him why he was late and started accusing him.	He also got upset, shouted, left the house and used injections again

Wife: I see... I guess I will learn to need to bring some changes in me.

- ◆ **Change in lifestyle:** The recovering client has to face many issues related to time, money and new roles/responsibility. The counsellor need to encourage family members to assist the client in:
 - ▲ Managing the finances – clearing debts, budgeting current expenses and investing for the future
 - ▲ Managing the time – scheduling meaningful activities, like a part-time job; engaging in a mutually interesting activity or hobby that the client used to like to do.
 - ▲ Roles/responsibility – the counsellor needs to discuss how the previous roles and responsibilities can be restored. Going too slow (e.g. not engaging client is decision-making) may make the client feel dejected and unwanted whereas going too fast (expecting client to immediately start taking previous responsibilities) may prove to be overwhelming. The counsellor, family members and client need to jointly decide how the client can start taking responsibilities in the house.

Box 56:

Ground-rules that counsellor can teach family members

- ◆ Trust is a major issue and will take time to build-up. But constant doubting of the client may lead to negative outcomes (that is, relapse, anger outbursts, other high risk behaviours).
- ◆ **Family member needs to learn:** “When in **doubt**, ASK”.
- ◆ Communication is a very important tool. It should be done in a positive manner, that is, fighting is not constructive communication, talking is.
- ◆ Blame-games need to be avoided by all family members.
- ◆ Criticism should be constructive. E.g. instead of saying, “*I know you will never improve. You are always lying to me. You never make an effort.*” One can say, “*I know that you are trying to quit, but if you keep meeting your drug-using friends, it would be difficult for you to leave.*”
- ◆ Understand that it may take time for the client to completely change and it cannot happen overnight. Thus, it is important to appreciate/reinforce even a slight change in behaviour such as a decrease in usage of unclean injections or other high risk behaviours or an increase in frequency of visiting the Drop-in-Centre.
- ◆ Taking help of the client, a family member can use a calendar to mark instances of higher and lower risk behaviours, such as when and how much quantity of drug has the client taken. On the days when he has not used or used a less amount than before, he can be appreciated.
- ◆ Encourage the client to go for regular follow-ups. Even if the client is not able to abstain, using safe injection practices and staying away from other risky behaviours like pick-pocketing, stealing, staying on streets/railway stations can be advantageous.
- ◆ Craving is a reality with the IDU and self-control alone will not help. It is a temporary phase and with family member’s help, client can overcome it. The client can discuss with family members when he/she has craving; at that time, family needs to be supportive and caring. Family may help by distracting the client till the craving has subsided.
- ◆ Problems can be solved – one just needs to be calm and think of alternative solutions. Don’t panic.
- ◆ It is important to listen supportively to client; getting emotional support from family can encourage the client to make active efforts towards reducing drug use.
- ◆ If the client comes in an intoxicated state, do not panic and stay calm. Talk to him/her when he/she is sober.

CONCLUSION

In our culture, one's family has always been a very important part of a person's life. And therefore, involving family members in the intervention can go a long way in keeping clients and their families safe.

Addressing burnout issues in counsellors

In human services occupations such as counselling, clients bring their collection of needs, conflicts and problems, often taxing counsellor's energy and emotional resources. In the field of addiction, drop-outs, frequent relapses and HIV-related high-risk behaviours are pretty common, giving rise to frustration among counsellors who invest significant emotional resources in the counsellor-client relationship. Over time, the cumulative effects of managing clients can lead to fatigue, exhaustion and burnout. This chapter would be dealing with burnout issues and ways of preventing burnout and suggesting coping strategies for counsellors.

What is burnout?

Burnout can be defined as a state of emotional, mental and physical exhaustion caused by excessive and prolonged stress. Burnout usually occurs when negative emotions are accumulated without a proper 'discharge'.

Types of counsellor burnouts

There can be three types of burnouts seen in counsellors dealing with IDUs:

- ◆ **Emotional exhaustion** – characterised by feelings of emotional over-strain and low energy levels making it difficult to meet every new day.
- ◆ **Depersonalisation** – It is the interpersonal component of burnout. When the counsellor feels emotionally exhausted (described above), he/she fights it through either isolation or by behaving negatively or aggressively towards other people.
- ◆ **Low self-esteem** – is characterised by an inner sense of low confidence in one's own ability and inability to cope.

Signs/symptoms of burnout

The symptoms of burnout can be at the physical, emotional or behavioural level as discussed below:

Box 57:

Physical symptoms	Psychological/emotional symptoms	Behavioural symptoms
<ul style="list-style-type: none"> ◆ Aches and pains ◆ Frequent stomach upsets/diarrhoea 	<ul style="list-style-type: none"> ◆ Anger and frustration ◆ Low self-confidence 	<ul style="list-style-type: none"> ◆ Emotional outbursts ◆ Social withdrawal

Physical symptoms	Psychological/emotional symptoms	Behavioural symptoms
<ul style="list-style-type: none"> ◆ Chronic feeling of tiredness ◆ Sleep disturbances ◆ Loss of weight ◆ Disturbances in appetite 	<ul style="list-style-type: none"> ◆ Loss of interest in work; failure to carry out day-to-day responsibilities ◆ Feeling of inadequacy ◆ Anxiety/apprehension ◆ Frequent mood changes ◆ Feeling of being a failure ◆ Constant worry about the future ◆ Decreased concentration ◆ Poor memory 	<ul style="list-style-type: none"> ◆ Neglect of responsibility ◆ Continual/increasing use of alcohol/other substances ◆ Decrease in activity level ◆ Difficulty in communicating with others

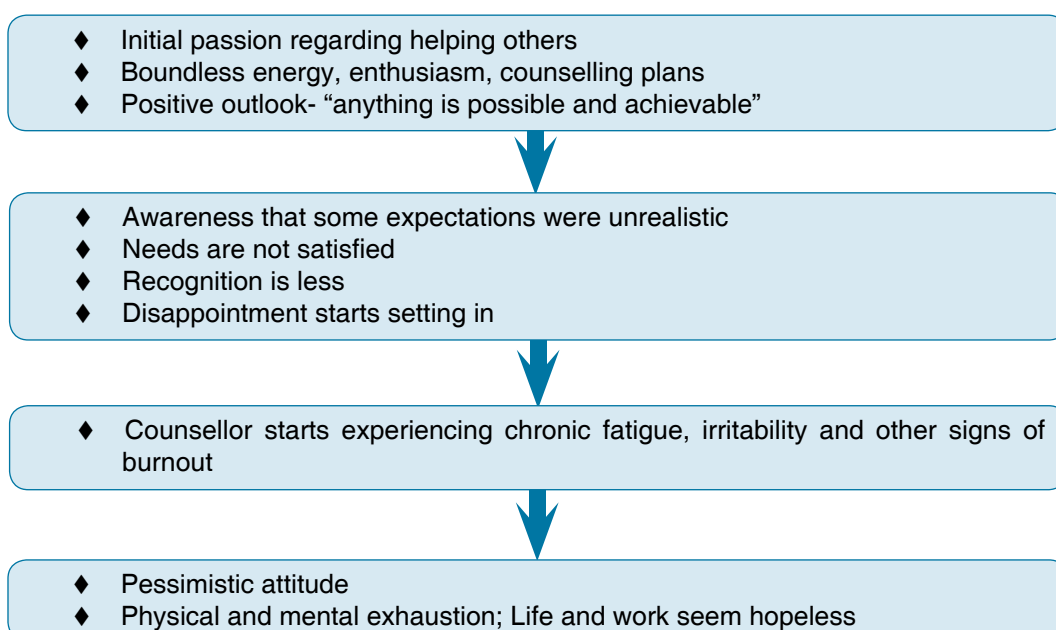
Development of burnout

Burnout does not happen overnight. It is a gradual process that occurs over an extended period of time. The signs and symptoms are gradual at first and they tend to get worse as time goes on. If the counsellor pays attention to the early symptoms and takes them as warning signs, a major break-down can be prevented. The development of burnout can happen at three levels:

- ◆ **Level 1:** The counsellor may experience mild-to-moderate, short-term and occasional symptoms. At this stage, the counsellor can work on it through various stress-reduction strategies and stop its progression.
- ◆ **Level 2:** The symptoms become prolonged and regular and are difficult to correct or stop.
- ◆ **Level 3:** The counsellor experiences chronic symptoms and may experience psychological problems like depression or physical problems like ulcers. At this stage, usually, professional help is required.

The diagram given below describes the various stages of burnout.

Box 58:



Reasons for burnout

Burnout is not caused solely by work demands or getting too many responsibilities. Other factors in the counsellor's life, for example, lifestyle and certain personality factors, can also lead to burnout. Some of the factors leading to burnout are:

Box 59: Factors leading to burnout

work-related	<ul style="list-style-type: none">◆ Excessive work-load.◆ Lack of recognition for work done.◆ Type of clients.◆ Little control over the outcome of the work put by the counsellor (possibility of relapse).◆ Reduced opportunity for promotion/advancement.
Lifestyle-related	<ul style="list-style-type: none">◆ Working overtime; not giving enough time for relaxation.◆ Too many expectations from others-as a counsellor, daughter, mother, wife.◆ Too many responsibilities without getting adequate social support.◆ Lack of close and supportive relationships.
Personality-related	<ul style="list-style-type: none">◆ Need to do everything perfectly- "I have to make sure that everything is perfectly well in the client's life."◆ Need to control.◆ Giving oneself personal responsibility for each situation- "If client is not getting better, it is my fault."◆ Difficulty asking for help.◆ Suppressing emotions/feelings.◆ Inability to say NO.◆ Difficulty with responsibility delegation.

Some of the individual factors that are important in causing burnout are:

- ◆ **Perfectionism:** That is the need to do everything till it seems 'perfect' with no chances of any deficits. For example, *"I have to make sure that everything is perfectly well in the client's life."*
- ◆ Need to control situations.
- ◆ **Exaggerated sense of responsibility:** That is, giving oneself personal responsibility for each situation. For example, *"if client is not getting better, it is my fault."*
- ◆ **Difficulty asking for help:** *"I sometimes feel stressed after counselling sessions, sometimes not even sure whether I am doing the right thing... But if I ask for help, it would show that I am not a good counsellor."*
- ◆ Suppressing emotions and feelings.
- ◆ **Difficulty taking vacations or enjoying leisure time:** *Workaholic.*
- ◆ **Inability to say NO:** "Thinking inside: *I can't take so many sessions in one day, I have to record them also, but how can I say no to work given to me.* But saying outside: *"Yes, sure, I will be able to manage these extra clients too."*

- ◆ **Difficulty with responsibility delegation** – *“I have to do everything myself, I am not sure somebody else would be able to handle it the way I do.”*

Preventing Burnout

There is a famous saying that “A stitch in time saves nine.” As discussed before, the earlier the signs of burnout are recognised, and prevention efforts taken, the easier it would be to halt the development of a full-blown burnout syndrome. There are four approaches that one can take to prevent burnout.

Box 60: Approaches to Prevent Burnout

- ◆ Creating a “Personal Inventory”
- ◆ Management of physical health
- ◆ Management of psychological health
- ◆ Obtaining work-related support

- ◆ **Personal Inventory** – The counsellor can maintain a diary/inventory as her own “Burnout prevention plan”. This can lead to a positive attitude that the counsellor can alter situations. The counsellor can note down the following things in her diary/inventory:
 - ▲ Changes in her emotions, thoughts and behaviours at the work-place or at home.
 - ▲ The triggers or stressful situations that can eventually lead to burnout. For example, feeling angry towards the client after hearing that he again shared needles despite educating him about the harmful effects of the same.
 - ▲ Contact information of people to whom the counsellor can go, if he/she is feeling stressed.
 - ▲ Some remedies to calm down, if feeling stressed. For example, “Stop... breathe deeply... Calm down”; call a friend; take a walk etc.
- ◆ **Physical health management** – Mind-body has a strong connection. A healthy mind can only dwell in a healthy body. Some of the ways in which the counsellor can take better care of his/her health are:
 - ▲ Proper nutrition – Eat properly, in adequate amount and not skipping meals.
 - ▲ Rest – Adequate amount of sleep and rest is necessary.
 - ▲ Taking time out to exercise.
 - ▲ Maintain good posture while talking to the client.
- ◆ **Psychological health management** – Counselling disturbed clients can be a strain to the counsellor’s emotional health. Thus, it is very important to take steps to take care of her psychological well-being. Some of the ways of doing so are:
 - ▲ Maintain a positive attitude – You are doing what you can to help, everything is NOT your responsibility.
 - ▲ Be aware of your own thoughts and emotions and take responsibility for them.
 - ▲ Practice relaxation exercises – meditation, deep breathing.
 - ▲ Use a lot of humour.

- ⤴ Develop clear boundaries between work and personal life.
- ⤴ Be socially active and maintain a good network of peer and family support.
- ◆ **Work-related support** – The counsellor spends his/her maximum time at the work-place, thus it is important to develop a support system there to counter the effects of stress:
 - ⤴ Keeping a network of other counsellors – to share both success as well as the stressors they face.
 - ⤴ Going for regular workshops to enhance knowledge and clear doubts.
 - ⤴ Obtaining clear feedback and guidance.
 - ⤴ Seeking clinical supervision from senior counsellors.
 - ⤴ Taking time out to bond with other colleagues.
- ◆ **Above all, remember, you cannot change or control everything occurring in your clients' lives.**

Coping with burnout

In case, the counsellor has reached the stage of burnout, merely adjusting his/her own attitudes of taking care of physical/psychological health will not help the counsellor. He/she can take the following steps:

Slow down: The counsellor needs to slow down or take a break. He/she needs to cut down some commitments and take time to rest, reflect and heal.

Get support: Rather than isolating himself/herself, the counsellor should seek support from supervisors, colleagues, friends and family. By simply ventilating out, he/she may feel somewhat better. The counsellor should not feel that asking for support makes her a weak person. Rather it should be seen as an opportunity to grow.

Re-evaluation of goals and priorities: The counsellor should take time out to re-think about his/her goals and dreams and ask him/her self – “Am I neglecting something that is really important to me?” This can give the counsellor an opportunity to re-discover what is important and change accordingly.

Summary

To summarise, the counsellor should accept that burnout is an important and serious issue and can happen to anyone. Preventing it is always better than trying to cure it.

Glossary

1. **Abscess:** Localised collection of pus in any area of the body due to infection caused by micro-organisms or any foreign body with a surrounding of inflamed tissue. When an area of tissue becomes infected, the body's immune system tries to fight it. White blood cells move into this area of infection and collect within the infected tissue which results in formation of pus. Pus is the collection of fluid, white blood cells, dead tissue, and bacteria or other micro-organisms.
2. **Abstinence:** The stage of having stopped any undesirable behaviour. In case of addiction, this means stopping drug use.
3. **Blame-game:** The tendency to blame each other for mistakes and not owing up responsibility for change. *"I will only change, when he/she changes."*
4. **Chasing heroin:** This refers to a particular method of using heroin through the inhalational route. In this method, heroin is placed on a foil (of cigarette or chocolate) and heated from below. The smoke emanating as a result of this heating is then inhaled by the user usually through a pipe (either metallic or prepared from a fold of paper).
5. **Collaborative approach:** To work together in order to achieve a common goal.
6. **Coping:** The process of managing taxing circumstances, expending effort to solve personal and inter-personal problems, and seeking to master, minimise, reduce or tolerate stress or conflict.
7. **Cues:** Cue is the trigger for an action to be carried out at a specific time. In case of addiction, this means triggers for taking the drug.
8. **Demographic information:** The basic information about a person – age, education, occupation, current employment status, marital status, monthly income, residence, religion.
9. **Detoxification:** The process of getting rid of the acute effects of the drug from the body, in an individual who is dependent on drugs.
10. **Expressed emotions:** It is a "qualitative" measure of emotions displayed by the family members. Are they hostile towards the client, do they pass critical comments frequently or they are emotionally over-involved or over-protective. Expressed emotions can act as risk factors for drug use.
11. **Facilitator:** The person who gives structure to counselling sessions and supports and guides the client to reach the determined target.
12. **Family of procreation:** The family one creates through marriage. Typically involves wife and minor children.

13. **High-risk behaviour:** They are all those behaviours that put the client in danger. HIV-related high-risk behaviours include sharing needles, syringes and other equipments with others, having multiple sexual partners or unprotected sex with more than one partner. Other types of high-risk behaviours include driving under intoxication, getting involved in illegal activities.
14. **Injecting Drug User:** An injecting drug user (IDU) is an individual who has used psychoactive drugs for recreational or non-medical purposes through the injecting route. Injecting may be in veins (intravenous), in muscles (intramuscular) or beneath the skin (subcutaneous). An IDU may or may not be using drugs daily through the injecting route. Under the NACP III, NACO defines a specific time period of having injected in the past **three months** for qualifying as an IDU.
15. **Lapse:** Refers to slipping into drug use. This means the first time drug is used after a period of abstinence. If the individual continues to use drugs and resumes his previous pattern of using drugs daily/regularly, it is referred to as relapse.
16. **Necrosis and Gangrene:** Necrosis is death of body tissue due to lack of blood flow to the particular area. If substantial areas of the tissue die, it is called as gangrene. In case of an IDU, injecting into vital veins for e.g. hand or thighs may cause blockage of the vein, resulting in necrosis or gangrene.
17. **Non-judgmental:** Not making or expressing an opinion regarding a person or thing; impartial.
18. **Opioid:** A drug having actions similar to opium.
19. **Positive reinforcement:** It is that thing, act or process that increases the likelihood that a certain behaviour would occur. For example, when the client uses injection, it acts as a positive reinforcer and thus increases the probability that the client would again use injections. If the client is appreciated or rewarded for not using injections, then gradually it would increase the chances of injections not being used.
20. **Protective factors:** These are factors that protect the individual against negative behaviours like drug use. Some protective factors in the family include supportive family environment, good communication patterns between family members, ability to face stress together.
21. **Psychoactive drugs/substances:** Drugs or substances which act on the brain and alter the mood, consciousness (ability of brain to be alert and awake) or sensations (ability to hear, see, taste, smell), which may lead to impairment of judgment and motor performance.
22. **Psychosis:** Psychosis is a loss of contact with reality, usually including false beliefs about what is taking place or who one is (delusions) and seeing or hearing things that are not there (hallucinations).
23. **Rapport:** Harmony, confidence, and respect underlying a relationship between two persons, which is essential to establish a bond between a treatment/service provider and client.
24. **Relapse:** To go back to the previous stage after having progressed to the next stage or step. In case of addiction, this usually means resumption of the previous state of drug use pattern. Relapse should be distinguished from the term 'lapse'.

25. **Remission:** Phase during which the client is abstinent from drugs.
26. **Risk factor:** These are factors that increase the risk of the individual engaging in negative behaviours, like drug use. Some risk factors in the family include family history of alcohol or drug use, broken families, frequent conflicts in the home, physical/sexual abuse.
27. **Ulcer:** Lesion on the surface of the skin. Ulcer is the final stage in abscess development, wherein the accumulated pus in the abscess breaks the skin surface due to pressure, leading to ulcer formations.
28. **Viral Hepatitis (Hepatitis B, Hepatitis C):** Infection of liver caused by viruses resulting in impairment in liver functioning.
29. **Withdrawal symptoms:** Withdrawal symptoms are those experienced by the client when he/she does not get adequate doses of the drug that he/she commonly injects. Some of the common symptoms include-yawning, sweating, decreased sleep, weight loss, vomiting, diarrhoea, increased pulse rate, increased blood pressure and abdominal cramps.

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High Risk Behaviour Scale

The HIV Risk Behaviour Scale (HRBS)

a) Drug Use Section	Score
Question 1. <i>How many times have you hit up (injected any drugs) in the last month?</i>	0-1-2-3-4-5
Question 2. <i>How many times in the last month have you used a needle after someone else had already used it?</i>	0-1-2-3-4-5
Question 3. <i>How many people have used a needle before you in the last month?</i>	0-1-2-3-4-5
Question 4. <i>How many times in the last month has someone used a needle after you have used it?</i>	0-1-2-3-4-5
Question 5. <i>How often, in the last month, have you cleaned needles before re-using them?</i>	0-1-2-3-4-5
Question 6. <i>Before using needles again, how often in the last month did you use bleach to clean them?</i>	0-1-2-3-4-5
b) Sexual Behaviour Section	Score
Question 7. <i>How many people, including clients, have you had sex with in the last month?</i>	0-1-2-3-4-5
Question 8. <i>How often have you used condoms when having sex with your regular partner(s) in the last month?</i>	0-1-2-3-4-5
Question 9. <i>How often did you use condoms when you had sex with casual partners in the last month?</i>	0-1-2-3-4-5
Question 10. <i>How often have you used a condom when you have been paid for sex in the last month?</i>	0-1-2-3-4-5
Question 11. <i>How many times did you have anal sex in the last month?</i>	0-1-2-3-4-5

Scoring the HRBS - The HRBS is easy to score. Each of the questions are scored on 0-5 scale, with a higher score indicating a higher degree of risk-taking. These scores are added up to provide measures of drug use risk taking behaviour, sexual risk-taking behaviour, and a global HIV risk-taking behaviour score. Scores on the whole test range then from 0-55, with higher scores indicating a greater degree of risk-taking behaviour. The HRBS provides three scores: a total score indicating level of HIV risk-taking behaviour; a Drug Use Sub-total indicating level of risk due to drug taking practices; and a Sexual Behaviour Sub-total indicating level of risk associated with unsafe sex. In all cases the higher the score, the greater the risk the subject has of contracting and passing on HIV.

(Adapted from -The HIV Risk Taking Behaviour Scale (HRBS) Manual - Jeff Ward, Shane Darke & Wayne Hall, National Drug and Alcohol Research Centre, 1990, Technical Report Number 10)

Individual risk assessment activity worksheet

Individual risk assessment activity worksheet

(This should be completed by the counsellor in consultation with the client)

	Client code: _____	
Client has regular partner:	YES/NO	
Regular partner's status:	HIV positive/Unknown /HIV negative	
Date of last test: _____		
Client/partner 1 indicates history of STI infection:	YES/NO	
Treatment referral required:	YES/NO	
Client/partner 2 reports symptoms of TB:	YES/NO	
Treatment referral required:	YES/NO	
Occupational exposure:	YES/NO	Date :
Date: Window period:	Yes/No	
Tattoo, scarification:	YES/NO	Date :
Window period:	Yes/No	
Blood products:	YES/NO	Date :
Window period:	Yes/No	
Vaginal intercourse:	YES/NO	Date :
Window period:	Yes/No	
Oral sex:	YES/NO	Date :
Window period:	Yes/No	
Anal intercourse:	YES/NO	Date :
Window period:	Yes/No	
Sharing injecting equipment:	YES/NO	
Window period:	Yes/No	
Client risk was with a known HIV-positive person:	YES/NO	
Client is pregnant:	YES/NO	
Stage of pregnancy:	1st trimester/2nd trimester/3rd trimester	
Client/partner is using contraception regularly:	YES/NO	
Client requires repeat HIV test due to window period exposure:	YES/NO	

Date for repeat retest:

Name of the counsellor

Date of interview

Signature

(Adapted from HIV Counselling for ICTC, PPTCT and ART Counsellors Training Modules- Facilitator's Guide-National AIDS Control Organization (NACO), Ministry of Health and Family Welfare Government of India)

Depression anxiety stress scale – 21 items

DASS 21	Name:	Date:
<p>Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all</p> <p>1 Applied to me to some degree, or some of the time</p> <p>2 Applied to me to a considerable degree, or a good part of time</p> <p>3 Applied to me very much, or most of the time</p>		
1	I found it hard to wind down	0 1 2 3
2	I was aware of dryness of my mouth	0 1 2 3
3	I couldn't seem to experience any positive feeling at all	0 1 2 3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0 1 2 3
5	I found it difficult to work up the initiative to do things	0 1 2 3
6	I tended to over-react to situations	0 1 2 3
7	I experienced trembling (e.g., in the hands)	0 1 2 3
8	I felt that I was using a lot of nervous energy	0 1 2 3
9	I was worried about situations in which I might panic and make a fool of myself	0 1 2 3
10	I felt that I had nothing to look forward to	0 1 2 3
11	I found myself getting agitated	0 1 2 3
12	I found it difficult to relax	0 1 2 3
13	I felt down-hearted and blue	0 1 2 3
14	I was intolerant of anything that kept me from getting on with what I was doing	0 1 2 3
15	I felt I was close to panic	0 1 2 3
16	I was unable to become enthusiastic about anything	0 1 2 3
17	I felt I wasn't worth much as a person	0 1 2 3
18	I felt that I was rather touchy	0 1 2 3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0 1 2 3
20	I felt scared without any good reason	0 1 2 3
21	I felt that life was meaningless	0 1 2 3



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