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United Nations Office on Drugs and Crime



# COUNSELLING IN TARGETED INTERVENTION FOR INJECTING DRUG USERS

– A Counsellor's Handbook





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**– A Counsellor’s Handbook**

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# ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
AVE	Abstinence Violation Effect
BCC	Behaviour Change Communication
DASS	Depression Anxiety Stress Scale
DIC	Drop-in-Centre
DOTS	Daily Observed Treatment Strategy
Hep C	Hepatitis C
HIV	Human Immunodeficiency Virus
HRBS	High Risk Behaviour Scale
HRG	High Risk Groups
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IDUs	Injecting Drug Users
LGV	Lymphogranuloma Venereum
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
NSEP	Needle Syringe Exchange Programme
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
TB	Tuberculosis
TI	Targeted Intervention
VCT	Voluntary Counselling and Testing



## ABOUT THE HANDBOOK...

The 'Handbook for Counsellors' is part of the training module being prepared by UNODC ROSA, in partnership with TISS, as part of the Global fund Round 7 HIV/AIDS Project 'Saksham'. The module is a training package containing three separate documents and prepared by a group of experts with experience in drug related counselling as well as harm reduction. The first two documents, 'Resource guide' and 'Facilitator's manual', is for the use of trainers involved in training of the IDU TI counsellors.

This handbook is for **use by IDU TI counsellors**, who can use this handbook as a ready-reckoner. The handbook is designed such that the counsellors can use it in any TI setting (including outreach settings) for providing counselling services to the IDUs. However, it should be remembered here that the handbook is ***not a substitute to training***, but will serve an additional resource for the IDU TI counsellor to recall important issues that she/he has to bear in mind while carrying out specific counselling activities.

The handbook is divided into three broad sections. **Section I** gives an overview on the background theoretical aspects related to drug use and problems associated with injecting drug use. **Section II** provides an overview of the IDU TI along with the role of an IDU counsellor in the context of IDU TI. The last section – **Section III** – is on the practical aspects of various counselling techniques related to IDUs. Additionally, appendices are provided at the end, which the counsellor can use while conducting the clinical activities.



## Section I

# INJECTING DRUG USE AND HIV: WHAT SHOULD A COUNSELLOR KNOW?

## Understanding Drug Use

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. Various substances can be used for the purpose of achieving intoxication and most of them – on repeated use – can make the person dependent on them. These substances include: **Alcohol (beer, whisky, rum, gin, wine, country liquor etc.), Opioids (opium, brown sugar, smack, buprenorphine, propoxyphene etc.), Cannabis (bhanga, ganja, charas), Sedative Hypnotics (calmpose, avil, phenargan, alprazolam etc.), Cocaine, Other stimulants, including caffeine, Hallucinogens, Tobacco and Volatile solvents (inhalants, such as ink-eraser fluid, paint thinners etc.).**

These substances are available in different forms, consumed in different ways, and lead to a wide variety of effects on the user. The common aspect linking all of them is their ability to cause dependence, upon regular and repeated use.

Various terminologies are often employed in the area of substance use, such as “Use”, “Abuse”, and “Dependence” or “Addiction.”

- ◆ **Use** is simply the ingestion of alcohol or other drugs **without experiencing any negative consequences**. When a person experiences negative consequence from the use of alcohol or other drugs it is **misuse**.
- ◆ **Abuse** is a maladaptive pattern of use resulting in physical, social, legal harm or continued use in spite of such negative consequences.
- ◆ **Dependence** has been defined as a cluster of physiological, behavioural and cognitive

### Criteria for diagnosing Substance Dependence (Three or more should be fulfilled)

Tolerance

Withdrawal

Loss of control

Preoccupation with substance use

Continued use in spite of harm

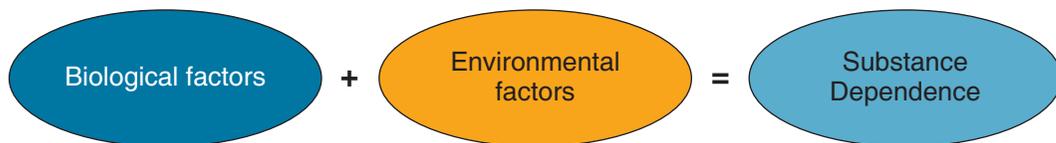
Craving (Strong desire to use)

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. The diagnosis of dependence is made when an individual satisfies three or more of the criteria outlined in the box.

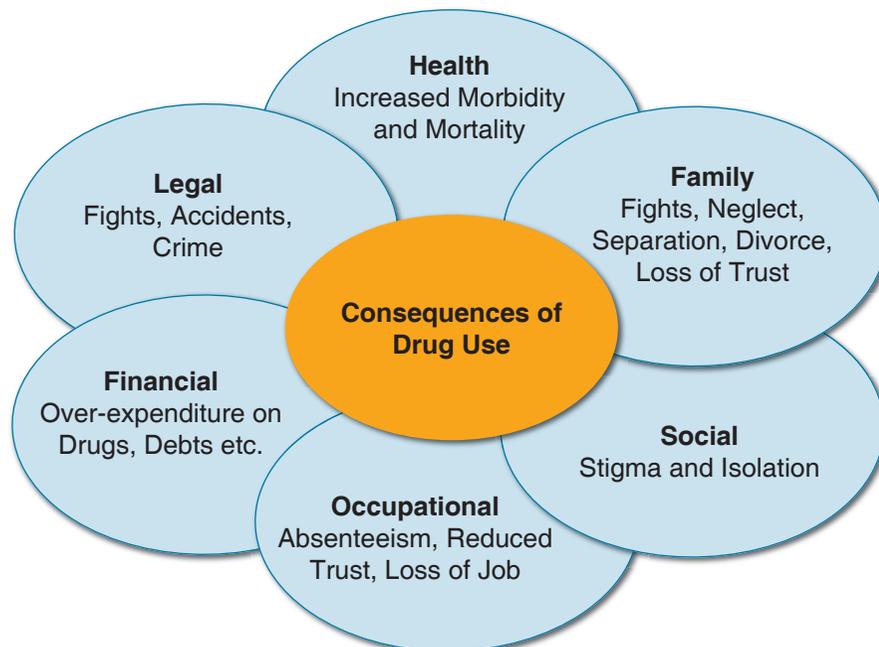
Thus, the stages of Use, Abuse and Dependence on a symptom can be seen as a pattern of substance use in increasing order of severity (Use → Abuse → Dependence).

Tobacco, alcohol, cannabis, opium and heroin are the major drugs of use in the country. India – being a vast country, has a lot of variation in the substance use pattern. However, it should be remembered that drug abuse is seen in both rural and urban parts of India. Mostly young adult males are affected by substance use. A small minority of women also indulges in substance use. Unfortunately, many substance users do not seek treatment.

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.



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



## Understanding Injecting Drug Use

Drugs can be taken through various routes. All these routes have their own advantages and disadvantages. In general, the injecting route of drug-taking 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. In India, almost all injecting drug users (IDUs) inject one or the other opioid drug through this route. 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’)**: injected mainly in the north-eastern states
- ◆ **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 (Proxylon/Spasmo-Proxylon/SP)**: This drug is available as capsules and NOT AS INJECTIONS. Still, some users (seen only in the northeastern states, very rare in other parts of the country), open the capsules, take the powder out, mix it with another liquid/drug and then inject it

While historically, the use of certain intoxicating substances has been prevalent in India for many centuries, Injecting Drug Use (IDU) is a relatively newer phenomenon. The phenomenon was first noted in the north-eastern states of Manipur and Nagaland. In the last few years, IDU has spread over many more parts of the country. Currently there are about 2 lakh IDUs in India. HIV infection among IDUs is also progressing in India at an alarming rate.

In India, it is very rare for drug users to start their drug-use careers with injecting. Usually the first drug that people start taking (usually in adolescence) is tobacco and/or alcohol. Thereafter, people start smoking cannabis (ganja or charas). This is followed by a period of using opioids through a non-injecting route – mostly smack/brown sugar through the chasing route. After this, drug users start taking opioids through the injecting route. However, there are always exceptions to this rule.

Since IDU represents a rather severe form of drug use, which is associated with many socio-occupational consequences, it is likely that the IDUs who require the services of an IDU TI are those who belong to the poorest section of society.

Consequently, the typical IDU who would come into contact with an IDU TI, would be a man, in his productive years, but not likely to be regularly and gainfully employed. He may be married, but likely to have poor social support. Years of drug dependence would have led to severe dysfunction in almost all aspects of his life. It is not uncommon for a typical IDU TI to cater to poor, homeless IDUs, who may have limited means to sustain themselves, to maintain their hygiene, or even to have two square meals a day. Involvement with the criminal justice system is also common.

Since injecting drugs is an illegal, socially-deviant act, IDUs usually inject at places which are hidden from the public view and are often unclean. Additionally, IDUs also find it difficult to clean the skin at the injecting site prior to injecting. In many cases, IDUs find that all the peripheral veins on their all four limbs have been blocked and are thus forced to inject in veins which are dangerous, such as those on the groin/thigh or neck. Another issue which makes injection risky is the risk of overdose and toxicity. The most risky aspect, from a public health perspective is however, the sharing of injecting equipments such as needles, syringes or other paraphernalia (i.e. the cookers or pots in which drug has been prepared for injecting). All of these sharing practices are associated with the risk of transmission of various blood-borne infections such as HIV, Hepatitis-B and Hepatitis-C.

## Understanding HIV

The term **HIV** stands for “**H**uman **I**mmunodeficiency **V**irus”. Viruses basically are micro-organisms, which are considered to be a connecting link between the living and non-living. HIV is the name of the virus which causes the infection, and AIDS is the name of the disease, which results from HIV infection. In other words, HIV causes AIDS (Acquired Immune Deficiency Syndrome). 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.

Certain conditions must be met for HIV transmission to occur from one individual to another. The body fluid which contains the HIV virus must enter into the body of another individual. Only certain body fluids (**Blood, Semen, Vaginal secretions, Breast milk, Pre-seminal fluid**) have the potential to infect another individual. Consequently, the HIV infection can be transmitted through the following routes:

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

Women are more vulnerable to HIV, due to various biological, socio-cultural and economic factors.

HIV causes AIDS by lowering the immune system of our body. Our bodies are normally protected by “white blood cells” against diseases. HIV attacks and weakens

the white blood cells. Consequently, when our bodies do not have enough white blood cells to protect them (AIDS), other diseases and infections can attack us and eventually cause death.

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, i.e. a "Positive HIV Test". 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.

Many people mistakenly believe HIV/AIDS to be a deadly condition. 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 life considerably and can enjoy a reasonable degree of quality of life.

## Sexually Transmitted Infections (STIs)

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 virus. Some of the common STIs are: **Syphilis, Gonorrhoea, Chancroid, Herpes, and Lymphogranuloma Venereum (LGV).**

Since these infections are transmitted through sexual routes, they primarily affect the sex-organs of the body. Consequently, the common symptoms of the STIs are ulcers, discharge or growth on or around genitals, anus or mouth (if mouth comes in contact with genitals during oral sex).

STIs can be dangerous and may sometimes lead to grave health consequences. While there is an obvious **risk of transmission to the partner**, untreated STIs can lead to an **increase in symptoms leading to pain, and disability**. Additionally, this may result in the **spread of infection to other parts of the 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 STI have 2 to 4 times increased risk of getting HIV infection.

With advances in medical sciences, it has now become possible to treat STIs effectively. In almost all government hospitals, facilities exist for diagnosis and treatment of STIs. Early diagnosis and treatment of STIs should be seen as a HIV prevention activity.

## Approaches to Drug Use Problems, Including Harm Reduction

As noted earlier, drug use is associated with a wide variety of adverse consequences or harms. These harms adversely affect not only the drug-using individuals but also their families, community, society and country.

A very common approach to address substance use problems has been to disrupt the supply and availability of drugs, i.e. **Supply Reduction**. In yet another approach, called **Demand Reduction**, other strategies are used. These include strategies aimed at young people to discourage initiation of drug use (i.e. *Primary prevention*) or identification of and providing effective treatment to drug users (*Treatment*).

However, even by adopting both – supply reduction and demand reduction strategies, we cannot expect a total control over drug-related problems. There will always be some people using drugs, some of whom may not be willing or successful in giving up drug use altogether. To help such individuals a different type of approach would be required, i.e. ‘**harm-reduction**’ approach. This approach entails “*policies and programmes that are aimed at reducing the harms from drugs, but not drug use per se.*”

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. Various strategies are employed using the harm reduction approach. These are:

- ◆ **Educational Interventions**
- ◆ **Needle Syringe Exchange Programmes**
- ◆ **Outreach**
- ◆ **Oral Substitution Therapy.**

## Section II

# IDU TI COUNSELLOR – ROLES AND RESPONSIBILITIES

## Overview of IDU TI

### General Considerations

- ◆ HIV epidemic in India is not a generalised epidemic; it is concentrated in certain pockets of the country and among 'High Risk Groups' (HRGs)
- ◆ Female Sex Workers, Men having Sex with Men, and Injecting Drug Users (IDUs) are the groups considered by the National AIDS programme in India as the HRGs
- ◆ IDUs have one of the highest prevalence of HIV among all the HRGs
- ◆ The behaviour of HRGs, illegality associated with HRG behaviour, and resultant stigma and discrimination make the HRGs vulnerable for HIV infection
- ◆ As a result, HRGs do not access services from the mainstream service providers (e.g. hospitals and health care centres) due to fear of disclosure of their HRG status and fear of stigma and discrimination
- ◆ Services specifically directed towards HRGs have to be provided – **Targeted Intervention**
- ◆ For providing services, HRGs have to be actively sought out at places where they are more likely to be found – **outreach** services
- ◆ For increased penetration into the HRG network and to make the services more acceptable, current or ex-HRGs are employed for providing services – '**Peer-based**' approach
- ◆ NACO is the nodal Government agency for responding to the HIV/AIDS problem in the country
- ◆ NACO emphasises the use of peer-based outreach through Targeted Intervention approach for providing HIV prevention services to the HRGs

### TI for IDUs

- ◆ IDU TIs are run by NGOs who are funded by their respective State AIDS Control Societies

- ◆ NACO advocates “Harm reduction” policy to reach out to the IDUs in TI setting
- ◆ NGOs employ the following staff for running an IDU TI
  - One Programme manager
  - One doctor (part time)
  - One ANM/counsellor
  - Outreach workers
  - Accountant
  - M & E officer (in some cases)
  - Peer educators who are paid honorarium for their services.
- ◆ The following services are provided in an IDU TI:
  - Counselling on risk reduction and behaviour change
  - HIV prevention materials – Needle/syringe; condoms
  - Provision of abscess prevention materials such as cotton swabs, tourniquet, etc.
  - Detection and treatment of sexually transmitted infections
  - Treatment of health-related conditions – general medical check up, abscess management, etc.
  - Referral to other services – ICTC, ART, detoxification centres, others (e.g. vocational training, night shelters, etc.)
  - Facilitating support group formation
- ◆ Services are provided through two approaches:
  - **Outreach-based services:** contacting and befriending the IDU client; providing risk reduction materials; counselling the IDUs; providing referrals; motivating the IDU to visit DIC; advocacy
  - **DIC-based services:** medical checkups; diagnosis and treatment for STIs; counselling; group activities; provision of risk reduction materials; referrals to appropriate health services

## IDU TI Counsellor – Roles and Responsibilities

At most of the places, in keeping with the revised guidelines (costing) framed by NACO for implementing TI programmes by NGOs, the ANM (Auxiliary Nursing Midwife) is given the additional responsibility of counselling the IDU clients also. In some cases and in states where there is a shortage of ANMs, a counsellor is appointed. It is recommended (in the revised costing guideline) that the counsellor should preferably be a post graduate in Psychology, Masters in Social Work (MSW) or Graduate with minimum two years experience in counselling or working with HRGs.

## Roles and Responsibilities

In an IDU TI, the counsellor is primarily and directly responsible for an individual client's counselling.

The counsellor is expected to perform the following roles:

- ◆ Counsel IDU clients primarily at the DIC
- ◆ Carry out a baseline assessment of an individual client, with emphasis on the psycho-social aspects of the client's functioning
- ◆ Provide different forms of counselling including motivational counselling, family counselling, group counselling
- ◆ Referrals for STIs, ICTC and other relevant services
- ◆ Ensuring that the client is screened for STIs, and general medical conditions
- ◆ Provide counselling to PLHIV
- ◆ Train the outreach staff on basic issues related to counselling of IDUs in the field
- ◆ Accompany the outreach staff in the field and provide group/individual counselling as required
- ◆ Carry out home visits, as and when required
- ◆ Link the spouses and family members of the IDU clients to the IDU TI programme
- ◆ Counsel the spouses and family members of IDU clients
- ◆ Assist the programme manager in conducting advocacy and networking
- ◆ Link up with the services/service providers in the vicinity for vocational training, night shelter, detoxification and rehabilitation centres, etc.
- ◆ Maintain records as required by the SACS and NACO
- ◆ Participate in the weekly staff meetings at DIC
- ◆ Participate in the training programmes organised for improvement of one's knowledge and skills.

The counsellor is expected to work under the guidance of the programme manager and the project director of the NGO.

## Basics of Counselling

The term "counselling" can be understood as a process in which a trained person (the counsellor) collects relevant information from the person who is seeking help (the client), and accordingly gives suggestions and professional guidance in a formal setting.

The TI counsellor is expected to have skills to make the client (and their family) comfortable so as to facilitate change in a positive direction.

The first important step in counselling is establishing a therapeutic relationship between the counsellor and client. Unless the client is able to trust the counsellor and is ready to work with the counsellor, any technique, however sound, can be unsuccessful.

The initial session is very important for building rapport. Some of the important points for an effective counselling are:

- ◆ The room where counselling would be held should be well-lit, comfortable and allow for privacy
- ◆ When the client comes into the room, it is important to use culturally appropriate greeting gestures and the client should be addressed by his name
- ◆ The counsellor should be aware of one's own non-verbal body language (Speech, Eye-to-eye contact, Posture, Gestures used, and Pauses) and specifically the tone of voice while counselling
- ◆ The client should be assured that all information in the counselling will be kept confidential. The confidentiality will only be breached if there is an imminent threat to the life of the client or to those around him/her. The confidentiality will be breached with prior information to the client
- ◆ Counselling is a two-way process and the client should be told that he/she is equally responsible for change in behaviour
- ◆ The counsellor should clearly articulate the “dos and don'ts” in the counselling session. The limit-setting should be done in a polite and firm manner. Example: Client cannot come to the session in an intoxicated state.

### **ATTENDING BEHAVIOUR OF THE COUNSELLOR**

**S:** Face the other **S**quarely

**H:** **H**ead nods

**O:** Adopt an **O**pen Posture

**V:** **V**erbal Following

**E:** **S**peech

**L:** **L**ean toward the other

**E:** Make **E**ye Contact

**R:** Be **R**elatively **R**elaxed

Once the counsellor has gained the client's trust, eliciting information becomes easier. Using the skills mentioned below, the counsellor can take case-history as well as help the client.

During the counselling sessions, the counsellor can make use of either open-ended or closed ended questions as and when applicable, but the focus should be on asking

open-ended questions. Each type has its own advantages and disadvantages, and the choice of use depends upon the kind of information required by the counsellor. Closed-ended style of questioning can be used when the counsellor wants specific information (for e.g. - when was the last time the client used injections and where did they get money from). Open-ended style of questioning can be asked when the counsellor wants to explore client's thoughts and emotions or more details about a particular situation.

**Examples of Closed-ended Questions:**

Do you think you have a problem?

Are you feeling disheartened?

**Examples of Open-ended Questions:**

What makes you think you have a problem?

How do you feel right now?

## Characteristics of an Effective Counsellor

The counsellor needs to be:

- ◆ Non-judgmental
- ◆ Genuine
- ◆ Calm and supportive
- ◆ Self-aware
- ◆ Objective.

## Counselling Skills

Counselling involves:

- ◆ An understanding of the client's problems
- ◆ Communicating that understanding back to the client
- ◆ Clearing ambivalences, and
- ◆ Exploring and planning for positive change with the client

All these goals require the use of counselling skills and techniques. Each of these skills requires regular practising and polishing.

- ◆ **Active Listening:** The counsellor needs to learn to listen to not just what the client says, but also what he “does not say”, which involves the use of actively and consciously listening to what the client is saying while minimising intrusion of one's own thoughts and biases.

For example:

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

Counsellor: *Hmmm... ok.*

- ◆ **Paraphrasing:** It involves summarising what the client has said using similar words used by the client. This is used when the counsellor wants to communicate his/her understanding back to the client.

For example:

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

Counsellor: *It sounds like that you don't know why your family has bought you here because as per what you think, you don't have any problem.*

- ◆ **Reflection:** This involves communicating to the client that the counsellor understands and acknowledges his underlying feelings. The counsellor uses his/her own words to communicate this understanding.

For example:

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

Counsellor (taking cues from body-language): *You seem irritated and angry with your family members for bringing you here forcibly.*

- ◆ **Clarification:** This is used to seek more information or clear some doubts regarding what the client has said or what the client means.

For example:

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

Counsellor: *I did not get it. Please elaborate on how does not liking your wife is related to you 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.*

- ◆ **Confrontation:** Sometimes, the client may give misleading information. In such a scenario, this technique can be used to confront him so as to promote self-understanding and push the client towards constructive change. However, the technique should be used sparingly and only when really necessary.

- ◆ **Probing:** The counsellor can use this technique to help the client explore his thoughts and emotions in greater depths.

For example:

*Client: I tried to leave injections and even succeeded for 5-6 days but then I again started using it.*

*Counsellor: What happened? **What** made you go back to the injections?*

*Client: I was passing from the market and I saw my friends using it. I could not control my craving and used it again. Once I used it, then I could not stop.*

*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 it.*

- ◆ **Silence:** In certain situations, the counsellor should maintain silence. This is used in situations in which the client is trying to understand his own behaviour and when the client wants to ventilate.

For example:

*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: hmmm... (Silence).*

*Client: I guess when that craving to use injections 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:** When the client gives discrepant information with respect to his speech and actions, the counsellor needs to interpret what the client has “not said”. The counsellor needs to be empathic, firm yet gentle in interpreting the client’s responses.

For example:

*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. Am I right?*

- ◆ **Empathic response:** It is a response which indicates that the counsellor understands the client's problem from his, that is the client's perspective. It involves both verbal as well as non-verbal communication of that understanding. The counsellor should remember the important difference between 'sympathy' (feeling sorry or distress for others) and 'empathy' (Putting oneself in "the other person's shoes" and understanding the situation).

For Example:

*Client: I feel so miserable... such a failure. I sometimes get confused 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 indicate that you are making efforts to leave, but still it is hard to change that makes you feel confused.*

- ◆ **Self-disclosure:** Sometimes, the counsellor can disclose some information about himself/herself which she thinks may help in the therapeutic process.

For example:

*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.*

- ◆ **Identifying alternatives:** This technique helps the client to explore alternatives after leaving drugs.

For example:

*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: Hmmm... 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 third option can be to bring your friends for treatment too.*

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

It is important for the counsellors to remember that counselling is not a one-time activity but a process which goes on every time the client comes to seek help.

## Burnout Issues in Counselling

In an effort to resolve the conflicts of the clients or meeting their needs, the counsellor may face a lot of mental stress. Excessive and prolonged stress can lead to a state of emotional, mental and physical exhaustion known as Burnout.

### Signs/symptoms of Burnout

Physical Symptoms	Psychological/Emotional Symptoms	Behavioural Symptoms
<ul style="list-style-type: none"> <li>▪ Aches and pains</li> <li>▪ Frequent stomach upsets/diarrhoea</li> <li>▪ Chronic feeling of tiredness</li> <li>▪ Sleep disturbances</li> <li>▪ Loss of weight</li> <li>▪ Disturbances in appetite</li> </ul>	<ul style="list-style-type: none"> <li>▪ Anger and frustration</li> <li>▪ Low self-confidence</li> <li>▪ Loss of interest in work; failure to carry out day-to-day responsibilities</li> <li>▪ Feeling of inadequacy</li> <li>▪ Anxiety/apprehension</li> <li>▪ Frequent mood changes</li> <li>▪ Feeling of being a failure</li> <li>▪ Constant worry about the future</li> <li>▪ Decreased concentration</li> </ul>	<ul style="list-style-type: none"> <li>▪ Emotional outbursts</li> <li>▪ Social withdrawal</li> <li>▪ Neglect of responsibility</li> <li>▪ Continual/increasing use of alcohol/other substances</li> <li>▪ Decrease in activity level</li> <li>▪ Difficulty in communicating with others</li> </ul>

### How Burnout Develops

Burnout is a gradual process which happens over an extended period of time. Initially, the symptoms may be mild and occur occasionally. If the counsellor is self-aware and pays attention to the early signs, then a major breakdown can be prevented. However, as the symptoms get worse, the counsellor may develop a full blown burnout syndrome where professional help would be required to deal with it.

**Stage 1:** When the counsellor starts work initially, there is positive outlook and initial optimism that anything is possible alongwith a zeal to help the client.

**Stage 2:** As days progress, the counsellor may realise that some expectations were unrealistic. This revelation along with work-load and type of clientele may lead the counsellor to feel stressed off and on.

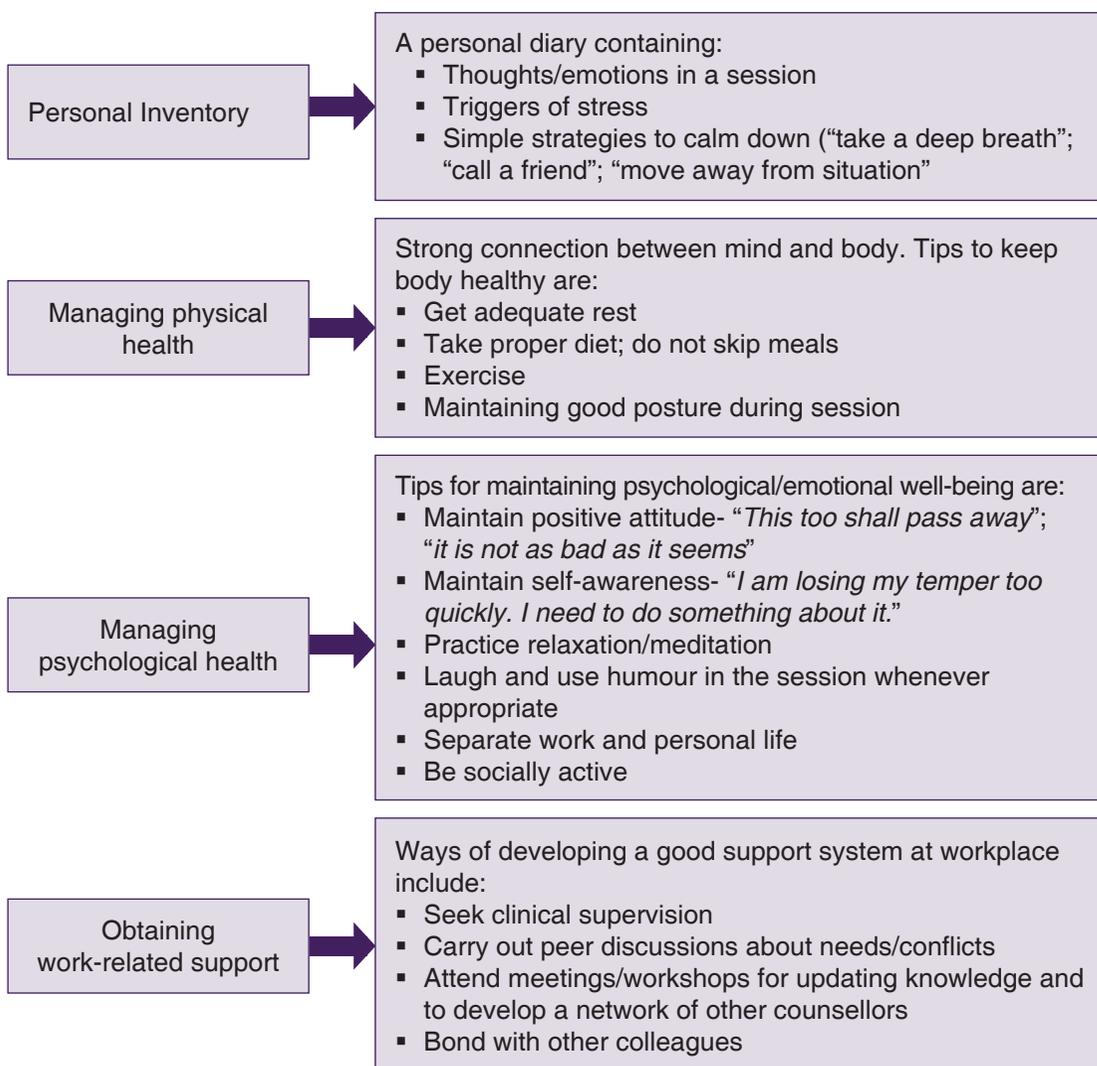
**Stage 3:** If the counsellor continues, without taking help from peers/supervisors, the stress may increase and the counsellor feeling physically and mentally exhausted and irritable more often than not.

**Stage 4:** Development of Burnout syndrome.

## Reasons for Burnout

Work-related	Lifestyle-related	Personality-related
<ul style="list-style-type: none"> <li>▪ Too much work-load</li> <li>▪ Not getting enough recognition for work done</li> <li>▪ Type of clients</li> <li>▪ Little control over the outcome</li> <li>▪ Less opportunity for promotion/advancement</li> </ul>	<ul style="list-style-type: none"> <li>▪ Working overtime</li> <li>▪ Role conflicts and demands</li> <li>▪ Too many responsibilities and less social support</li> <li>▪ Lack of close &amp; supportive relationships</li> </ul>	<ul style="list-style-type: none"> <li>▪ Perfectionism</li> <li>▪ Need to control</li> <li>▪ Personalisation Difficulty asking for help</li> <li>▪ Not being able to express emotions/feelings</li> <li>▪ Inability to say NO</li> <li>▪ Difficulty with delegating responsibility</li> </ul>

## Prevention of Burnout



## Coping with Burnout

Once the burnout syndrome develops, usually professional help is required. The counsellor can take the following steps to cope with the burnout syndrome.

- ◆ **Slow Down:** Cut down commitments, take time out to reflect and heal
- ◆ **Get support:** Seek support from friends, colleagues, supervisor and family. Ventilation can help in calming down and finding alternatives to problems
- ◆ **Re-evaluate goals and priorities:** Reflect upon what is important and re-prioritize. It would help in understanding what has been lacking in life and the counselor can work towards achieving the same.



## Section III

# IDU COUNSELLING: PRACTICAL TIPS

## Assessment and Diagnosis

### General Considerations

- ◆ Assessment is basically getting an understanding of the client's problem in order to help the client to overcome the problem
- ◆ Utility of an assessment are manifold:
  - Building a rapport with the IDU client
  - Diagnosing the client's problem
  - Measuring the extent of problems faced by the IDU
  - Planning appropriate management
  - Motivating the client to seek help
  - Planning referrals
- ◆ Assessment is not a one-time task, but has to be conducted periodically, both to revisit the information as well as assessing the client's progress
- ◆ For successful assessment:
  - Establish rapport
  - Have a non-judgemental attitude
  - Communicate effectively
  - Listen patiently
  - Ensure confidentiality of the information provided by the client
  - Inform client on the benefits of assessment
  - Ensure that the client is neither intoxicated nor in withdrawals during assessment

### Carrying Out Assessment:

- ◆ Greet the client appropriately
- ◆ Initiate small talk to make the client feel comfortable

- ◆ Make the client understand the benefits of assessment and the procedure to be followed for assessment
- ◆ Begin by asking the client's background information: name, age, sex, marital status, current living status, educational status, and place of residence
- ◆ Details of drug use:
  - Type of drug used
  - Frequency and amount of drug being used
  - Mode of use of drugs
  - Last dose used
- ◆ Complications associated with drug use: Physical, Psychological, Legal, Marital, Familial, Social, Occupational and Financial
- ◆ High risk behaviour: Injection-related and sex-related
- ◆ HIV-related knowledge, attitude & belief
- ◆ History of referrals sought till now, with results of the referrals
- ◆ History of medical and mental illness
- ◆ Family history of drug use and mental illness
- ◆ Motivational level
- ◆ Physical examination (*to be performed by the doctor*)

## Diagnosis

- ◆ Diagnosis involves:
  - Diagnosis of the drug-related problem
  - Diagnosis of the concomitant physical and mental problems, if any
- ◆ Diagnosis of **dependence** – three or more of the following criteria:
  - Tolerance: consuming more amounts of the drug to have the same amount of high/relieve withdrawals
  - Withdrawal: physical and psychological symptoms upon stopping/not getting the drug
  - Craving: irresistible desire to take drugs
  - Continued intake despite of harms to the body or mind
  - Increased time spent on drugs
  - Stopping other activities and preferring the drugs over other activities
- ◆ Diagnosis of **harmful use** – repeated drug use leading to
  - Evidence of Physical harm
  - Evidence of psychological harm
  - Continued use despite either or both of the above harms

# Counselling: Injection Related Risk

## General Considerations

- ◆ An IDU faces multiple risks at various stages: procurement of drug, obtaining money to procure drug, drug intake, coming out of the effect of drug, during withdrawal stage
- ◆ IDUs face risk because of the following reasons:
  - Lack of knowledge related to injecting
  - Lack of adequate time for injecting
  - Injecting in hazardous places
  - Non-availability of injectable drugs
  - Non-availability of adequate needles/syringes
  - Non-availability of cleaning materials prior to injecting
  - Non-availability of veins for injecting
- ◆ Risks of injecting: local and systemic infections, loss of veins, scarring of tissues, septicaemia, arterial injection, injection of internal organs, overdose
- ◆ Carry out an assessment specifically on injection-related knowledge & current injection-related practices followed by client
  - Conduct interview in closed settings
  - Make the client comfortable
  - Ask open-ended questions
  - Provide feedback to the client – summarise the important points brought out in the assessment
  - Emphasise and praise the safe/correct techniques used by the client for injecting
  - Use examples from the client's injecting practice during the counselling to improve the client's injecting practices
  - Tailor the counselling sessions depending on the client's risky practices; Do not conduct the session like a tape-recorder playing the same song again and again

## Injection-related Risk Reduction Counselling

- ◆ Counselling depends on the motivation level of the client
- ◆ For a client who is **not able to stop sharing**, provide the following advice:
  - Ask the client to carry a fresh needle/syringe every time to be ready for a scenario when he may have to inject without access to one
  - Cleaning used needles/syringes by any method does not guarantee 100% protection against infections, including HIV
  - Bleach is the best disinfectant to be used for cleaning; however, it too does not provide 100% protection

Recommended method to clean needles/syringes	Points to remember during cleaning
<ul style="list-style-type: none"> <li>▪ Pour bleach into one cup or bottle and water into another</li> <li>▪ Draw up freshly prepared bleach solution into dirty needle and syringe</li> <li>▪ Expel bleach away (not back into the cup or bottle)</li> <li>▪ Repeat steps 2 and 3</li> <li>▪ To remove the bleach, draw up cold water into the needle and syringe</li> <li>▪ Expel water down the sink</li> <li>▪ Repeat steps 5 and 6 two or three times</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bleaching previously used equipment should only be a last resort option</li> <li>▪ Clean equipment both before and after use</li> <li>▪ Boiling plastic syringes melts them</li> <li>▪ Cold water is recommended as warm water may encourage blood to coagulate and hence will be harder to expel through the needle</li> <li>▪ Diluted and old bleach can lose its effectiveness</li> <li>▪ Using new/clean injecting equipment is the safest option</li> </ul>

- ◆ For a client who is **not able to stop injections**, teach/counsel the client on the following:
  - Discuss the possibilities of sharing injecting equipments during injecting episodes, however well prepared the client is for such an episode
  - Regular use of new needle/syringes from an NSEP TI programme
  - Education on the need to return used needles and syringes
  - Education on safe injecting techniques
  - Education on overdose prevention and management
  - Refer to OST programme, if available in the vicinity, and if the client is ready to stop injections, including illicit opioids, but is unable to do so.

### Safer Injecting Techniques - Before Injecting

The client should be given the following advice:

- Choose a safe and clean environment for injecting, so that you can be relaxed
- Do not inject alone; inject in the presence of other peers, so that help is available, if something goes wrong
- Keep the immediate surroundings clean: use a clean paper to lay down the injecting equipments to avoid infections
- Choose the smallest bore needle as possible
- Dissolve brown sugar with acidifiers (such as vitamin c tablets, etc.) to increase their dissolvability; otherwise insoluble particles will enter the body
- Use sterile water always, if possible; if not, use cooled freshly boiled water
- Do not heat the drug too much, if being boiled
- Do not touch the metal cap/spoon used for heating with needle tip

## Safer Injecting Techniques - During & After Injecting

### *During injecting*

- Prefer intravenous to subcutaneous route for injecting
- Clean the area before injecting: best way is with plenty of soap and water; if not possible, use alcohol swabs
- Best site for injecting: veins on the front of the elbow joint
- Certain veins should be avoided for injecting (e.g. groin, neck, breast, head, penis, hands & legs)
- Differentiate an artery from a vein
- Inject with needle at 45 degree angle
- Administer the drug slowly
- Do not repeatedly push the blood down and draw it back into the syringe

### *After injecting*

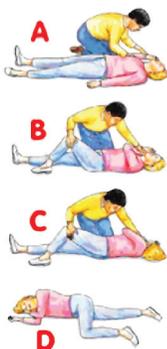
- Slowly remove the needle from the vein
- Immediately apply pressure after removal of needle with dry cotton swab
- Safely dispose off the used needles and syringes after use
- Rotate sites for injecting – do not use the same site

## Counselling for Opioid Overdose Prevention

Provide the following advice to the client

- ◆ Know the following **risk factors** about overdose:
  - Periods of abstinence (as few as 3 days) from drugs
  - Change in purity of street heroin
  - Ill health
  - Recent infections
  - Mixing different drugs for injections
- ◆ Take a small dose first before taking a full dose to test the purity of the sample
- ◆ Take injections in the presence of someone else, so that help is readily available
- ◆ Overdose symptoms appear and progress gradually (over 1 – 2 hours), so there is enough time for your peers to help
- ◆ The common symptoms of opiate overdose are: decreased consciousness, pale skin, slow pulse, shallow breathing, bluish discoloration of fingernails, vomiting, choking, small pupils
- ◆ Call emergency, if someone in your group develops symptoms of overdose

- ◆ Till the ambulance comes, provide first aid for overdose:
  - Breathing mouth to mouth
  - Put the overdosed client in 'Recovery position'.



## Counselling: Sex Related Risks

### Counselling for Sexual Risk Reduction

1. The first step of sexual health counselling is **sexual risk assessment**. More than one session may be required to complete the assessment. The following questions need to be asked during this assessment:
  - ◆ 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

2. Steps to be followed in the **sexual risk reduction counselling:**

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

3. During **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
- ◆ Help redesign strategy with the client
- ◆ Discuss potential barriers and possible supports
- ◆ Motivate to seek Counselling & Testing for HIV on voluntary basis
- ◆ Agree on a final strategy and timeline
- ◆ Endorse a follow up plan.

## STI Counselling

1. The first step is **motivation for screening:**

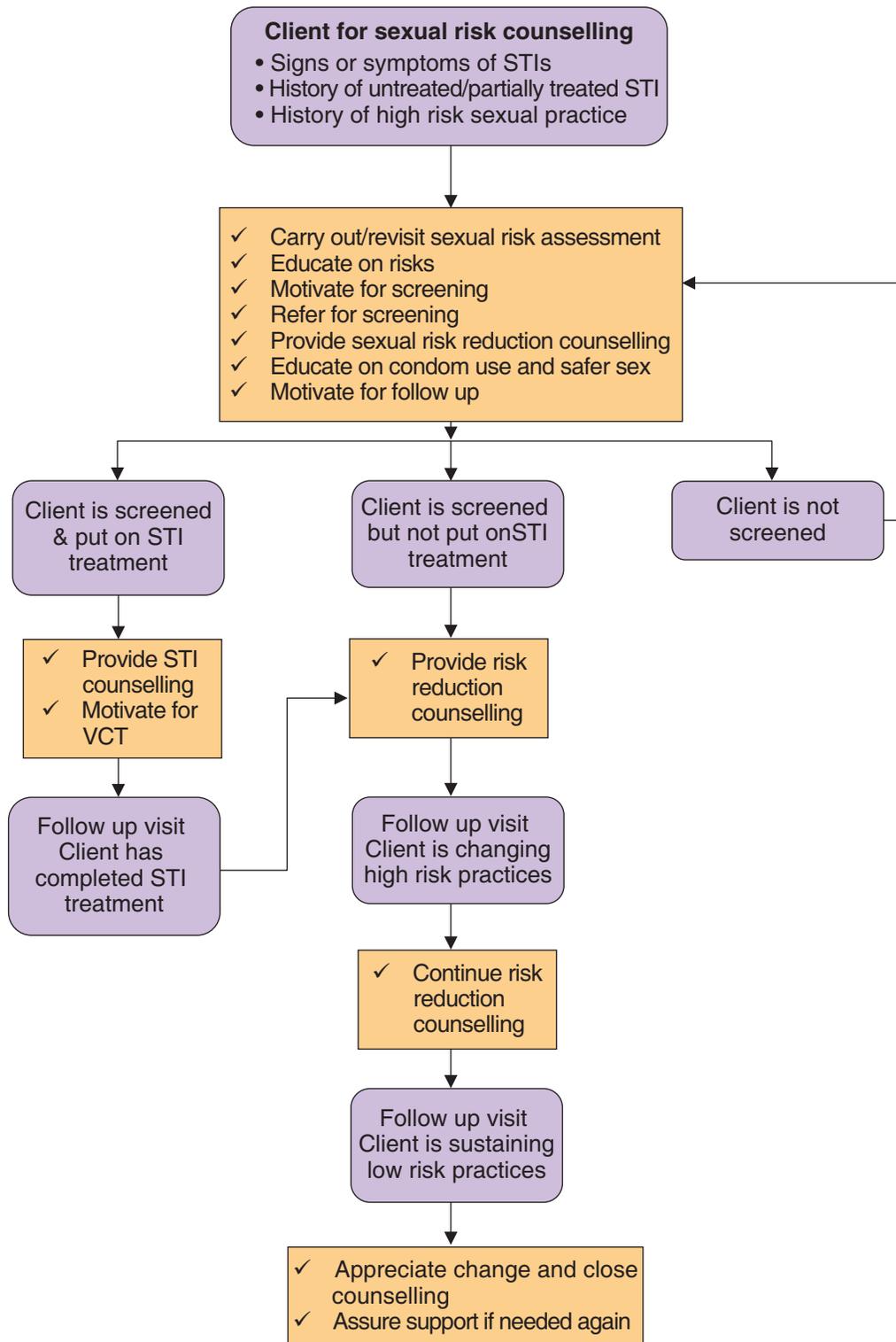
- ◆ Share the level of risk of the client based on his/her sexual practices
- ◆ Educate client on STIs (making use of the signs and symptoms reported by the client, if the client has reported them), their complications, both present and future

- ◆ Educate the client on the need for screening
  - ◆ Motivate for undergoing screening by helping the client to evaluate the pros and cons of seeking treatment
  - ◆ Refer for STI screening
  - ◆ Endorse a follow up plan
2. If the client is **identified as infected**, further counselling will be needed on STIs and their treatment as follows:
- ◆ 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 treatment regimen
  - ◆ 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 (e.g. metronidazole) 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

### Counselling for Condom Promotion

- ◆ Assess current safe sex practices and condom use
- ◆ Review client's knowledge about and attitude towards condom use
- ◆ Explain the need for correct and consistent use of condoms as a part of treatment of STI and protection from STI, HIV, Hep-B & C infections and unwanted pregnancy
- ◆ Educate on correct use of condom through demonstration using penis and vagina models
- ◆ Inform the client about where all condoms are available
- ◆ Address client's concerns regarding condom use
- ◆ Discuss and plan how client will introduce condom in to sexual relationships – either regular or occasional or paid

## Flow Chart of Sexual Risk Reduction Counselling



## Counselling: HIV Related Issues

1. The first step to HIV counselling is **HIV risk assessment**
  - ◆ This can be done using the High Risk Behaviour Scale (HRBS). The scale is provided at the end of the chapter (as Appendix A)
  - ◆ Additionally, Individual Risk Assessment Activity Worksheet prepared by NACO is also used in assessment (provided as Appendix B)
2. **Pre test counselling:** When recommending HIV testing adopt the following steps:
  - ◆ Provide reasons for recommending the test (symptoms or history of risk behaviour)
  - ◆ Discuss the advantages (access to ART and related services) and disadvantages (risk of discrimination and abandonment) of testing
  - ◆ Inform about services available for both positive and negative results
  - ◆ Inform on confidentiality of the test results
  - ◆ Share that test is only voluntary and the client has the right to decline; declining test will not affect access to other services
  - ◆ In case of positive results, disclosure to intimate partners and contacts may be encouraged
  - ◆ Importance of not engaging in high risk activities before the test should be highlighted
  - ◆ It should be explained to the clients that the test is only for HIV and does not screen for other infections related to injecting (hepatitis B, C or syphilis)
3. **Post-test counselling:** In case the result is negative, the following steps are to be taken:
  - ◆ Explain the result and its significance to the client
  - ◆ Educate client on
    - Window period and a recommendation for retest in case of recent exposure
    - Prevention of HIV transmission, especially based on the high risk practices of the client
    - Risk reduction (safer injecting and safer sex including condom use)
  - ◆ Motivate client for drug treatment services especially OST where available
  - ◆ Inform about provision for condoms and sterile needles and syringes
  - ◆ Endorse plan for follow up with defined time for re-test, if needed

The counsellor, in discussion with the client, should assess the need for further services, especially for risk reduction.

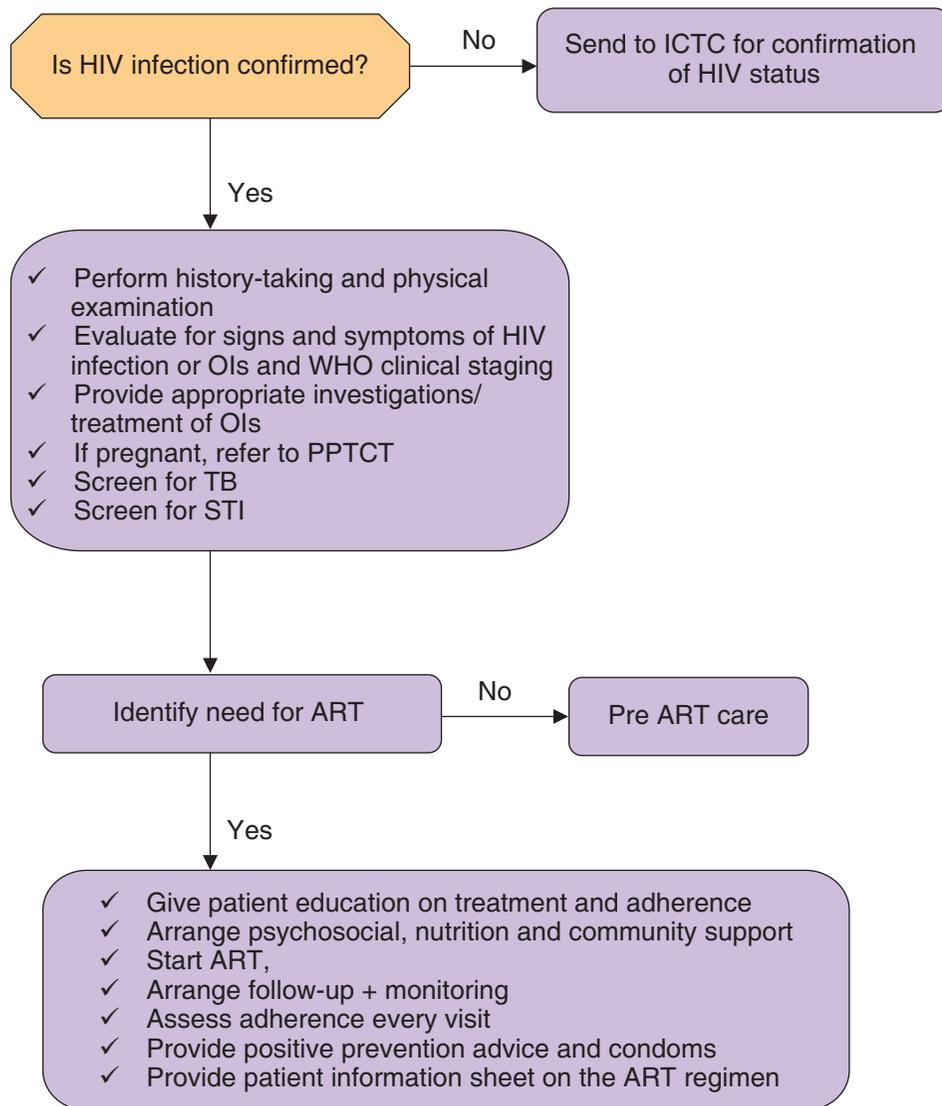
4. In case, the **result is positive:**

- ◆ Explain the significance of the result fully
- ◆ Assist client in coping with the stress and emotions of the result
- ◆ Discuss immediate concerns of the client and their implications
- ◆ Discuss available social support so that the client may seek immediate assistance there from
- ◆ Explain treatment and refer to ART centre
- ◆ Educate on
  - need for preventing onward transmission, re-infection and infection from newer strains of HIV and prevention of transmission to others
  - prevention of common infections
  - services available, their accessibility and their advantages
- ◆ Explore disclosure of results, especially to the intimate partners (when, how and to whom)
- ◆ Motivate for testing and counselling of intimate partners and children
- ◆ Advise on other investigations (like liver function, hepatitis B and C, pregnancy, TB) that may be required
- ◆ Advise on referrals to treatment, care, counselling, support and other services, as required (e.g. screening for 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 the possible measures to ensure the physical safety of clients, particularly women diagnosed HIV-positive

5. Disclosure of **positive HIV test result to partner/s**

- ◆ Discuss advantages and disadvantages of disclosure
- ◆ Encourage disclosure to intimate partners
- ◆ If willing to disclose, prepare the client for the same (whom, when and how, how to manage consequences) and offer support
- ◆ In case the client does not agree to voluntarily share the HIV status with the spouse/partner, ensure the following protocol for partner notification:
  - Client is thoroughly counselled on the need for partner notification and encouraged to voluntarily inform the partner or bring the partner to the ICTC for joint counselling
  - Client is given advance notice of the intention to notify
  - Post-notification follow-up counselling, information and support are provided to the partner and the HIV-positive person to prevent violence, family disruption, etc.

## Assessment and Management of HIV-infected Persons



*Adapted from Antiretroviral Therapy Guidelines for HIV-Infected Adults and Adolescents Including Post-exposure Prophylaxis – NACO, Ministry of Health and Family Welfare, Government of India*

### 6. Pre-ART phase:

- ◆ Educate client on
  - The treatment aspects and allied services available
  - The need for these services and their accessibility at ART/ICT centres
  - The need for regular check-ups and follow-ups

- The ART medication and need for adherence
- The issues related to continued drug use and their implications in HIV treatment
- ◆ Motivate for
  - Family screening and testing (if not done already)
  - Seeking drug treatment services (OST, if available, detoxification, etc. as required)
  - Registering in the NACO-designated ART clinics for pre-ART registration for continued services

## 7. Counselling IDUs for ART

- ◆ Address specific factors that may affect the timing of initiation and the choice of ART (CD4 counts, social instability, active use of illicit drugs and the presence of co-morbidities, such as mental problems and co-infection with hepatitis viruses)
- ◆ Inform client on need for appropriate treatment prior to initiation
- ◆ Refer for appropriate treatment and requisite services
- ◆ Prepare client for ART
- ◆ Help client understand the treatment goals, need for adherence and lifelong nature of ART
- ◆ Help client solve problems to ensure adherence
- ◆ Implications of drug use on ART
- ◆ Drug use and adherence- may need support to adhere due to the psychological issues of drugs

## Counselling: Physical Co-morbidity

### A. Tuberculosis

- ◆ TB is caused by bacteria, which cannot be seen by the naked eye
- ◆ TB usually affects lungs (pulmonary TB), but it can affect any body system also (extra pulmonary TB)
- ◆ TB spreads through droplets of saliva or mucus from an infected person in air
- ◆ A person whose immunity is lowered will get infected and manifest the disease
- ◆ The prevalence of TB is higher among IDUs due to a number of reasons – poverty, homelessness, poor living conditions, low immunity, poor nutrition, high HIV prevalence
- ◆ Early symptoms of TB may be mistaken for other conditions associated with IDU. Hence, during every follow up, symptoms of TB must be actively enquired
- ◆ The counsellor should ensure that a baseline screening must be conducted by the doctor
- ◆ Every client must be educated on the signs and symptoms of TB
- ◆ Clients presenting with signs and symptoms of TB must be referred to the nearby TB diagnostic centre

- ◆ For those clients who are diagnosed with TB and are on DOTS, the necessity of regular adherence to anti-TB medications must be emphasised by the counsellor.

## B. Hepatitis C

### General Considerations

- ◆ Hepatitis is inflammation of liver, which is a vital organ of the body
- ◆ Hepatitis C is one of the five viruses causing hepatitis – A, B, C, D & E
  - Hepatitis A & E are transmitted by eating unhygienic food
  - Hepatitis B & C are transmitted by injecting and sexual route
  - Hepatitis D occurs only along with Hepatitis B infection.
- ◆ Mode of spread of Hepatitis C:
  - More commonly through injecting route or through transfusion of infected blood/blood products; not only needle syringes, but sharing other equipments used for injections (e.g. water, cooker, tourniquet) can also spread Hepatitis C infection
  - From mother to baby
  - Chances of transmission through sexual route is low, though possibility exists.
- ◆ Soon after infection
  - Some individuals experience symptoms of ‘acute hepatitis’
  - In 25% of the infected individuals, the virus is cleared from the body without medical interventions
- ◆ Remaining 75% will have chronic hepatitis. Among those with chronic hepatitis:
  - 45% do not develop liver damage, 30–40% develop mild liver damage, 10–20% develop cirrhosis (liver scarring with uneven growth) and 1–5% will develop liver failure or cancer
- ◆ Not everybody requires treatment for hepatitis C; currently treatment is very costly in India and the success rate is about 30–40%
- ◆ The prevalence of hepatitis C among IDUs is very high. In some parts of India, the prevalence is >80%.

### Counselling Points

- ◆ Educate each and every client on how Hepatitis C spreads, and the ways/ means of preventing Hepatitis C
- ◆ Repeat the advice provided in the session on ‘safe injecting’
- ◆ Instil hope and confidence in the client that every case of Hepatitis C is not fatal
- ◆ Educate that alcohol will aggravate the liver damage. Hence, alcohol **should be avoided**
- ◆ There are no special dietary requirements, however fat intake can be minimised in case of chronic hepatitis.

## Counselling: Psychiatric Co-morbidity

- ◆ If the client presents with some of the following signs and symptoms of mental illness, check for the presence of other signs and symptoms of the particular illness also

### Symptoms of depression

Presence of the following symptoms continuously for more than two weeks, leading to difficulty in work or personal suffering incurred:

- Sadness of mood
- Decreased energy
- Increased tiredness/fatigue
- Loss of interest in pleasure
- Reduced concentration
- Decreased confidence
- Reduced self-esteem
- Disturbed sleep
- Loss of appetite
- Feelings of guilt
- Feelings of hopelessness / helplessness /worthlessness
- Wishes to die/suicidal ideas or attempts

### Symptoms of Psychosis

- Delusions\*
- Hallucinations<sup>0</sup>
- Thought disorder
- Inappropriate behaviour
- Negative symptoms<sup>#</sup>

### Symptoms of anxiety disorder

- Anxiety: irrational fear
- Excessive, unrealistic worrying
- Trembling
- Churning stomach
- 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

Anxiety disorder can be of the following types:

- Specific phobia
- Social phobia
- Panic disorder
- Obsessive compulsive disorder
- Generalised anxiety disorder

\* **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 negative sense (referential delusions), of having superlative powers and worth (grandiose delusions).

<sup>0</sup> **Hallucinations:** are sensory perceptions without any stimulus. This includes that for hearing (a person hearing, when in reality no sounds are being produced), smell, touch, seeing, etc. The most common type of hallucinations are auditory hallucinations, in which the patient hears voices talking to him or about him in a derogatory manner.

<sup>#</sup> **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 affect), not speaking even when required to do so, loss of feelings, loss of goals in life, not taking initiatives in life, etc.

- ◆ A standard assessment scale (e.g. DASS 21 item scale, added in Appendix C) can be used for assessment
- ◆ In case of doubt that the client may be suffering from any mental illness, the client should be referred to a psychiatrist for further help
- ◆ Educate the client that:
  - Most of the common mental illnesses are treatable
  - Having a mental illness does not mean that the client has some character defect/weak will power
  - Instil hope regarding the outcome of the mental illness, especially depressive and anxiety disorder
- ◆ Reinforce the risk reduction messages, and forewarn the client that he/she may feel like indulging in high risk behaviour to improve his/her condition or to attempt suicide
- ◆ Inform the family members about the possibility of the client overdosing himself to commit suicide
- ◆ Seek family members' support during the crisis period

## Detoxification

### General Points

- ◆ When a person becomes dependent on the drug that he/she takes, he develops 'withdrawal' – physical and psychological symptoms on stopping the drug

#### **Alcohol withdrawal symptoms**

- Anxiety or nervousness
- Irritability
- Nightmares
- 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
- Delirium tremens -- a state of severe confusion and visual hallucinations
- Fever
- Seizures

#### **Opioid Withdrawal Symptoms**

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

- ◆ The withdrawal symptoms, their intensity, start time and end time differ according to the type of drugs on which the person is dependent
- ◆ The severity of withdrawal symptoms for the same dependent drug will differ from one person to another depending on the physical status, presence of other illnesses, and psychological status
- ◆ Withdrawals from some drugs, especially alcohol and other sedative hypnotic medicines may result in death in some cases
- ◆ Withdrawal from opioids rarely results in death

**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 an aim of stopping drugs altogether either for a short period of time or for forever (complete abstinence).

### Counselling Points for Preparing a Client for Detoxification

- ◆ Understand the factors leading the client to undergo detoxification
- ◆ Assess the motivation level of the client to undergo detoxification
- ◆ Educate the clients on the expectations regarding detoxification:
  - detoxification is the first step towards living a life without drugs
  - treatment should continue beyond detoxification also
  - more effort is required to continue to stay away from drugs than stopping drugs itself.
- ◆ Explain the administrative issues followed in the centre where the client will undergo detoxification procedure
- ◆ Caution the client on the risks of overdose, in case of resumption of drugs after detoxification
- ◆ Offer continuation of services even after the client relapses after detoxification.

## Motivation Enhancement

### General Considerations

- ◆ Motivation is a very important aspect of any kind of behaviour change
- ◆ Motivation is dynamic, keeps changing
- ◆ The change in desired direction can be brought about by a social or professional interaction (such as an interaction between an IDU client and a counsellor)
- ◆ For achieving any kind of behaviour change, an individual needs to pass through certain stages:

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 he 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.

### Motivation enhancement: strategies

- ◆ **Feedback:** involves giving feedback to the client regarding the ACTUAL negative consequences the client has faced in the past due to his behaviour
- ◆ **Decision balancing:** the client is helped to compare ('weigh') two different situations – the benefits of change vis-à-vis benefits of staying the same and compare it with cost of staying the same vis-à-vis cost of change. In other words, help the client to compare pros and cons of changing and not changing the behaviour and arrive at a decision
- ◆ **Developing discrepancy:** 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, 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 that he does not change his behaviour
- ◆ **Supporting self-efficacy:** 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.

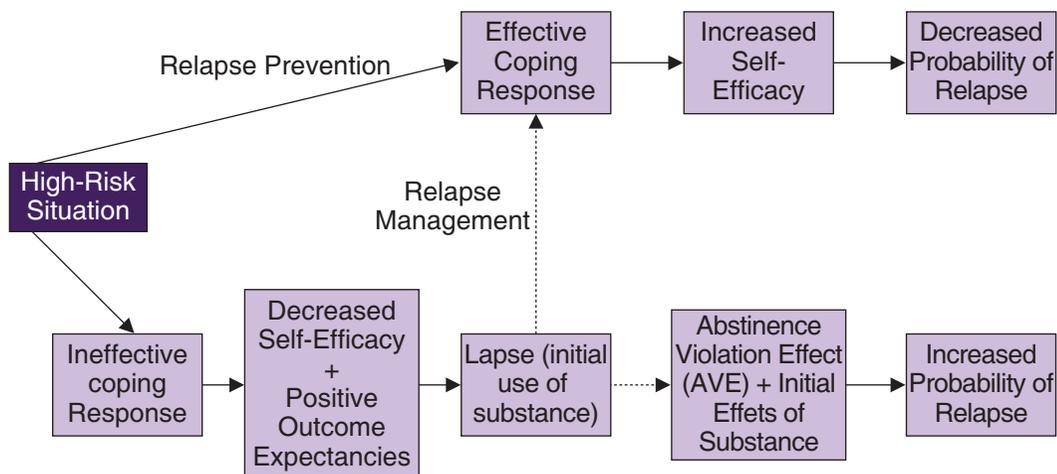
### Caution

- Do not lose heart if the client appears non-motivated. Since motivation is dynamic, at a later date the client may be more receptive to the counselling.
- Do not force the client to see things from your perspective.
- Accept that the counsellor cannot be responsible for bringing positive changes in each and every client's behaviour.

## Relapse Prevention Strategies

### General Considerations

- ◆ Drug use is characterised by relapses and remissions
- ◆ Lapse – first episode of drug intake, after a period of stopping drugs
- ◆ Relapse – resumption of previous pattern of drug use (e.g. taking it regularly, neglect of other areas of work, etc.)
- ◆ Factors governing initial lapse upon presentation of a high risk situation are:
  - Coping mechanism: how does the client deal with the risky situation
  - Outcome expectancy with regard to drug use: what does the client expects to happen after drug use? (for instance, “oh! If I take it just once, it will not be harmful”)
  - Self efficacy: the confidence the client has in his own ability to stay away from lure of drugs.
- ◆ Factors governing progression from lapse to relapse are:
  - Exposure to high risk situations
  - Initial experience with drug during lapse episode
  - Abstinence violation effect: negative emotions a client experiences after a lapse. For instance, “oh, what have I done. My parents were right. Once a drug user, always a drug user. I can never remain drug free.”



## Relapse Prevention Therapy: Steps

- ◆ **Assessment** of possibility of exposure to high risk situations and coping skills. The possible high risk situations are:
  - Dealing with negative emotional states
  - Dealing with negative physical states
  - Dealing with positive emotional states
  - Giving in to craving/temptations
  - Wanting to test one's control
  - Dealing with interpersonal conflict (with spouse, family, colleagues)
  - Influence of other person/s to use drugs (peer pressure)
- ◆ Teach clients how to handle high risk situations

### HANDLING HIGH RISK SITUATIONS

- Listing out the high risk situations likely to be encountered
- Avoidance of the situation
- Encouraging client to prepare specific strategy to handle each high risk situation
- Guiding client on preparing strategy – direct instructions
- Behavioural rehearsal – exposing the client to high risk situations (either creating the situation artificially or actual exposure to the situation) and making the client practice the strategy.

- ◆ Enhancing the client's coping skills through teaching 'problem solving' method

### PROBLEM SOLVING METHOD

- Identify the problem
- Elicit different ways of solving the problem
- Weigh the pros and cons of each solution
- Based on the weights provided, choose the best solution.

- ◆ Teaching the client how to manage stress through relaxation techniques
- ◆ Dealing with lapse and abstinence violation effect:
  - Ask the client to stop and assess the reason for lapse
  - Make the client understand that lapse is a warning sign
  - Prepare a lapse management plan: carry out a situational assessment leading to lapse and develop specific strategies to deal with the same
  - Educate the client that relapse is a process, and having a lapse does not mean that the client cannot stop further drug use
  - Encourage the client to vent out his/her emotions regarding the lapse
- ◆ Life style modification
- ◆ Dealing with urges and cravings through urge surfing.

# Opioid Substitution Therapy

## General Points

- ◆ OST is recommended to those who are desirous of stopping illicit opioid drugs (including injecting and non-injecting drugs), but are not able to do so because of craving; also those who have previously attempted detoxification but have failed
- ◆ OST is the administration of a prescribed daily dose of opioid medicines with long lasting effects to patients with opioid dependence under medical supervision. The most commonly used medicines as OST are methadone and buprenorphine. In India, buprenorphine is the only medicine used by NACO currently for OST

## Counselling Points

- ◆ Assess the reasons for the client desiring OST and his motivation level
- ◆ Educate the client on the benefits of OST:
  - Reduction and stopping the use of illicit opioid 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 social and psychological support
  - Reduced overdose mortality
  - Significant reduction in criminal activities in the community
  - Decreased domestic violence and abuses against family members
  - Increased productivity
- ◆ Make the client understand the difference between OST medications and illicit opioids that he/she is using currently:

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

- ◆ Make the client understand the implications of being on OST, e.g. visiting the OST centre daily for medications
- ◆ Break the myths regarding OST. For e.g.

Myth	Fact
Taking OST medicines alone is enough	Psycho-social counselling along with OST medicines increases the chance of a client staying away from illicit opioids
OST helps in other drug problems also	OST helps in management of opioid intake only

## Family Counselling

As a result of drug use, not only the IDU, but also the family of IDU face stigma and whole plethora of problems in various spheres of life. In India, since the family plays an important role in client's life, it is desirable to include the family in treatment session. Picking up conflictual family situations from the client's life, he can be explained the need to call family members. He can be made to understand that a supportive family environment would help him to bring about desirable changes. For example, if the client tells the counsellor that he used injections after a fight with his wife. The counsellor can ask the client to elaborate and then present the need to psycho-educate the wife and help her in understanding his needs.

However, it is important to remember that client is the index person and the family should not be included in treatment if the client does not want it.

If the client permits the inclusion of family, then the counsellor can either call the family members on phone and fix an appointment or can do it with the help of the client. The client also needs to be reassured that the information provided by him will be kept confidential and will not be disclosed to the family without his permission. Some important points that should be kept in mind are:

- ◆ The family acts as both a risk as well as a protective factor. Objective of involving family members into treatment is to enhance their role as protective factors
- ◆ The family unit should be considered from client's point of view
- ◆ Talk to client and family members separately
- ◆ Maintain a non-judgmental attitude and avoid taking sides
- ◆ Do not disbelieve the client just because he takes drugs – look for evidence in what the client or family reports
- ◆ When in doubt, always remember that the client is the primary case.

### Important Steps in Family Counselling

- ◆ Greet the family members appropriately
- ◆ Address each by their name and appropriate salutations (for example, adding the suffix 'ji' after the name)
- ◆ Make the family members comfortable and allow for privacy
- ◆ Allow family members to express their problems, needs and emotions
- ◆ Express empathy and genuine acceptance of their distress

- ◆ Instil hope in family members that not all is lost
- ◆ Assess family members' expectations
- ◆ Make the family member understand the purpose of why they have been involved in the treatment process
- ◆ Carry out a detailed assessment

### **ASSESSMENT AREAS**

- Knowledge of family members regarding drugs and injections, abstinence attempts made by the client and reason for lapse or relapse and maintaining factors of drug use
- Family history of drug use
- Family members' reactions and attitudes towards the IDU
- Family member's expectations from the IDU member
- Impact of client's drug use on family and family's financial and social status
- Health status of family members – any previous HIV screening
- Relationship quality of the client with various family members

- ◆ Provide education to the family on:
  - Types and nature of drugs used by the client
  - Physical and psychological impact of drug use
  - Craving and various signs of withdrawal
  - Sexual practice and reproductive health
  - Concept of harm-reduction
  - Process of change
  - Need for long-term treatment
  - Life-style changes.
- ◆ Using the model of “Antecedent-Behaviour-Consequences” help the family members identify their roles in supporting the IDU in treatment and teach appropriate strategies to prevent relapse.

### **GROUND-RULES TO TEACH FAMILY MEMBERS**

- Trust is a major issue and will take time to build-up
- When in doubt, ASK the client
- Fighting is not good communication... talking is
- Blame-games need to be avoided
- Criticism should be constructive and focused
- It may take time for the client to change, but appreciation/reinforcement of even a small change is important
- It is important to encourage the client to go for regular follow-ups
- Craving is a reality with the IDU and self-control alone will not help
- 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
- If the client comes in an intoxicated state, do not panic and stay calm. Talk to him/her when he/she is sober.

# Crisis Management and Counselling

## General Considerations

- ◆ Certain situations that are unexpected, sudden and of high intensity that throws the client off-guard are known as *crisis*. For example, death of a friend with whom injections were shared, being thrown out of the job, physical abuse, homelessness, getting aware about one's own HIV status etc.
- ◆ Crisis situations can lead to a temporary state of emotional turmoil and disorganisation.

DOs	DON'Ts
<ul style="list-style-type: none"><li>▪ Be available to the client at the time of crisis situation and provide timely help</li><li>▪ Be supportive and accept the client's distress</li><li>▪ Be flexible in approaching the client</li><li>▪ Be innovative and gather as much resources as possible for the client</li><li>▪ Be more focused on "How the crisis can be resolved" as compared to focusing on why it happened</li><li>▪ Listen actively and empathetically</li><li>▪ Address unrealistic expectations that the client may have from the service providers in solving their crisis</li><li>▪ Ensure safety of the client – don't trivialise threats of suicide (e.g. overdose, cutting self) or homicide</li></ul>	<ul style="list-style-type: none"><li>▪ Don't probe the client to the point where he feels under attack</li><li>▪ Don't criticize or embarrass the client</li><li>▪ Don't 'preach'</li><li>▪ Do not blame the client</li><li>▪ Don't become impatient and appear rushed</li><li>▪ Don't become too over-involved with the client's crisis</li></ul>

*Remember ...Not every problem is a crisis*

## Important Steps in Crisis Intervention

- ◆ Make the client comfortable
- ◆ Assure him that support is available
- ◆ Express genuine concern for his condition
- ◆ Let the client talk and ventilate out all his negative emotions
- ◆ Validate his experiences and needs
- ◆ Assess what is it that he requires immediately
- ◆ Make a referral to a medical facility if need be (For example, in case of injection-related injuries)

- ◆ Gather as many resources as possible for the client
- ◆ Once the client has calmed down to some extent, use problem solving strategy to help him get a perspective about his problem and the probable solution
- ◆ Assure him that the problem can be resolved if handled calmly
- ◆ Problem-solving Strategy: teach problem-solving strategy (steps outlined in relapse prevention).

### Remember that...

- Crisis is a temporary phase
- Crisis can happen any time
- If tackled in time, significant problems can be averted in client's life
- It is extremely important to remain calm and composed and model the same to the client.



# GLOSSARY

1. **Abscess:** Localised collection of pus in any area of the body due to infection with 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 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 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:** process of managing taxing circumstances, expending effort to solve personal and interpersonal 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 addiction, this mean 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 are they 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:** These are all those behaviours that put the client in danger. HIV-related high risk behaviours include sharing needles, syringes and other equipment 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 the slip into drug use. This means the first time that the 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 kind of behaviour would occur. For example, when the client uses injection, it acts as a positive reinforcer and thus increases the probability that 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 a 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 judgement 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 aren't 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 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 family include family history of alcohol or drug use, broken families, frequent conflicts in house, 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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# APPENDICES

## Appendix A: High Risk Behaviour Scale

<b>HIV Risk Behaviour Scale -(HRBS)</b>	
<b>a) Drug Use Section</b>	<b>Score</b>
<i>Question 1. How many times have you hit up (injected any drugs) in the last month?</i>	0-1-2-3-4-5
<i>Question 2. 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
<i>Question 3. How many people have used a needle before you in the last month?</i>	0-1-2-3-4-5
<i>Question 4. How many times in the last month has someone used a needle after you have used it?</i>	0-1-2-3-4-5
<i>Question 5. How often, in the last month, have you cleaned needles before re-using them?</i>	0-1-2-3-4-5
<i>Question 6. 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>b) Sexual Behaviour Section</b>	0-1-2-3-4-5
<i>Question 7. How many people, including clients, have you had sex with in the last month?</i>	0-1-2-3-4-5
<i>Question 8. 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
<i>Question 9. How often did you use condoms when you had sex with casual partners in the last month?</i>	0-1-2-3-4-5
<i>Question 10. 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
<i>Question 11. How many times did you have anal sex in the last month?</i>	0-1-2-3-4-5
<p><b>Scoring the HRBS-</b>The HRBS is easy to score. All 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.</p>	

## Appendix B: Individual Risk Assessment Activity Worksheet

<b>Individual risk assessment activity worksheet</b> (This should be completed by the counsellor in consultation with the client)		
<b>Client code:</b> _____		
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: <b>Window period</b>	<b>Yes/No</b>	
Tattoo, scarification	YES/NO	Date
<b>Window period</b>	<b>Yes/No</b>	
Blood products	YES/NO	Date
<b>Window period</b>	<b>Yes/No</b>	
Vaginal intercourse	YES/NO	Date
<b>Window period</b>	<b>Yes/No</b>	
Oral sex	YES/NO	Date
<b>Window period</b>	<b>Yes/No</b>	
Anal intercourse	YES/NO	Date
<b>Window period</b>	<b>Yes/No</b>	
Sharing injecting equipment	YES/NO	
<b>Window period</b>	<b>Yes/No</b>	
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 VCT, PPTCT and ART Counsellors Training Modules Facilitator's Guide-National AIDS Control organization (NACO), Ministry of Health and Family Welfare, Government of India.

## Appendix C: Depression Anxiety Stress Scale (DASS) – 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 over the past week. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><b>The rating scale is as follows:</b>  <b>0</b> Did not apply to me at all  <b>1</b> Applied to me to some degree, or some of the time  <b>2</b> Applied to me to a considerable degree, or a good part of time  <b>3</b> 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 (e.g., 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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