

Reducing risk-taking behaviour among young drug users

Introduction

Early intervention in the drug using life of users is seen as an important component of reducing risk-behaviour - hence the need for bridging the gap between substance users and service providers. UNODC, Regional Office for South Asia's Project RAS/G23, has designed this peer led intervention that focuses primarily on risk-reduction among young drug users in South Asia and allows cultural adaptation to the local settings of use.

The peer-led intervention is designed to roll out in four steps: preliminary phase, phase one, two and three. In the preliminary phase, agencies to be engaged in the intervention are identified and their staff members trained using the Training of Trainers' manual in the Peer-led Intervention Toolkit. Assessing the vulnerability and resources in the site of the intervention is an initial step in phase one. Identifying key stakeholders, mobilising the community through setting up a committee of concern, and giving ownership of the intervention sets up the enabling environment. Networking the service providers, stressing on a "two way" referral, a referral system of services needed by substance users in their journey to treatment and rehabilitation is set up. This intervention can then be seen as one of a basket of services provided to the substance users.

In phase two, substance users are engaged into reducing risk behaviour. The present training manual is for the use of trainers, outreach and field workers of agencies for risk-reduction training given to current users in this phase of the intervention.

Phase three provides access to services to bridge the gap between users and services. Two kinds of support groups/self-help groups are set up to provide continued support to users; the first for those who have reduced risk-behaviour, and the second for those who are have completed medical treatment and want to maintain sobriety.

Review of Literature

It has been found that outreach based services are effective in reaching out-of-treatment drug users, providing the means for behaviour change, and inducing behaviour change in the desired direction². Use of peers, i.e. active drug users, for spreading HIV/AIDS prevention message among

² Coyle, L.S., R.H. Needle, and J. Normand. 1998. Outreach-based HIV prevention for injecting drug users: a review of published outcome data. *Public Health Reports*, 113 (Supplement 1): 19-30.

fellow drug users however, is a relatively recent phenomenon. Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic. Peer education has been used extensively in different settings for the reduction of risk-taking behaviour related to drug abuse and HIV/AIDS. As compared to outreach workers peers have been found to be more effective in recruiting drug users for HIV/AIDS interventions³.

Peer education typically involves training and supporting members of a given group to effect change among members of the *same* group. Peer education is often used to effect changes in knowledge, attitudes, and practices at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in policies and programs.

Numerous definitions of the word “peer educator” are found in literature⁴. In some instances “peer educator” is a recovering/ex-drug user who is not a member of the peer group where an intervention is in place. In other instances, “peer educator” is used for a current drug user of a peer group who not only is used for intervention within his/her peer group but as an outreach worker for intervention in other peer networks⁵.

In this peer-led intervention design, the term “peer outreach worker” is used to describe a staff member of the intervention team who is either an ex-addict and not a current user, or a non-user field worker. The term “peer volunteer” is used for a person who is a current user willing to be recruited for risk-reduction intervention and volunteers for training members of his/her peer group into risk-reduction practices. The “peer volunteer” may **not** be used as an outreach worker outside his/her own peer group.

Research indicates that peer-interventions work best when part of a larger basket of services and both, outreach as well as peer volunteers/educator approaches have been described as complementary to each other.

Definitions

Risk

WHO defines risk in relation to HIV as the probability of contracting HIV. It deals with the person’s own perception of probability of getting HIV.

³ Stocker S. (1999). Among drug users, peers can help spread the word about AIDS prevention. *NIDA notes* (research findings), (4) 5.

⁴ McDonald, J., A.M. McDonald, M. Durbridge, and N. Skinner. 2003. *Peer education: From evidence to practice – An alcohol and other drugs primer*. Adelaide: Flinders University of South Australia, National Centre for Education and Training on Addiction.

⁵ Sherman S, Latkin, C., Bailey-Koche, M, Peterson, J., 1997. *The SHIELD Community Outreach Worker Training: Facilitator’s Manual*, SHIELD (Self-help in Eliminating Life-threatening Diseases) Study, The Lighthouse, Johns Hopkins School of Public Health, Baltimore.

Risk behaviour

Risk behaviour is defined as “specific form of behaviour, which is proven to be associated with increased susceptibility to a specific disease or ill-health,” (in this case, AIDS / Hepatitis B, Hepatitis C, and other health hazards associated with drug use).

Risk behaviour in relation to drug abuse and HIV/AIDS

Following is an abbreviated list of risk behaviours in relation to drug abuse and HIV/AIDS

- Drug abuse (any kind);
- Injecting drug abuse, particularly sharing of unclean injection paraphernalia; direct and indirect sharing;
- Unprotected sex;
- Having multiple sexual partners.

Risk-reduction

Risk-reduction in relation to drug abuse and HIV aims at interventions that increase risk-perception and encourage and sustain changes towards healthy behaviour. These interventions are designed to bring about a change at four levels:

1. Individual;
2. Interpersonal (with a focus on the relationships between self and other persons in the social network of the drug user, norms of the sub-group);
3. Community (peer opinion, social norms, working together);
4. Socio-political (drug demand reduction policy, or HIV/AIDS prevention policy, law enforcement policy).

Research has shown that whether individual drug users attempt or achieve risk-reduction behaviour change often depends on whether this change is endorsed or encouraged by their peer group. Research also suggests that an individual’s attempts at, e.g., condom use are considerably easier when there exists a peer norm, which is supportive or accepting of condom use. If “safety norms” exist they make it easier for individuals to initiate behaviour change. A norm of healthy drug use, for those not willing for abstinence, and a norm of safe sexual behaviour is needed.

Intervention in reducing risk-taking behaviour

Intervention in reducing risk-taking behaviour in relation to drug abuse and HIV/AIDS is a set of seven half day, *once a week*, training sessions. These are interactive knowledge and skill building sessions, using behaviour change communication, participatory training and learning action tools.

Training of recruited current users/peer volunteers shall provide:

Knowledge:

Problems faced by drug users – with a focus on health hazards:

- Concept of infection, disease and disease causing micro-organisms, modes of transmission;

- Basic information about HIV/AIDS and modes of transmission;
- Risk-behaviour in relation to drug abuse and HIV/AIDS and other health hazards in the context of the current user's reality.

Introduction to risk behaviour:

- Risk related to injecting drug use;
- In sharing drug paraphernalia: direct sharing and indirect sharing;
- Risk related to unsafe sex;
- Multiple sex partners;
- Myths related to ability of identifying HIV safe sex partner;
- Risks associated with drug overdose;
- Assessment of risk-behaviour.

Strategies to minimize risk behaviour related to drug use and HIV/AIDS in the context of the current user's reality:

- Use of bleach to clean injecting equipment for injecting drug users;
- Reducing the risk of sexual transmission of HIV;
- Correct use of a condom;
- Introduction to drug substitution.

Problems faced by drug users – with a focus on social consequences.

Obstacles to altering risk behaviour.

Services available in the community for drug users for treatment of drug dependence, HIV/AIDS, Hepatitis B, Hepatitis C, Tuberculosis, STI, etc.

Accessing services.

Self-help/support groups:

- For maintaining reduction in risk-taking behaviour;
- For maintaining abstinence (sobriety).

Introduction to changing behaviour and practices.

Role-modeling.

Relapse, recognising relapse and relapse prevention.

Legal status of current drug use and relationship with law enforcement.

Skills:

- Life skills:
 - Communication skills:
 - Conversation skills;
 - Assertiveness;
 - Information and advice giving.
 - Leadership skills;
 - Decision making skills:
 - Negotiation skills;
 - Refusal skills;
 - Problem solving;
 - Graded goal setting;

- Dealing with emotions and stressful situations.
- Motivating and training others.
- Training in how to minimize danger to self:
 - Demonstration and rehearsal/practice sessions in condom use (and using bleach to clean syringes/needles for injecting drug users).

Attitudes:

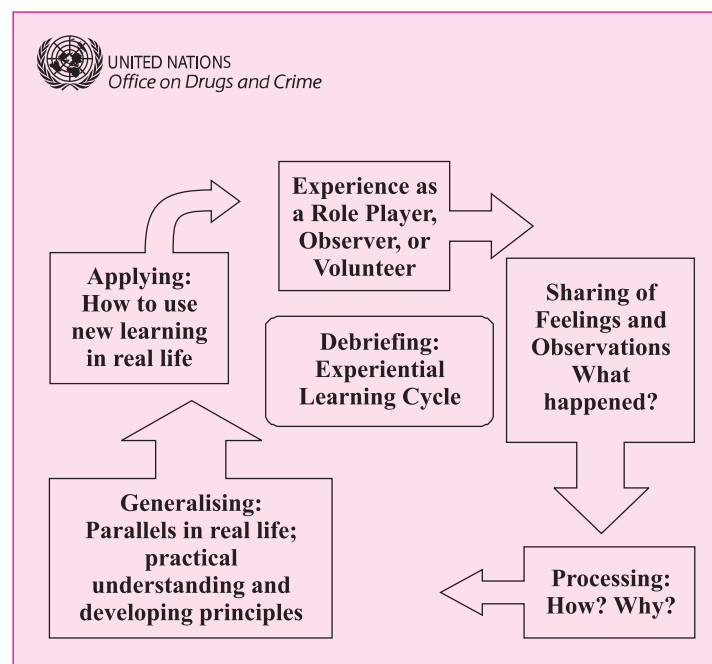
- Sensitivity to the problems faced by family and other users/PLWA.
- Commitment to train others in the peer group and role model risk-reduction behaviour.

Methodology for training

This intervention model relies on behaviour change communication and participatory learning and action (PLA) methods to impart the training. The guiding sequence for training of peer volunteer starts with an assessment of where the person is in the following hierarchy, and tailoring graded goals for each individual to move down the hierarchy:

- Unaware
- Aware
- Concerned
- Knowledgeable
- Motivated to change
- Practicing trial behaviour change
- Practicing sustained behaviour change

The use of debriefing through experiential learning cycle is relied upon throughout the training.



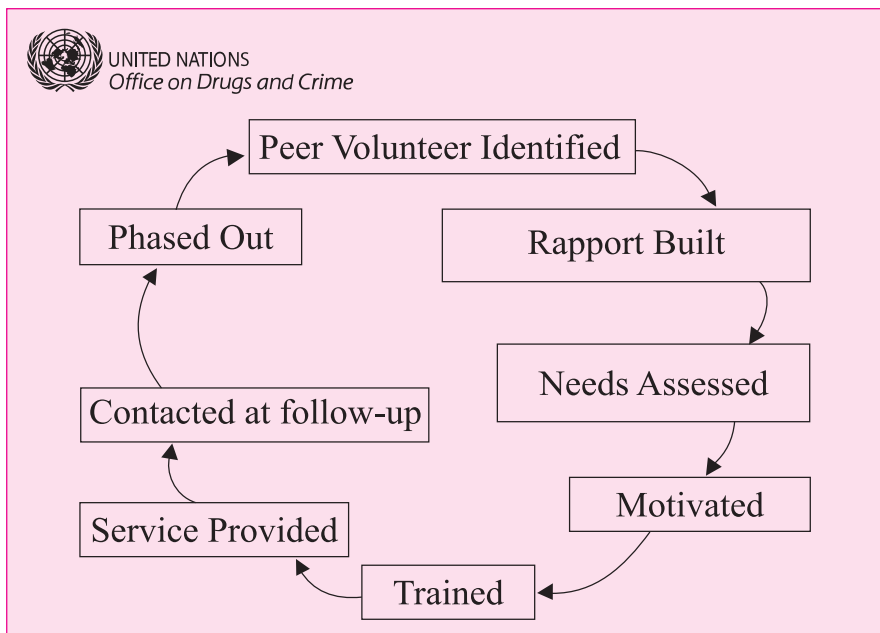
Ethical considerations in engaging current users as peer volunteers

Outreach teams are likely to reach greater numbers of hidden drug users if they consist of full-time peer outreach workers who have the responsibility of coordinating and supervising a small team of peer volunteers. This is likely to be more cost effective than relying on the outreach contacts made by full time outreach workers alone. Peer volunteers may provide information about the locations where drug users collect/assemble. However, to obviate exposure to higher risk behaviour of another peer group, this intervention has designed the service component of a recruited and trained current user/peer volunteer to contact and educate only his/her own peer group members.

Recruitment process

The recognition of a peer volunteer starts when the first contact is made with a current drug user peer group. Some current users show consistent approach behaviour⁶ towards the peer-outreach worker. In conversational interviews with users showing approach behaviour and while mapping the user networks, an assessment is made of the needs of the users and the risk-practices of the members of the peer group. Current users who show sustained approach behaviour and who offer to be recruited for the intervention are selected on certain criteria. One current user in each peer group / network is informed about the expectations the project has of him / her in terms of the service expected in training other peer group members in risk-reduction. After assessing the needs of a drug user, he / she is inducted into training and motivated to function

Service cycle for peer volunteer



⁶ User who is friendly, is easy to talk to, and is consistently approachable when re-visiting the community.

as a peer volunteer. (See diagram of service cycle for a peer volunteer below). Once trained to function as a peer volunteer he / she is expected to deliver services i.e. reduce risk reduction practices amongst and serve as a 'role model' of change for his / her peer group.

During the third phase, contact is maintained with the peer volunteer. The volunteer is encouraged to follow-up with the training agency, attend the support group regularly and encouraged to function as a responsible member of the community. Once it has been determined that the peer volunteer has delivered the services expected of him / her the volunteer is phased out from active engagement. At any point in time, during the service cycle, as and when the peer volunteer displays a desire and motivation for treatment and rehabilitation, he / she is provided assistance and referral service. To forestall problems in separation from the programme, the service cycle is explained to each volunteer at the outset.

Forming the group for training

Peer volunteers are trained in batches of 10-12 to focus intensely on each person. After each session, each peer volunteer trains members of his/her peer group. More than one member of a peer-group volunteering for attending the training programme cannot be refused. However, a special mention of this fact should be made on the baseline-assessment record of the peer-volunteer.

Caution: The trainees are matched with the pattern of drug use and level of risk behaviour shown. Selection of peer volunteers for group training is based on an assessment of homogeneity of risk-behaviour. Care should be taken to ensure that the group of peer volunteers selected for a particular training schedule is as homogenous as possible (for example avoid mixing IDUs with non-IDUs).

Pre-training session

This pre-training session is conducted by the trainer and consists of:

Needs assessment;

Explaining the service cycle for peer volunteer;

Role modelling as inducers of health-seeking behaviour;

Motivation to train peer group members and to act as a role model;

Baseline Assessment using the KAP assessment questionnaire.

Needs assessment

In a conversational interview ask the reality situation of the volunteer with regard to current life style and what the volunteer would like the ideal life situation to be. In a participatory manner, enquire about the gap between the current and ideal situation. Allow the volunteer to discover ways he / she would bridge this gap.

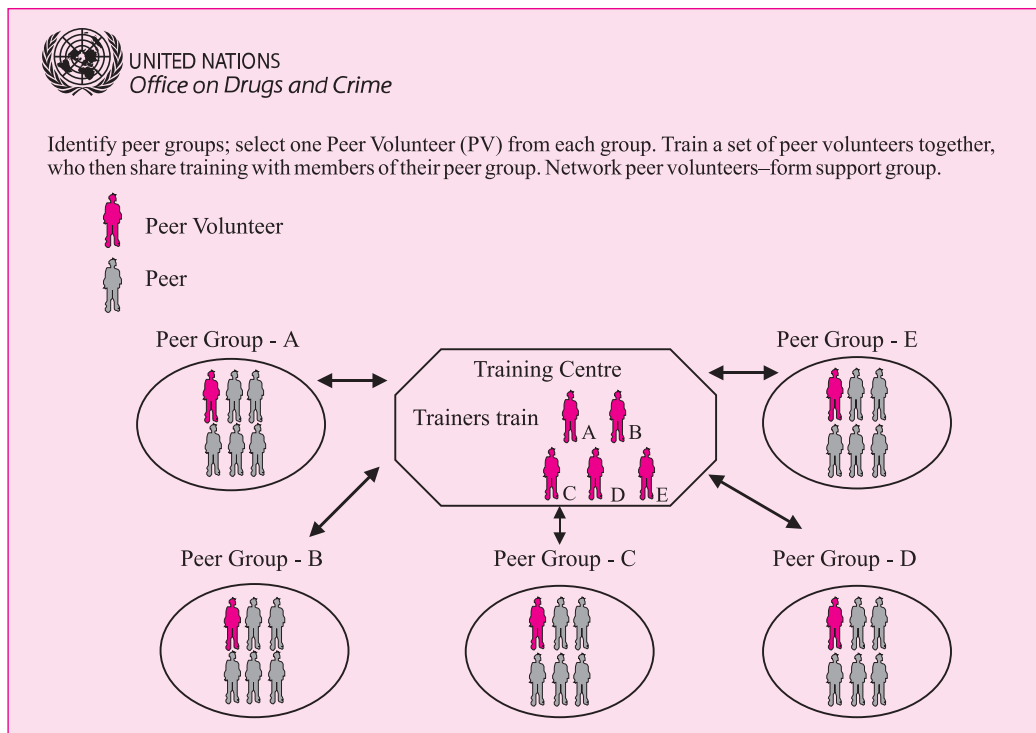
Baseline assessment

The questionnaire for baseline assessment of knowledge, attitudes and practices has been translated into the local language, and then by a person not familiar with the original instrument, translated back into English; this translation has been compared to the original instrument to test the correctness of the first translation. Review the instruction manual for the baseline assessment questionnaire. Rehearse the administration of the baseline assessment with the supervisor.

The training programme for reducing risk-taking behaviour

Training peer volunteers selected from peer groups is depicted in the following diagram. The peer volunteer selected from each peer group is trained in the training centre along with other peer volunteers. Each peer volunteer trains his / her own peer group members. At the end of the training the trainees are encouraged to continue coming to the training centre to attend a support group and are encouraged to bring along members of the peer group.

Multiplier effect of peer education



Practical difficulties in holding weekly sessions with current users

During field trials of this model, several agencies reported difficulties in holding weekly sessions with current users. In some cases, the numbers attending the sessions each week varied. The reason for sessions being held weekly is to give sufficient time for change to be practised and to make graded goal setting meaningful. However, some agencies have successfully held sessions

twice a week and found that in phase three, holding support groups twice a week flowed more easily.

Structure of a session

Each session is structured in the following manner:

1. *Recap of the previous session.* (In the first week's session, this is replaced by an *introduction* to the training programme).
2. *Debriefing* of the previous week's experience in training others, behaviour change in self and peer group members (In the first week's session, this activity is replaced with a session on meeting strangers and the process of change).
3. *Knowledge:* new knowledge or building on previous knowledge, clarifying distortions or myths.
4. *Demonstration* of a risk-reduction method or how to manage difficult situations/emotions (skill building).
5. *Practice* (mock-session/rehearsal): of a risk-reduction method, of training others, or managing difficult situations (skill building) - where possible.
6. *Graded goal setting and commitment* (in bringing change in self, training others/ bringing change in others).

Throughout the training, the peer volunteer is encouraged into *playing the role* of a person practicing safe, risk-free behaviour.

Sessions in this training programme

Details of weekly sessions for training peer volunteers are tabulated below:

Sessions	Time
<p>Pre-assessment: <i>Baseline Assessment.</i></p> <p>Explaining the service cycle for peer volunteer. Needs assessment. Diagnosis of where in BCC hierarchy the peer volunteer is in. Motivation to train peer group members and act as a role model.</p>	70 min
First Week's sessions	
Meeting strangers.	30 min
Objectives of the training programme.	30 min
Problems faced by the drug users – with a focus on health hazards.	30 min

<p>Basic concepts: infection, disease and disease causing micro-organisms, modes of transmission:</p> <ul style="list-style-type: none"> • Basic facts about HIV, Hepatitis B, Hepatitis C. <p>Role modelling – concept – acting as if.</p> <p>Demonstration of acting like a role model – role play.</p> <p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self - based on behaviour change communication hierarchy. 	<p>50 min</p> <p>40 min</p> <p>15 min</p>
<p>Second week's Sessions</p>	<p>Time</p>
<p>Recap of previous session.</p> <p>Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.</p> <p>Behaviour Change Communication – Stages of change:</p> <ul style="list-style-type: none"> • Graded goal setting. <p>Introduction to risk-behaviour: Risks taken by drug users.</p> <p>Identification of Risk-behaviour:</p> <ul style="list-style-type: none"> • Denial of risk-taking behaviour in peer group members; • Situations where risk behaviour occurs. <p>Practice of training others – Rehearsal sessions – on change hierarchy.</p> <p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change. communication hierarchy 	<p>15 min</p> <p>30 min</p> <p>40 min</p> <p>20 min</p> <p>40 min</p> <p>20 min</p> <p>15 min</p>
<p>Third week's Sessions</p>	
<p>Recap of previous session.</p> <p>Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.</p> <p>Life skills:</p> <ul style="list-style-type: none"> • Leadership skills – Identification of a leader; • Communication – • Passive, assertive and aggressive communication; • Problem solving; • Decision making. <p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change communication hierarchy. 	<p>15 min</p> <p>30 min</p> <p>20 min</p> <p>20 min</p> <p>30 min</p> <p>30 min</p> <p>25 min</p> <p>15 min</p>

Fourth week's Sessions	Time
<p>Recap of previous session.</p> <p>Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.</p> <p>Sexual Risk and Prevention – The use of condoms – Demonstration on correct use of a condom.</p> <p>Practice of training others – rehearsal sessions – on condom use.</p> <p>Negotiating safe sex.</p> <p>Refusal skills for risk-related behaviour.</p> <p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change communication hierarchy. 	<p>15 min</p> <p>30 min</p> <p>30 min</p> <p>10 min</p> <p>40 min</p> <p>40 min</p> <p>15 min</p>
Fifth week's Sessions	
<p>Recap of previous session.</p> <p>Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.</p> <p>Problems faced by a drug user with a focus on social consequences.</p> <p>*****</p> <p>The following sessions need to be structured depending upon the composition of the group. Discuss the risks associated with the drug(s) used by the group.</p> <p>Opioid users</p> <p>Risks associated with opioid use.</p> <p>Overdose of opioids – introduction to first aid and transfer to emergency health care.</p> <p><i>Alternate session for injecting drug users:</i></p> <p>Risks associated with Injecting Drug Use - Risks associated with non-aseptic injecting in general, risks of direct and indirect sharing.</p> <p>Risk reduction (Using bleach – demonstration and practice).</p> <p><i>Alternate session for opioid users:</i></p> <p>Self-assessment of risk.</p> <p>Introduction to drug substitution.</p> <p>Alcohol users</p> <p><i>Alternate session for alcohol users:</i></p> <p>Consequences of alcohol/cannabis use – Risks associated with alcohol use, overdose, consequences of use of spurious alcohol (e.g., methanol).</p> <p>Self-assessment of risk.</p> <p>Introduction to drugs as deterrents to alcohol use.</p> <p>*****</p>	<p>15 min</p> <p>30 min</p> <p>30 min</p> <p>30 min</p> <p>30 min</p> <p>30 min</p> <p>30 min</p> <p>60 min</p> <p>30 min</p>

<p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change communication hierarchy. 	15 min
<p>Sixth week's Sessions</p>	
Recap of previous session.	15 min
Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.	30 min
Obstacles to altering risk behaviour.	20 min
Managing stress situations.	40 min
Managing emotions: grief and anger.	40 min
<p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change communication hierarchy. 	15 min
<p>Seventh week's Sessions</p>	
Recap of previous session.	15 min
Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.	30 min
Accessing treatment for substance abuse.	25 min
Forming Self-help/support groups for risk-reduction.	25 min
Alternate session for those who have sought treatment with a goal of abstinence:	
Forming Self-help/support groups for sobriety after getting treatment.	25 min
Practice of motivating others – rehearsal sessions – on accessing help and forming self-help groups.	40 min
<p>Winding up:</p> <ul style="list-style-type: none"> • Motivation to train peer group members and act as a role model; • Goal setting for service to peer group over the next week; • Goal setting for change in self based on behaviour change communication hierarchy. 	15 min
<p>Reassessment</p>	
Reassessment using the KAP assessment questionnaire – positive reinforcement by recognition. This is to be done three months after the last training session.	