



**UNODC**

United Nations Office on Drugs and Crime



**Preventing illicit drug use  
and treating drug use disorders  
for children and adolescents**

TECHNICAL REPORT 2014

children  
our future ● our responsibility

## ***Children - Our Future, Our Responsibility***

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## ***Children - Our Future, Our Responsibility***

### **Executive Summary**

This document serves as a preliminary description of the implementation of protocols, tools and guidance documents developed specifically for implementation of UNODC's GLOK42 project, *Prevention of illicit drug use and treatment of drug use disorders for children, adolescents and women at risk*.

The challenges of drug use and drug dependence in children and adolescents remains mostly hidden as the populations most affected, the most vulnerable and the most at risk are also the most easily ignored. Initially, it is difficult to identify the exact problem because current data collection systems rarely capture this population. Because the numbers are not readily available, the policy makers are not easily swayed to implement prevention or treatment programs. The resulting reality is a cadre of children facing the world with little hope find themselves in a situation of no hope for the future.

Researchers and policy makers have not dedicated time and resources to studying this vulnerable population of children and adolescents exposed to drug use and dependence at an early age. Implementation of a structured model and intervention based on science allows for more data collection and serves as a foundation for future research studies. The work done through a pilot in Afghanistan allows for the refinement of protocols as research informs practice. This is a classic demonstration of the mutually beneficial relationship between research and practice or, between practice and research.

More comprehensive resources and technical guidance pertaining to working with children and adolescents is available through UNODC.

## ***Children - Our Future, Our Responsibility***

### **Introduction to the Global Children's Project**

As the world becomes smaller due to advancements in technology, development of resources and exponential growth of populations, little attention is given to the foundation of our global future – **children**. Children are our investment in the future but all too often are forgotten in the priorities of the present, and worse, made vulnerable by the actions of adults. Youth and adolescents around the globe are victims of starvation, neglect, war and trauma, abuse, violence, illiteracy, trafficking in persons, and drug use. Each day the precious faces of our future confront the challenges of poverty, war and conflict, and various health conditions such as malaria, tuberculosis, drug dependence and HIV/Aids.

Due to actions of adults, children have become victims at all points of the drug trade industry including the growing, manufacturing, distribution, and use of illicit drugs. Families in West Asia grow poppy as a means to survive and to feed their children. The very crop that puts food on the table also exposes the children to second hand smoke and other residue from opium. These same children then face a future of farming the crop that generations before them have grown, and living the legacy of drug dependence passed to them from the previous generation.

Children in Latin America have become an integral component of the drug trafficking system, voluntarily or involuntarily participating in the manufacturing of cocaine and the smuggling of cocaine across the border. In Eastern European countries, illicit drugs are just one component in the complex process of trafficking in persons. The human trafficking trade results in children enslaved as domestic servants, agricultural workers, factory workers or sex workers prostitutes, all having in common the use of or dependence on illicit drugs as a way to escape the horrific realities of life.

And, we know that children living in countries of war, conflict or post-conflict are made vulnerable to dire risks in multiple ways. Some youth are recruited into a life of soldiering that exposes them to illicit drug use at an early age. Drugs are made available to child soldiers as a means to manipulate their behaviors and often helps to mute the trauma of violence and violent behaviors that they are forced to participate in. Other children in conflict areas fall victim to the trauma and devastating violence that they have witnessed, and seek solace where they can find it, including illicit drug use. Many children are displaced and or live in refugee's camps with little means of escaping the social challenges, staying in challenging living situations much longer than they anticipated.

UNODC's Children's Project, GLOK42, was developed to promote a worldwide coordinated response to children and adolescents at risk of using drugs, and youth affected by drug use dependence. The project goals include addressing the health and social consequences for children, with the aim of preventing drug use, treating drug dependence and facilitating their positive re-integration into and contribution to the larger community.

## ***Children - Our Future, Our Responsibility***

Large scale mobilization, including the involvement of government ministries, member civil society, academics, media and high ranking personalities to call for immediate action to improve the living conditions of children worldwide, reduce the risks of developing drug use disorders and provide appropriate treatment strategies tailored to respond to the specific needs of this age group, are the project's main strategies. Initially, the Children's Project was piloted in Afghanistan but has expanded to include Liberia, Bangladesh, India and Pakistan.

The project was developed in response to the Political Declaration and the Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem (General Assembly resolution S-20/3) adopted at General Assembly Special Session on Drugs in 1998; the United Nations Guidelines for the Prevention of Juvenile Delinquency (The Riyadh Guidelines), General Assembly Resolution 45/112, Annex, section IV); and the United Nations Guidelines for the Prevention of Crime (Economic and Social Council Resolution 2002/13, annex). Through the Political declaration and the Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem, UNODC has been mandated by the General Assembly to identify and disseminate best practices/strategies in all areas of demand reduction including drug abuse prevention and to support capacity building and strategy development in these areas.

The project provides a model, within a strong framework of evaluated strategies, which in turn can be adapted to support Member States developing a strategy for the scaling up of services to meet the needs of those affected by drug use, in particular children and adolescents at risk and/or those affected by drug use dependence and its health and social consequences. The focus is on science-driven public health approaches in drug control as the springboard for existing good practices. Meeting the needs of children in particular presents a challenge due to the limited availability of research specific to the psychosocial and pharmacological interventions effective for this vulnerable population. Additionally, there are social constructs such as denial, stigma and ideological considerations that present barriers to providing interventions that target children and adolescents. In this environment, UNODC has developed innovative and efficient responses to the individual and social burden inflicted by drugs specifically for children under twelve years of age and adolescents up to eighteen years of age.

More systemically, the Children's Project focuses on providing technical assistance to national and local authorities working to address the needs of children and young adolescents within a planned system of integrated and mutually reinforcing activities, rather than a series of fragmented and competing initiatives. The multi-pronged approach includes structured psychosocial interventions and medically administered pharmacological therapy.

## ***Children - Our Future, Our Responsibility***

### **Target Beneficiaries**

Systemic implementation of this model results in a multi-level benefits at the national, community and individual levels. Protocols have been developed based on the age of children, as follows:

- Guidelines providing guidance to healthcare providers and policy makers related to drug use during and directly following pregnancy, have been developed and published through the World Health Organization. They are available on the WHO website.
- Psychosocial Protocols for
  - Children age 4 – 7, eight modules
  - Children age 8 – 13, eight modules
  - Adolescents age 14 – 18, eight modules
  - Adults, primarily women, eleven modules
- Pharmacological Protocols as advised by medical doctor

These ages reflect current evidence-based practices but can be revised to address diverse cultural and systemic issues.

UNODC encourages a comprehensive assessment of the needs, and the most current national data regarding children and adolescent drug use. This assessment will allow a more targeted prioritization of services and a systemic approach to the issues, and thus contributes to a larger number of children and adolescents being served. Implementation in the pilot based in Afghanistan focused on the following four specific groups of children and adolescents:

1. Children/adolescents at-risk to become or are currently using drugs. This will include children who are marginalized and living in poverty, children whose parents are drug dependent, children who lack education or are not attending school, children who are victims of abuse or neglect, children who have experienced trauma, children with mental or physical health challenges and any children who lack the support networks required to abstain from drug use and dependence.
2. Children/adolescents in public or private orphanages.
3. Children/adolescents who are living and working on the street.
4. Children/adolescents involved with the juvenile justice services.

Additional groups of children may include school drop outs, mentally or physically challenged children, children involved with social welfare departments or other culturally relevant “pockets” of vulnerable children and adolescents. Selection of the target populations is directly correlated to the assessment process previously described.

Implementation of a package of services for children, adolescents and families also serves to benefit the community. The structure of the modules as presented in this model

## ***Children - Our Future, Our Responsibility***

of implementation can be used to increase community awareness, prevent onset of drug use and ensure consistent messages integrated across services providers.

Additionally, this structured protocol can be implemented as a foundation for training and educating professionals working within the healthcare fields, beyond the implementation in traditional drug treatment facilities. Law enforcement officers can be trained to recognize and make referrals, emergency or acute care workers can be trained in screening, and faith-based organizations can work to educated families about the challenges children and adolescents suffering with drug use disorders face.

### **Geographic Implementation**

This work was piloted in six provinces in Afghanistan, including both rural and urban settings. Multiple government ministries, international organizations and local non-governmental organizations were involved in the planning, designing and implementation of thirty eight service delivery points including outreach, outpatient, residential and follow up services. Over 350 healthcare professionals have been trained and the project has a strong monitoring and evaluation component.

Since the initial pilot, the work has expanded to include Liberia, Pakistan, India and Bangladesh with future prospects to include Nepal, Paraguay and Chile.

While many of these countries are considered developing countries, it does not imply that children and adolescents involved in drug use and drug use disorders are solely from disadvantaged parts of the world. On the contrary, children of drug users, children living in poverty, children who have dropped out of school, children living with trauma and children with mental health challenges living anywhere in the world, are more vulnerable and at risk to initiate and use drugs at an early age.

### **Evidence**

Substance use disorders include a wide range of conditions, such as tobacco and alcohol abuse and dependence, illicit drugs' use, abuse and dependence, non-medical use of prescription drugs. All undermine health, wellbeing, social cohesion and security in different ways. The scientific community, WHO and UNODC consider substance dependence a multi-factorial health disorder affecting the brain, often following the course of a chronic disease characterized by addictive behaviour.

Substance use disorders appear to be more problematic when the age of onset is low, given the increased damage that is produced in the underdeveloped brain. The larger the number of adolescents and young adults exposed to experimenting with alcohol, tobacco, illicit drugs and controlled psychoactive medications, the larger the rate of vulnerable population at risk of developing addiction.

## ***Children - Our Future, Our Responsibility***

In most cases, the decision to experiment with psychoactive substances in adolescents and young adults is related to a combination of genetic and environmental factors contributing to psychobiological vulnerability and reduced resilience. Adverse childhood experiences such as neglect and abuse, together with temperament and personality traits at risk, lack of bonding to family and poor parenting, low levels of engagement in school activities, social deprivation and exclusion, extreme poverty, instability and exposure to violence, early onset mental health disorders may be frequently evidenced in the history of addicted individuals.

Evidence-based prevention methods are effective in reducing or delaying the exposure to psychoactive substances and decreasing the rate of those becoming dependent. Accordingly, a wide range of ethical and science-based treatment methods and rehabilitation programs have been proven effective in stopping or reducing the behavioural consequences of addiction, providing the opportunity of a normal life for a large number of the patients and standard expectation of life. Human and economic capital can be saved when cost-effective prevention and treatment tools are used to alleviate the consequences of substance abuse.

Children in conflict and post-conflict areas are often heavily affected by severe problems. In general, it seems that the prevalence of mental diseases in post-war countries is increasing, particularly posttraumatic stress disorder. Children's mental health is affected by severe traumatic experiences such as the killing of family members; posttraumatic stress disorder develops through permanent exposure to violent events. These factors increase the vulnerability to drug use and drug use disorders.

Despite the violent environment and the war-related events experienced by individuals living in Afghanistan, Kanji et al (2007), identified three main protective factors that help them coping with life: religious beliefs, family support and community support. Religious beliefs provide Afghanistan citizens not only with hope for the future, but also a driving force to engage in the other protective factors such as family and community support. A culture of hospitality and family values ensure such things as an understanding of the importance of bodily cleanliness, respect for elders and respectful communication skills. In Afghanistan as in other places around the world, ideology and political processes help families rationalise the experiences of armed conflict and everyday coping is supported by a consistent religious orientation.

### **A Structured Implementation Model**

Drug dependence is considered a multi-factorial health disorder with an inherent risk of relapse and remission, a chronic disease pattern. Unfortunately across the globe, children using and dependent on drugs are nearly invisible. Many communities do not recognize drug dependence as a health problem and in a case of double jeopardy further compound the challenges by stigmatizing the person using or misusing drugs. Scientific evidence indicates that the development of the disease is a result of a complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors.

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In many parts of the world, children and adolescents are particularly vulnerable to situations of repeated exposure, such as circumstances where a parent addicted to heroin. Concurrently, children living in conflict areas or post-conflict areas experience complex environmental factors such as poverty, trauma, stress and illiteracy.

Children and adolescents suffering with the challenges of drug use and drug dependence are entitled to access services provided by qualified healthcare professionals, within a framework of effective science-based practice in a comprehensive system of care that provides support at all phases of the disease process. UNODC supports a human rights balanced approach that requires nothing less than what would be provided for other medical conditions and that is supported by high quality standards of care.

However, experts in the field of addiction and its treatment are in the early phases of identifying and providing services to this vulnerable population. The science has formed a foundation upon which UNODC has built the following model. It has been designed to protect children and treat them with dignity, respect and hope for the future. The model presented is structured but allows for flexibility to meet the specific needs of Member States and communities.

Additionally during implementation of the model, detailed monitoring and feedback processes are strongly encouraged. These processes will protect children and will provide ongoing opportunities to fine tune the implementation to best meet the specific needs of the target populations.

The model is delivered and integrated concurrently across multiple service delivery points. This requires a systemic approach that incorporates data collection, training of staff and a commitment to follow up with clients as they reintegrate into the community. The service delivery points include outreach, outpatient, residential and follow up services. In the early development of the national model, it is important to identify “touch points” in the public health system where children and adolescents are already served. Staff at these key points of contact can then be trained to screen and refer or the health services can be expanded to include services for drug use disorders if the intensity of the need for services exists.

Implementation of services for children and adolescents requires a systemic perspective that relies on key elements such as:

- Data collection and analysis to drive policy decisions
- Knowledgeable and trained healthcare professionals
- Client-centered, patient-based and human rights-based services
- A core belief that drug use is a health disorder and can be treated
- Implementation of services based on science and evidence
- Diverse and non-threatening voluntary service delivery

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Below is a general service systems model of the implementation of the Children’s Project:

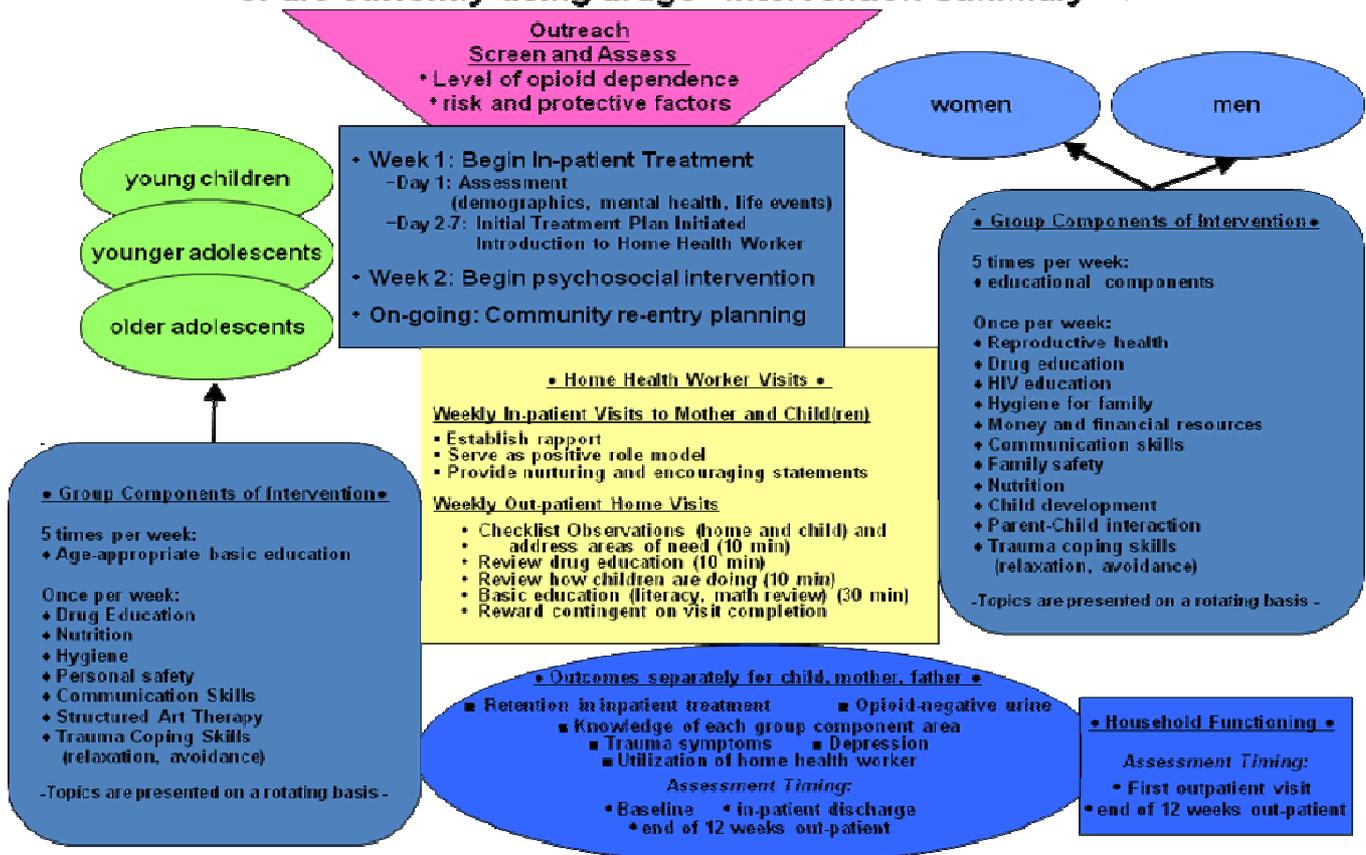
| <b><u>Outreach</u></b>   | <b><u>Outpatient</u></b>  | <b><u>Residential</u></b>   | <b><u>Follow Up</u></b>  |
|--|---|---|--|
| <b>Activities:</b> <ul style="list-style-type: none"> <li>• Drop-in Centers (this should come under outpatient services)</li> <li>• Community-based</li> <li>• First Line Social Assistance</li> <li>• Screening</li> <li>• Awareness building – modules</li> <li>• Counseling, Brief Motivational Interviewing</li> <li>• Referrals</li> <li>• Follow up and aftercare services</li> <li>• Facilitate self help support groups</li> </ul> | <b>Activities:</b> <ul style="list-style-type: none"> <li>• Outpatient centers</li> <li>• Screening &amp; Assessment</li> <li>• Registration of clients using drugs</li> <li>• Counseling, Brief Motivational Skill development – modules</li> <li>• Referrals</li> <li>• First line medical and Social Assistance</li> <li>• Child module education</li> </ul> | <b>Activities:</b> <ul style="list-style-type: none"> <li>• Screening &amp; Assessment</li> <li>• Treatment Plan</li> <li>• Psychosocial Protocols</li> <li>• Pharmacological Protocols</li> <li>• Counseling, Brief Motivational</li> <li>• Vocational training</li> <li>• Medical follow up</li> <li>• Referrals for follow-up &amp; aftercare</li> </ul> | <b>Activities:</b> <ul style="list-style-type: none"> <li>• Weekly contact</li> <li>• Group Counseling</li> <li>• Vocational and education placement</li> <li>• Volunteer opportunities</li> <li>• Halfway house model</li> <li>• 12 Step model</li> </ul> |
| <b>Data:</b> <ul style="list-style-type: none"> <li>• Initial intake data</li> <li>• Initial screening</li> <li>• Community connections</li> <li>• Geographic Mapping of “hot spots”</li> </ul>  | <b>Data:</b> <ul style="list-style-type: none"> <li>• Confirm intake data</li> <li>• Screening &amp; Assessment tools</li> <li>• Client registration</li> <li>• Client referrals</li> </ul>   | <b>Data:</b> <ul style="list-style-type: none"> <li>• Reconfirm intake data</li> <li>• Screening &amp; Assessment tools</li> </ul>  | <b>Data:</b> <ul style="list-style-type: none"> <li>• Changes to contact data</li> <li>• Screening &amp; Assessment tools</li> <li>• Follow-up &amp; Aftercare</li> <li>• Income generation</li> </ul>   |
| <b>Professional Development:</b> <ul style="list-style-type: none"> <li>• Psychosocial protocols – 8 modules and 11 modules</li> <li>• Counseling skills</li> <li>• Conflict management</li> <li>• Communication</li> </ul>  | <b>Professional Development:</b> <ul style="list-style-type: none"> <li>• Psychosocial protocols – 8 modules and 11 modules</li> <li>• Counseling skills</li> <li>• Conflict management</li> <li>• Communication</li> </ul>   | <b>Professional Development:</b> <ul style="list-style-type: none"> <li>• Psychosocial protocols – 8 modules and 11 modules</li> <li>• Counseling skills</li> <li>• Conflict management</li> <li>• Communication</li> </ul>   | <b>Professional Development:</b> <ul style="list-style-type: none"> <li>• Psychosocial protocols – 8 modules and 11 modules</li> <li>• Counseling skills</li> <li>• Conflict management</li> <li>• Communication</li> </ul>                                |
| <b>Integration Component:</b> <ul style="list-style-type: none"> <li>• Participate in monthly Integration Meetings</li> <li>• Network with key partners in the community</li> <li>• Inform treatment plan upon referral to outpatient</li> </ul>   | <b>Integration Component:</b> <ul style="list-style-type: none"> <li>• Participate in monthly Integration Meetings</li> <li>• Inform treatment plan upon referral</li> <li>• Participate on public health committees</li> </ul>   | <b>Integration Component:</b> <ul style="list-style-type: none"> <li>• Participate in monthly Integration Meetings</li> <li>• Inform treatment plan</li> <li>• Integrate family into treatment</li> <li>• Inform referral to outreach</li> </ul>  | <b>Integration Component:</b> <ul style="list-style-type: none"> <li>• Participate in monthly Integration Meetings</li> <li>• Inform recovery plan</li> </ul>  |

**RECOVERY**

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The graphic below summarizes the implementation of services for children, adolescents and their families as part of the pilot for the Children's Project in Afghanistan. This serves as the foundation for use in other geographic regions and is tailored to meet the needs of children, adolescents and families specific to each region.

**► Figure 2: Children/adolescents at-risk to become or are currently using drugs— Intervention Summary ◀**



Outreach teams identify and screen children that are identified as at risk, or self-identify as requesting services. The child or adolescent is screened and assessed to properly determine the need for outpatient drug dependence treatment services or inpatient, residential drug dependence treatment services. At this time, every effort is made to make sure that members of the immediate family are also screened and provided services concurrently to create a safer environment into which the child will return following treatment services.

## ***Children - Our Future, Our Responsibility***

This structured model allows for flexibility in that the user will define the populations that are directly targeted for services. At-risk children are a product of their environment and given that countries and circumstances are diverse, it is expected that data will be collected and populations selected to achieve the best results for the largest number of children and adolescents in that country.

Treatment services begin with a period of screening, assessment, detoxification and building a team of professionals to support the patient as they transition through the full spectrum of services. Following this, the patient will receive pharmacological services and psychosocial services in line with the results of the screening process. Currently in Afghanistan, pharmacological services include medications to relieve the symptoms of detoxification. We are awaiting approval to fully implement a more extensive pharmacological protocol within the limits of policies in Afghanistan. Again, to reiterate, each country will determine the extent to which they define use of pharmacological protocols with children. However, all drug dependence treatment services must be monitored by a medical doctor with all approved medications available to relieve the symptomatic challenges of detoxification at any age.

The psychosocial protocol is currently being fully implemented with each child or adolescent receiving age-appropriate education daily and once per week on a rotating basis, one of seven modules in Afghanistan. Currently adolescents are remaining at residential centers in Afghanistan for a full 180 days and during this time the modules will gradually become more complex and in-depth to meet the changing needs of the patient. As indicated earlier, every effort is made to provide services to the adult care givers of each child, with the modules expanded slightly to include education daily and one of eleven other modules.

An important component of this model is to provide follow up care upon discharge from the treatment program. Early in the intervention a team is engaged that will continue to meet with the child and family post treatment intervention. In Afghanistan, the close knit ties of the community and organized religion lends itself to closing the loop of services with the outreach workers also providing the recovery support services. We have found that this strategy in Afghanistan seems to provide a level of consistent interaction with patients and families which supports recovery and may decrease incidents of relapse. The structured model focuses on follow up and recovery support services and UNODC anticipates that at the global level there will be a variety of methods designed to meet the patients' needs in recovery.

To reiterate, the model described above was developed after extensive meetings with key stakeholders in Afghanistan and multiple expert group meetings. UNODC believes that the underlying structure of the model, with outreach, outpatient, inpatient and recovery services delivered within the context of consistent interventions and the modules as described below will be consistent in any community around the globe. The basic model can then be tailored to meet the identified needs of the country or community implementing the services.

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UNODC suggests that Member States interested in implementing these protocols, work with a University Institutional Review Board, specifically designed to protect the rights of those receiving treatment. In the pilot of the psychosocial protocols, UNODC submitted to an IRB review through Johns Hopkins University in the United States and the Afghanistan IRB. UNODC sought IRB approval for this groundbreaking work to ensure that the rights and dignity of children and adolescents are protected, and no harm would come to children participating in this pilot project in Afghanistan. Children, and their families or caregiver, are given a full description of the services to be provided, are made aware of confidentiality and are provided the opportunity to voluntarily agree to participate.

Following the model, the process begins with outreach in the community. Outreach teams target specific neighborhoods and districts within their area based on data suggesting a high prevalence of substance use. Outreach teams are comprised of a minimum of three individuals. Each team includes at least one person of each gender and each team member is trained to identify and engage at-risk children, adolescents, and their families. In the pilot project in Afghanistan, UNODC considers outreach to be the cornerstone of reaching the most vulnerable children and adolescents. Fortunately we were able to attract medical doctors, key religious and community leaders and other compassionate persons who care about the future of Afghanistan to participate as members of the outreach teams. Outreach teams conduct the following activities:

- Build relationships with additional key community leaders, religious leaders, and educators to recruit their assistance in identifying children/adolescents at risk.
- Engage children, adolescents, and their families to determine potential risk and implement the initial screening process.
- Build rapport with children, adolescents, and their families to assess the need for an intervention and the level of the necessary intervention.
- Make appropriate referrals for additional health screenings, mental health services, and drug prevention or drug dependence treatment services.
- Follow-up with the person who is referred to ensure that they attended the referral appointment. If the person did not attend the appointment then the outreach team member works with the person to help identify and overcome the barriers which prevented the appointment from being kept.
- Provide semi-structured sessions to introduce the eight modules and familiarize the family with the core elements such as counseling.

As indicated, outreach is the first step to building rapport with the community and with the patients. Well trained, compassionate workers who have a strong knowledge of the local values are essential to look beyond the denial and issues of stigma to support families and children to seek services. Without successful outreach efforts, the rest of the services will likely have very low enrollment.

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The outreach teams work closely with the Outpatient Centers to make referrals and inform community members of the services and support available. Outpatient services are defined as services provided in a community setting, in which the participant accesses services voluntarily at a specified site and then returns to their daily activities. Outpatient services include but are not limited to the following:

- First-line social assistance to include food, clothing, and housing assistance, when possible
- Education – literature, information, and classes in drug prevention education, literacy education, and vocational training as per the modules
- Group and individual counseling sessions
- Health screening and assessment, followed by referrals for additional services

Out-patient service provision is flexible and provided to meet the identified needs of the community and the specific patient. Services may be provided at an Outpatient Center, a Drop-in Center, or a Residential Drug Treatment facility.

A full set of screening and assessment tools are used for each patient and records are kept to highlight the progress being made when possible. The below collection of instruments is used both for screening and for assessment of drug use, psychological distress, trauma exposure, behavioral, emotional and social issues and physical health. These instruments were selected based upon their relative simplicity, and staff were trained in how to implement and use each tool. Modifications of these tools were made to accommodate specific cultural concerns such as translation, but whenever possible we maintained fidelity to the instrument.

### **Screening and assessment instruments and timing of collection for young children, younger adolescents, and older adolescents**

|                   | Measures   | Baseline                 | End of In-Patient | 12 weeks |
|-------------------|--|--------------------------|-------------------|----------|
| <b>Domain/Age</b> | <ul style="list-style-type: none"> <li>• <i> Screener Child and Adolescent Form (used to screen for issues in all domains of interest and for all ages)</i></li> </ul> | <input type="checkbox"/> |                   |          |

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|  |   |  |  |  |
|--|---|--|--|--|
| <b>Drug Use:</b>                             | <ul style="list-style-type: none"> <li>• <b>Biological Matrix and self-report quantity and frequency of drug use (all ages)*</b></li> </ul> | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Child</b>                                 |   | <input type="checkbox"/>                             |  |  |
| <b>Younger Adolescent</b>                    | <ul style="list-style-type: none"> <li>• <b>ASSIST-Y *</b></li> </ul>   | <input type="checkbox"/>                             |  |  |
| <b>Older Adolescent</b>                      | <ul style="list-style-type: none"> <li>• <b>ASSIST-Y *</b></li> <li>• <b>ASSIST-Y *</b></li> </ul>  |  |  |  |
| <b>Psychological Distress:</b>               |   |  |  |  |
| <b>Child</b>                                 | <ul style="list-style-type: none"> <li>• <b>SCARED *</b></li> </ul>   | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Younger Adolescent</b>                    | <ul style="list-style-type: none"> <li>• <b>SCARED *</b></li> </ul>   | <input type="checkbox"/><br><input type="checkbox"/> | <input type="checkbox"/><br><input type="checkbox"/> | <input type="checkbox"/><br><input type="checkbox"/> |
| <b>Older Adolescent</b>                      | <ul style="list-style-type: none"> <li>• <b>ASCL †</b></li> </ul>   | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Trauma:</b>                               |   |  |  |  |
| <b>Child</b>                                 | <ul style="list-style-type: none"> <li>• <b>CRIES Questionnaire *</b></li> </ul>  | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Younger Adolescent</b>                    | <ul style="list-style-type: none"> <li>• <b>ASCL †</b></li> </ul>   | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Older Adolescent</b>                      | <ul style="list-style-type: none"> <li>• <b>ASCL †</b></li> </ul>   | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |
| <b>Behavioral, Emotional, Social Issues:</b> |   |  |  |  |
| <b>Child</b>                                 | <ul style="list-style-type: none"> <li>• <b>Child SDQ*</b></li> </ul>   | <input type="checkbox"/>                             | <input type="checkbox"/>                             | <input type="checkbox"/>                             |

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|  |   |                          |                          |                          |
|--|---|--------------------------|--------------------------|--------------------------|
| <b>Young Adolescent</b>  | • <b>Child SDQ*</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Older Adolescent</b>  | • <b>SRQ-20 and Quality of Life<sup>†</sup></b>                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Medical and Developmental Problems:</b>                           |   |                          |                          |                          |
| <b>Child</b>   | • <b>Medical Exam (for all ages)*</b>   | <input type="checkbox"/> |                          |                          |
| <b>Young Adolescent</b>  |   | <input type="checkbox"/> |                          |                          |
| <b>Older Adolescent Knowledge Gained:</b>                            |   | <input type="checkbox"/> |                          |                          |
| <b>Child</b>   | • <b>Verbal quiz that covers key messages from each psychosocial component*</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Young Adolescent</b>  |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Older Adolescent</b>  |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>*Staff or physician-administered      <sup>†</sup>self-report</b> |   |                          |                          |                          |

The staff are trained to use the screening and assessment tools within the context of additionally building a relationship or a rapport with the patient. This has made the implementation rate of this high number of instruments more appealing. Below is a description and summary of the instruments used.

- **Medical Exam.** The physician will investigate the body of a patient for signs of disease. A medical history will be taken in order to account for the symptoms as experienced by the patient. Together with the medical history, the physical examination aids in determining the correct diagnosis and devising the treatment plan/map. The physical examination includes vital signs (Temperature recording, blood pressure, pulse,

## **Children - Our Future, Our Responsibility**

respiratory rate, signs for chronic illness and other communicable diseases) and basic biometrics (height, weight, body mass index).

- *Biological matrix.* An objective measure (e.g., urine sample or saliva sample) of recent use of a variety of substances will be collected.
- *Self-reported drug use.* A self-reported accounting of each type of drug use in terms of past month frequency and quantity and route of use will be gathered. At baseline, both lifetime and past month will be gathered.
- *Substance Use Disorder.* The ASSIST-Y *The Alcohol, Smoking and Substance Involvement Screening Test for Youth (ASSIST-Y)*. This measurement tool was developed for the World Health Organization [WHO; (WHO ASSIST Working Group, 2002)] by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings. It has been used in numerous countries and has been translated into more than 10 languages. It has cut-off scores to identify who is at low to highest risk for dependence on various substances. The Drug and Alcohol Services South Australia (DASSA) has developed versions of the test for young people.
- *Self-Report for Childhood Anxiety Related Emotional Disorders (SCARED)* The SCARED (Monga et al., 2000) is a reliable and valid screening tool for determining anxiety disorders in children and adolescents.
- *Child Revised Impact of Events Scale (CRIES)* and *Depression Self-Rating Scale (DSRS)*. The CRIES (Panter-Brick, Goodman, Tol, & Eggerman, 2011) is a 13-item, 4-point scale and the DSRS is an 18-item, 3-point scale that are widely used in disaster and conflict settings to assess, respectively, posttraumatic stress and depressive symptoms. The CRIES was implemented only for children reporting trauma exposure, because intrusion/avoidance items measuring levels of distress consistent with posttraumatic stress disorder are tied to specific traumatic experiences. Dari/Pashtu versions showed good internal reliability (DSRS,  $\alpha = 0.69$ ; CRIES,  $\alpha = 0.82$ ) and seven-day test-retest reliability ( $r = 0.76$  and  $r = 0.78$ , respectively,  $p < .0001$ ).
- *Child Strengths and Difficulties Questionnaire (SDQ)*. The SDQ (A. Goodman & Goodman, 2009; R. Goodman, 2001) is an internationally- and Afghan-validated 25-item questionnaire providing balanced coverage of behavioral, emotional, and social problems for multi-informant completion. Four subscales assess emotional, behavioral, hyperkinetic, and peer problems, yielding a total difficulty score (range 0–40) for the previous 6 months. A fifth subscale taps prosocial strengths. Supplementary questions measure the impact (none/minor/definite/severe) of a child's difficulties in terms of distress and interference in everyday life. The SDQ permits explicit comparison of self-rated and parent-rated scores about the same child: multi-respondent scores are usually discrepant but significantly correlated, and the SDQ performs well compared with other outcome indicators reviewed in the literature.

## ***Children - Our Future, Our Responsibility***

- *Afghan Symptom Checklist (ASCL)*. The ASCL (Miller et al., 2006) is a 22-item self-reported check list that has excellent reliability ( $\alpha = .93$ ) and good construct validity, correlating strongly with a measure of exposure to war-related violence and loss ( $r = .70$ ).
- *Self-Reporting Questionnaire-20 (SRQ-20)*. This measure was developed by the WHO to screen for psychiatric disturbance in individuals living in developing countries. It has adequate reliability and internal consistency ([http://whqlibdoc.who.int/hq/1994/WHO\\_MNH\\_PSF\\_94.8.pdf](http://whqlibdoc.who.int/hq/1994/WHO_MNH_PSF_94.8.pdf)).
- *Quality of Life*. This measure has been developed for the project.
- *Verbal Quiz: Key messages from each component of the psychosocial intervention*. This measure has been developed for the project.

Implementation of the psychosocial protocols in the In-Patient or Residential Centers follows the model previously introduced with regular opportunities for individual and group counseling as well as psycho-education components or modules. Women, children and adolescents voluntarily agree to participate in assessments and detoxification. Beginning in week two, the psychosocial program is provided 5 times a week over the course of 45 days for children and 180 days for adolescents. Each group session lasts 1 hour. An example schedule of inpatient components of treatment for the children/adolescents can be found in the table below.

## ***Children - Our Future, Our Responsibility***

**Table: Example schedule of components of the intervention that the children/adolescents receive while inpatient for 45 days, with the cycle repeating for adolescents that continue for the full 180 days.**

| Week | Sunday  | Monday  | Tuesday   | Wednesday  | Thursday  |
|------|---|---|---|--|---|
| 1    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |
| 2    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |
| 3    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |
| 4    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |
| 5    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |
| 6    | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Trauma coping skills</li> </ul> | <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Drug education</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Structured art therapy</li> </ul> | <ul style="list-style-type: none"> <li>• Hygiene</li> <li>• Personal safety</li> </ul> | <ul style="list-style-type: none"> <li>• appropriate basic education</li> <li>• Communication skills</li> </ul> |

The model defines eight modules for use with children and adolescents. Staff have been trained to give age appropriate knowledge, skills and activities for each module.

## ***Children - Our Future, Our Responsibility***

Implementation of the modules is defined in the chart above but trained staff are encouraged to build a rapport with the children and adolescents, and to engage them in increasingly more complex and creative thinking. The overall approach for each module is a skills-based approach, encouraging the child or adolescent to learn a skill structured to be useful outside the drug dependence treatment setting. The following is a short description of the eight modules which are further defined in the training package:

***Age-appropriate basic education:*** For those children 4-7, the foundations of education will be covered thrice weekly. Examples of topics covered include the alphabet, shapes, size relationships, opposites, writing of letters and numbers, numbers and numeric relationships. For younger and older adolescents, literacy and basic mathematic functions, applying math to daily living, will be covered.

***Drug education:*** In an age-appropriate manner, the different types of drugs, how they are used, the effects of drugs and how drug use hurts people will be explained. It can cause illnesses, impaired coordination, slowed growth, and emotional harm such as feelings of isolation or paranoia. It is also important to discuss the legal issues associated with drug and alcohol use because a conviction for a drug offense can lead to prison, loss of a job education. Talk about positive, drug-free alternatives and explore them together

***Nutrition:*** Using the UNICEF publications, the nutritional information will be tailored to the age of the children. Topics covered include a discussion of what are healthy foods, the types of vitamins and minerals needed for healthy growth, how to prepare healthy foods and simple meals will be discussed.

***Hygiene:*** In an age-appropriate manner, the importance of hand washing, brushing teeth, and caring for the body will be discussed. The use toilets or latrines and the need to practice good hygiene, protect water sources, and safely dispose of waste water and refuse will be presented. Children are taught how to make soap.

***Personal safety:*** In an age-appropriate manner topics covered include basic living safety such as avoiding open cooking fires, bare light bulbs, live electrical wires, land mines, identifying hazards in the home, basic ways to stay healthy, how to interact with adults and avoid and/or keep yourself safe during family violence situations.

***Trauma coping skills:*** Children/adolescents and caregivers will be taught to: Deal with intrusive thoughts and feelings, skills to reduce arousal (relaxing, concentrating, and sleeping), and skills to manage avoidance (fears/difficulties facing reminders). Role-playing and practices of skills will be undertaken. Participants will draw, write, and talk about the incidents. They will also be shown how to look to the future rather than the past (avoidance).

***Communication skills:*** In an age-appropriate manner, effective communication techniques will be taught. Items covered will include interaction and communication with

## ***Children - Our Future, Our Responsibility***

adults, conflict resolution, positive self-talk, culturally appropriate self-advocacy communication, de-escalation of angry situations.

***Structured art therapy:*** In an age-appropriate manner, participants are given materials and guided to explore and express emotions. Topics include making self-masks, memory boxes, boxes representing themselves, painting pictures to express emotions, creating clay objects to express stories about their life events. This art therapy helps children/adolescents deal with and recover from traumatic events in their lives.

These eight core modules form the foundation of the Children's Project. They are modified and available through outreach services, outpatient, residential and all follow up services. These eight modules are the core of the model but how they are implemented, specific activities to be done and to whom they are targeted at is defined at the country and local level. As the project expands beyond Afghanistan these eight modules will remain but we envisage they will be tailored to meet the needs of each country.

UNODC has noted that a high number of children being screened for drug use live in homes or situations where an adult or caregiver is using drugs. Eleven modules have been designed for use with the parents or caregivers seeking drug dependence treatment for themselves and their families. The eleven modules for adults are as follows:

***Basic Education:*** Adult literacy and basic mathematics will be covered.

***Drug Education:*** A discussion of the types of drugs that can be abused, their effect and harms on the body, other and society will take place. How to avoid drugs, refuse drugs, and find drug-free alternative recreation is presented.

***Reproductive Health:*** This component draws from the growing literature on this topic [e.g., (Apfel & Simon, 1996; Haider et al., 2009)]; UNICEF publication *Child Development: Facts For Life*.

[http://www.unicef.org/publications/files/Facts\\_for\\_Life\\_EN\\_010810.pdf](http://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf).

This covers aspects such as the benefits of spacing child spacing (timing births years apart) for mothers, children, family and society; the dangers of childbirth, ways to increase safe motherhood (e.g., via prenatal care), breastfeeding, and the importance of giving children colostrum.

***HIV and Sexually Transmitted Infection Education:*** This component draws from publications focused on Afghanistan and other war-torn areas [e.g., (Apfel & Simon, 1996; Haider et al., 2009)]; UNICEF publication *Child Development: Facts For Life* [http://www.unicef.org/publications/files/Facts\\_for\\_Life\\_EN\\_010810.pdf](http://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf)). There is a specific section *Why it is important to share and act on information about HIV* in the UNICEF document that provides a foundation for how to cover how HIV and STIs are contracted, advise mothers and fathers on STIs, including HIV, and if they are infected with HIV, how to care for themselves to reduce the chance of getting infected, provide messages about testing and that although HIV is still incurable, it is a manageable

## ***Children - Our Future, Our Responsibility***

condition. If infected infants and children are diagnosed early, receive effective treatment and take antiretroviral drugs as prescribed, they have a better chance to grow, learn, develop and have dreams for the future, discuss breastfeeding in a way that reduces the risk of infecting the child

***Hygiene for family:*** Several important messages are delivered including the fact that all human waste, *including* those of babies and young children, should be disposed of safely. Making sure that all family members use a toilet, latrine or potty (for young children) is the best way to dispose of feces. Where there is no toilet, feces should be buried. All family members, including children, need to wash their hands thoroughly with soap and water after any contact with human waste, before touching or preparing food, and before feeding children. Where soap is not available, a substitute, such as ash and water, can be used. Washing the face and hands with soap and water every day helps to prevent eye infections. In some parts of the world, eye infections can lead to trachoma, which can cause blindness. Raw or leftover cooked food can be dangerous. Raw food should be washed or cooked. Cooked food should be eaten without delay or thoroughly reheated before eating. Safe disposal of all household refuse helps to keep the living environment clean and healthy. This helps prevent illness. Hygiene is very important during menstruation. Clean and dry feminine hygiene products should be available to girls and women. A clean, private space should be provided to allow them to clean themselves and wash and dry their clothes. Sanitary napkins need to be disposed of carefully.

***Money/resources:*** We discuss what resources are most important to the participants, creative ways to make few resources last longer, how to develop a budget and how to manage basic finances.

***Communication-skills:*** We present ways of communicating with others to make points clear, how to deescalate conflicts in the home, how to keep each person in the family safe when arguments or violence occurs in the home.

***Family safety:*** This component draws from publications focused on Afghanistan and other war-torn areas (e.g., UNICEF publication *Child Development: Facts For Life* [http://www.unicef.org/publications/files/Facts\\_for\\_Life\\_EN\\_010810.pdf](http://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf)). There is a specific section *Why it is important to share and act on information about Child Protection* in the UNICEF document. Examples of important learning messages from this component include: (1) girls and boys must be protected from all forms of violence and abuse (i.e., physical, sexual and emotional abuse, neglect and harmful practices such as child marriage). (2) Families, communities and authorities are responsible for ensuring this protection. (3) Children must be protected from hazardous work. Work should not prevent children from attending school. Children should never be involved in slavery, forced labor, drug production or trafficking. (4) Girls and boys can be at risk of sexual abuse and exploitation in their home, school, workplace or community. Measures should be taken to prevent sexual abuse and exploitation. Sexually abused and exploited children need immediate help to stop such abuse.

## ***Children - Our Future, Our Responsibility***

***Nutrition:*** This component covers how to know if you and your child are eating enough food and the right foods. What are the basic building blocks of nutrition, how to prepare foods to retain their nutrients, how to keep food and water clean and safe.

***Child Development:*** This component covers child mental health, the importance of immunization, child development, and attention to illnesses such as diarrhea, worms, coughs and colds, and malaria [e.g., (Apfel & Simon, 1996; Haider et al., 2009)]. Materials that will be incorporated into this component includes:

***Child Development: Facts For Life,*** a widely distributed UNICEF booklet ([http://www.unicef.org/publications/files/Facts\\_for\\_Life\\_EN\\_010810.pdf](http://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf)), and the WHO Child Growth Standards (<http://www.who.int/childgrowth/en/>). This component covers the basic developmental milestones at different ages and of basic principles of childhood mental health. Through this component, men and women learn that "the child's greatest need is the love and attention of adults," a message that can be reinforced in discussion with families at every contact and also demonstrated by the professionals and home health volunteer workers in kind and loving behavior toward the parents and children. Another UNICEF publication, *Helping Children Cope With Stresses of War: A Manual For Parents and Teachers* [(Macksoud & Aber, 1996); [http://www.unicef.org/publications/files/Helping\\_Children\\_Cope\\_with\\_the\\_Stresses\\_of\\_War.pdf](http://www.unicef.org/publications/files/Helping_Children_Cope_with_the_Stresses_of_War.pdf)] is a short booklet that has been field tested and that can be used with great effectiveness in transmitting some basic lessons about child developmental as well as signs of stress children show (e.g., bedwetting, clinging, night terrors) and how to deal with these issues in a loving way. This component also covers how to identify, treat, and protect children and families from diarrhea, coughs and colds, and malaria based on the in depth materials provided from UNICEF's publications.

***Parent Child interaction:*** UNICEF publications, *Helping Children Cope With Stresses of War: A Manual For Parents and Teachers* [(Macksoud & Aber, 1996); [http://www.unicef.org/publications/files/Helping\\_Children\\_Cope\\_with\\_the\\_Stresses\\_of\\_War.pdf](http://www.unicef.org/publications/files/Helping_Children_Cope_with_the_Stresses_of_War.pdf)] and *Child Development: Facts For Life* , a widely distributed UNICEF booklet ([http://www.unicef.org/publications/files/Facts\\_for\\_Life\\_EN\\_010810.pdf](http://www.unicef.org/publications/files/Facts_for_Life_EN_010810.pdf)) both have key messages and materials that are used to develop this component to reinforce how to soothe children, how to nurture their bodies and minds and how to help them develop into capable individuals. This component also draws from the International Child Development Program (ICDP) approach which aims to bring out and sustain high-quality interaction between caregivers and their children and sensitize caregivers by creating a warm human environment, without imposing readymade formulas from the outside. The objectives of the ICDP are to influence the caregiver's positive experience with the child; promote sensitive emotional expressive communication; promote enriching, stimulating interaction; and reactivate indigenous childrearing practices. The ICDP is rooted in modern developmental psychology (Hundeide, 1991) and it has been developed and used in many different countries, and it is simple, sensitive, and culturally adaptable [e.g., (Dybdahl, 2001)]. Furthermore, the characteristics of caregiver-child interactions similar to those promoted in the ICDP have been associated with adequate growth and development in children (Myers, 1992).

## ***Children - Our Future, Our Responsibility***

***Trauma coping skills:*** Participants are taught: How to deal with intrusive thoughts and feelings, skills to reduce arousal (relaxing, concentrating, and sleeping), and skills to manage avoidance (fears/difficulties facing reminders). Role-plays and practices of skills will be undertaken. Participants will draw, write, and talk about the incidents. They are shown to look to the future rather than the past (avoidance). The mothers and fathers are also shown that early development takes place largely within the context of the care-giving relationship. The impact of trauma on infants and young children is unique because it occurs within a critical developmental period and is vastly influenced by the nature and quality of the care-giving system (Scheeringa & Zeanah, 2001). When the care-giving relationship is characterized by uncertainty, unpredictability, or fear, it affects a child's basic sense of safety within relationships and in the world (Hesse & Main, 2006). Within the context of this component, staff will also emphasize the attachment system as a foundation on which to base clinical intervention is critical in the promotion of recovery with young children affected by complex trauma (Osofsky, 2004). In the realm of child mental health, the term *complex trauma* has been used to reference the "dual problem of exposure and adaptation" frequently observed in victims of severe and sustained childhood abuse and neglect [(Spinazzola et al., 2005), p. 433], namely, the effects of chronic maltreatment on immediate and long-term outcomes across domains of impairment, including attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self concept (Cook et al., 2005). The Attachment, Self Regulation, and Competency (ARC) Framework is one of a handful of emerging treatment models being developed in partnership with the National Child Traumatic Stress Network (NCTSN) as an intervention for children and adolescents impacted by complex trauma (Cook et al., 2005) and aspects of this framework are incorporated into this component.

Using this overall model of service provision for children, adolescents and their families, has provided a more consistent approach to meeting the needs of patients struggling with drug use and drug use disorders. Implementing these modules, eight for children and eleven for adults, has provided additional structure to the services being provided for families. The consistent use of these modules reinforces the information previously taught and then allows for the introduction of new ideas and concepts as the patients are ready.

## ***Children - Our Future, Our Responsibility***

### **Afghanistan Results of Psychosocial Protocol Implementation**

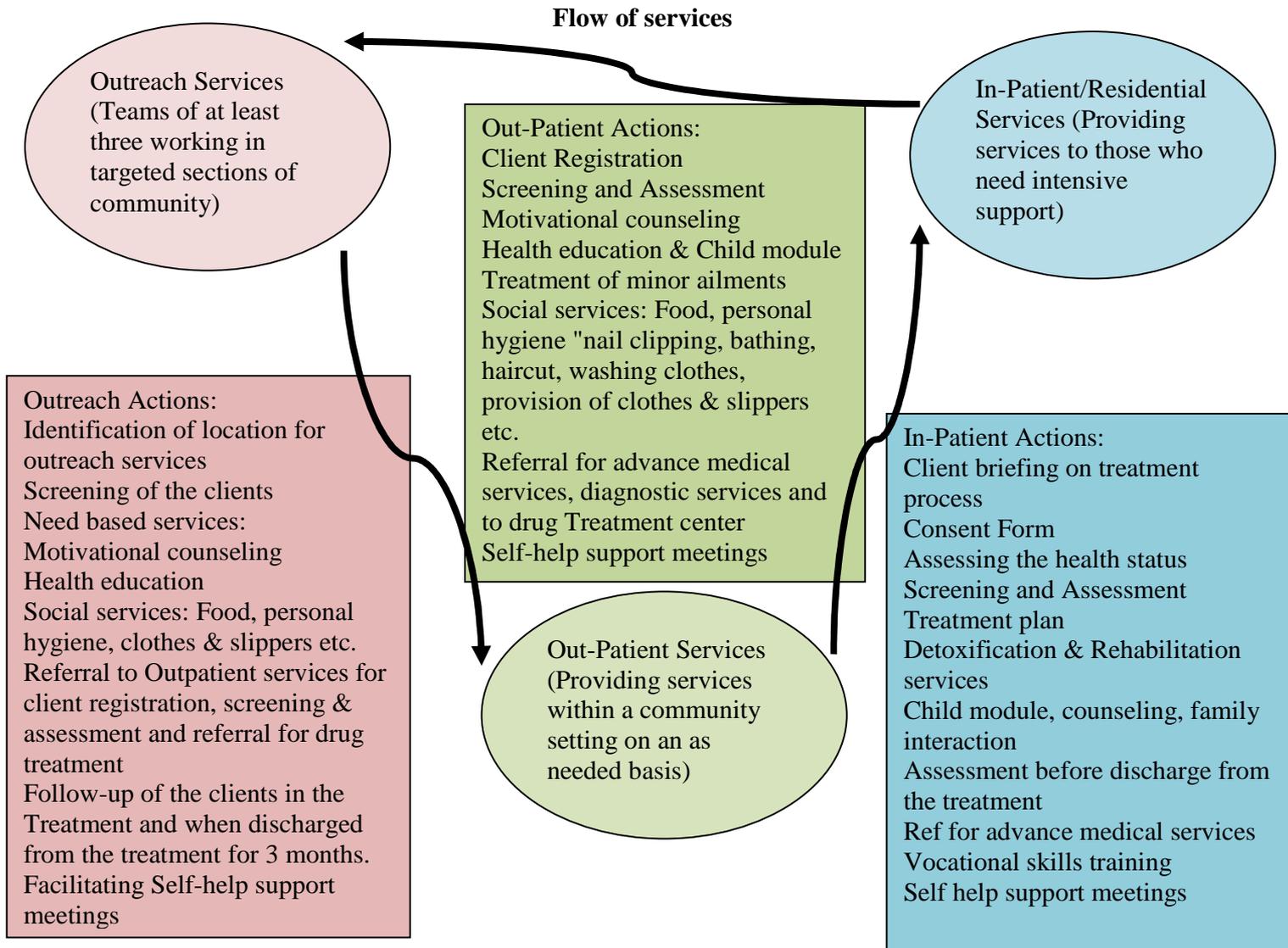
In summary, the most notable results of the pilot in Afghanistan has been the following:

- Increased number of children and adolescents receiving services, 1160 (residential drug treatment services) in 18 months.
- Increase the number of healthcare and drug demand reduction staff meeting the challenge of drug use and drug dependence in children and adolescents.
- Expansion of existing drug treatment service to include thirty eight additional service point delivery with outreach (11 teams), outpatient (8 centers), residential (19 centers) for children, adolescents and women.
- Institutionalize provincial coordination meetings with key stakeholders and quarterly task force meetings at the national level.
- Develop and implement a data collection system to formalize data collection.
- Build the capacity within the Ministries and within a cadre of substantive experts as trainers to disseminate knowledge and skills to other professionals.

This increase in such a short time, was made possible because UNODC was able to capitalize on the strong foundation in drug dependence treatment services developed by the US State Department, INL and the Colombo Plan, an International NGO with more than seven years of experience in Afghanistan.

One of the cornerstones of this pilot project was a focus on coordination of services at multiple levels. First, a strong emphasis was placed on involving the Ministries and building the capacity of government staff related to drug demand reduction services, especially for children and adolescents. Second, the project asked each of the implementing partners identified above to meet monthly within their province to exchange ideas, discuss challenges and success, and to coordinate the services to provide a seamless and fully supported experience for the patients. This involves coordinating services from outreach to out-patient to residential services and then comes full circle to recovery and follow up services as demonstrated in the graphic below.

## **Children - Our Future, Our Responsibility**



### **Conclusion**

UNODC Children's Project (GLOK42) has been successfully piloted in Afghanistan and will continue to support the children and adolescents in Afghanistan as funding permits. Additionally the project has recently expanded to India, Bangladesh, Pakistan, Liberia and West Africa. UNODC looks forward to working in these unique settings and tailoring the existing protocols to meet the needs of children and adolescents. In implementing this groundbreaking project at the early pilot stages, UNODC has identified the following ten Key Learning's:

## ***Children - Our Future, Our Responsibility***

1. A paradigm shift is required to work with children using drugs or dependent on drugs. The most at-risk children and those requiring treatment are likely to have been exposed to drugs at a very early age by a caregiver or family member. These children have not chosen to use drugs for pleasure but rather drugs have become the only means they know to survive.
2. Countries, regions, cities, families and children themselves are in denial about substance use in children under the age of 12. It is crucial to develop a trusting relationship, build empathy and maintain confidentiality.
3. Coordinated, organized and easy to understand service implementation creates a less threatening environment for families to negotiate treatment services. Providing clear, concise and consistent information supports sustained involvement of families and children.
4. Outreach services are the core of the model. Given the stigma that often accompanies substance use, families are not initially likely to bring their children into a Center. Compassionate, and culturally appropriate outreach workers can engage the family and slowly build a level of confidence that allows them to seek the needed services.
5. Children and adolescents thrive in a supportive, caring, empathetic, and structured type of setting with consistent expectations and consequences. However, it is crucial to provide time for creativity, introspection and time to allow for the patients to a safe place and space for them to have a childhood, sheltered from the adult issues they face in their lives. They are given time to be engaged in age and developmentally appropriate child behaviors and be “children”.
6. All too often the children and adolescents using and dependent on drugs are living in a world with little or no hope for the future. Instilling a sense of hope one day at a time, supports a transition to hope for the future. A key element of instilling a sense of hope is working with the staff to ensure they themselves have a level of hope for the patients themselves but also for the larger community.
7. This model is not static nor does it exist in a vacuum. A systemic approach that involves all persons, government ministries, organizations and community members that engage with children are necessary for successful implementation.
8. A basic tenant of this project is that drug use, and drug dependence, is a multi-factorial public health issue. Children and adolescents who are using or

## ***Children - Our Future, Our Responsibility***

dependent on drugs are not “bad” people to be punished or disciplined but rather have a health condition that needs the same care as other identified medical conditions.

9. Follow up and recovery services are the cornerstone of success for children and adolescents. Providing a child the education to re-enter the community at a level similar to their peers is important. Additionally, it is imperative that the environment that a child returns to be safe and whenever possible parents and caregivers with a past history of drug use should be in recovery as well.
  
10. The time, resources and effort of many persons go into supporting the recovery of just one child or adolescent. But the benefits of creating a safe and healthy means for a child to grow and develop into the future of their choice gives us all hope for the future.

# Appendix A

## ***Children - Our Future, Our Responsibility***

### **UNODC Children Project Services in Afghanistan**

#### **KABUL**

##### **TREATMENT SERVICES**

- Children Treatment center (40 Beds) (01) WADAN
- Adult Female treatment center (20 Beds) (01) WADAN
- Children Treatment center (10 Beds) (01) SSAWO
- Adult Female treatment center (05 Beds) (01) SSAWO
- Male adolescent Treatment center (40 Beds) (01) NEJAT

##### **OUTREACH SERVICES**

- Outreach Team (01) WADAN
- Outreach Team (01) NEJAT
- Outreach Team (01) OHSS
- Outreach Team (01) ASP
- Outreach Team (01) ASP

##### **OUTPATIENT SERVICES**

- Outpatient center (01) WADAN
- Outpatient center (01) NEJAT
- Outpatient center (01) OHSS

#### **NANGARHAR**

##### **TREATMENT SERVICES**

- Children Treatment center (05 Beds) (01)  
WADAN
- Adult Female Treatment center (05 Beds) (01)  
WADAN
- Female adolescents Treatment center (10 Beds) (01)  
WADAN
- Male Adolescent Treatment Center (20 Beds) (01) NEJAT

##### **OUTREACH AND OUTPATIENT SERVICES:**

- Outreach Team (01) WADAN
- Outpatient Center (01) NEJAT

#### **BADAKHSHAN**

##### **TREATMENT SERVICES**

- Children Treatment center (25 Beds) (01) SHRO
- Adult Female Treatment center (10 Beds) (01) SHRO

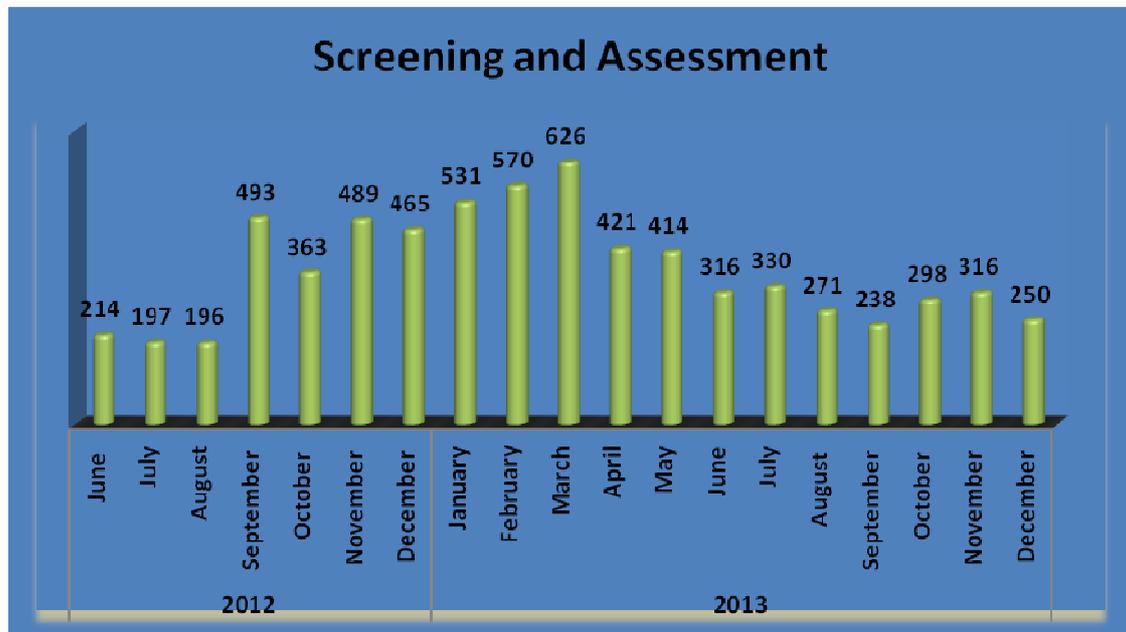


# Appendix B

## ***Children - Our Future, Our Responsibility***

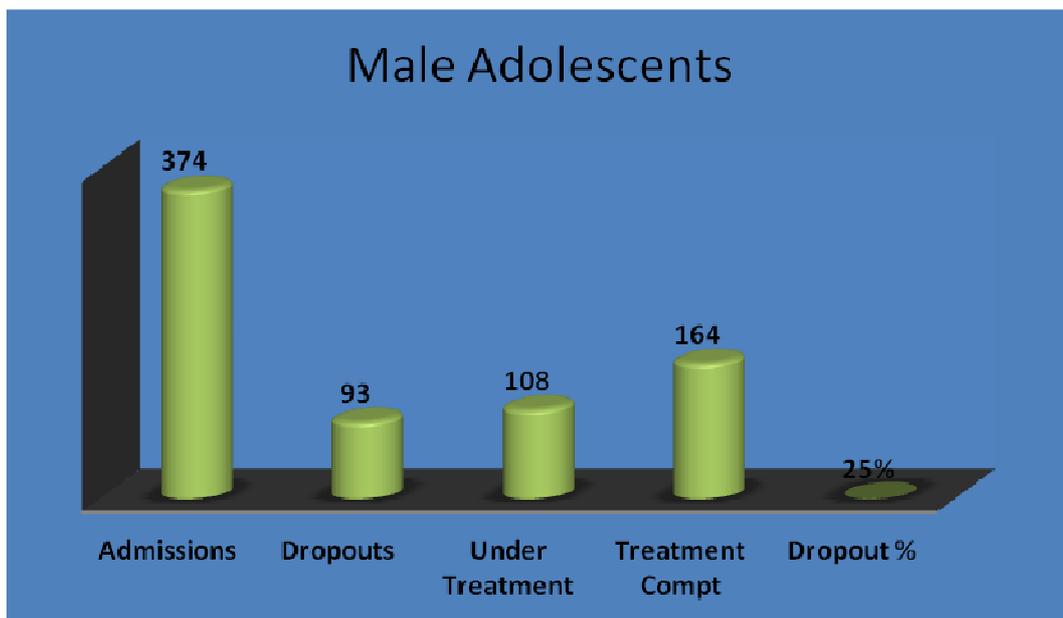
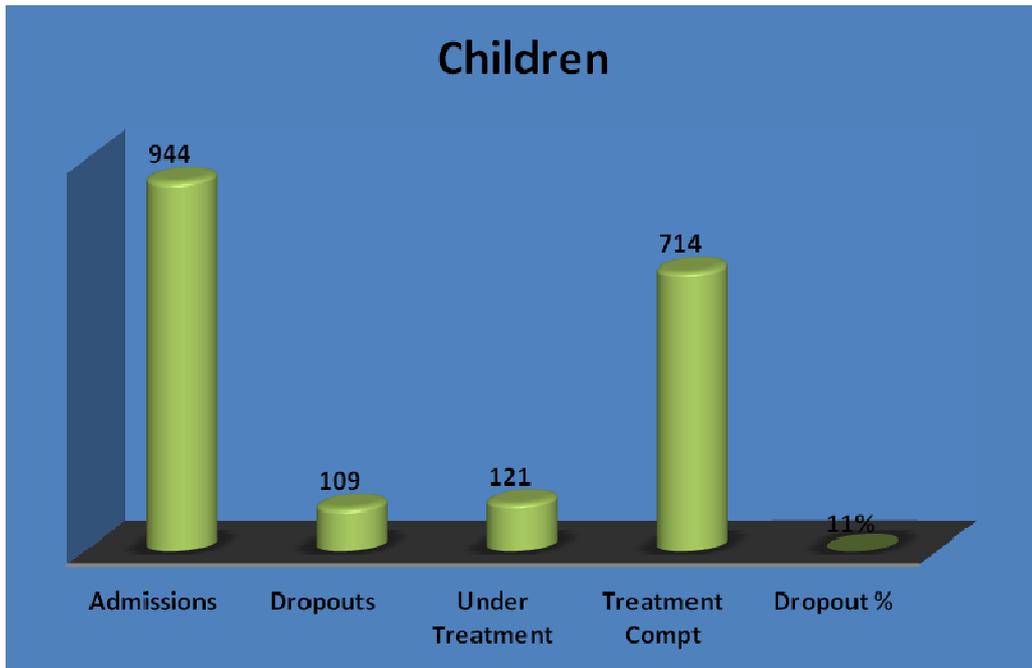
### **Number of Clients Screened and Assessed June 12 to May 13**

Screened and Assessed: 4863 Clients in Outpatient Centers

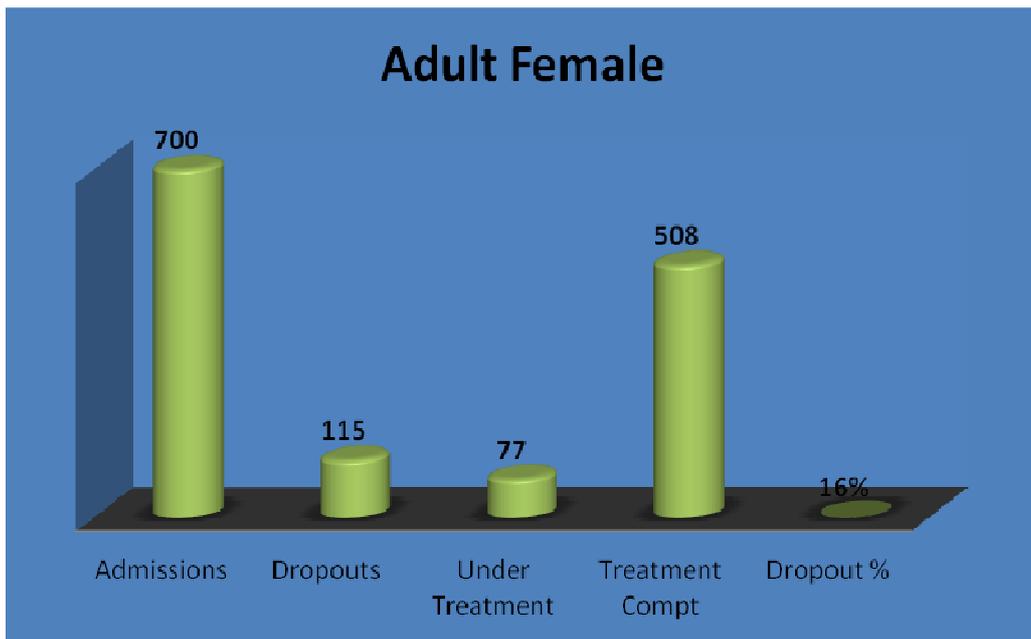
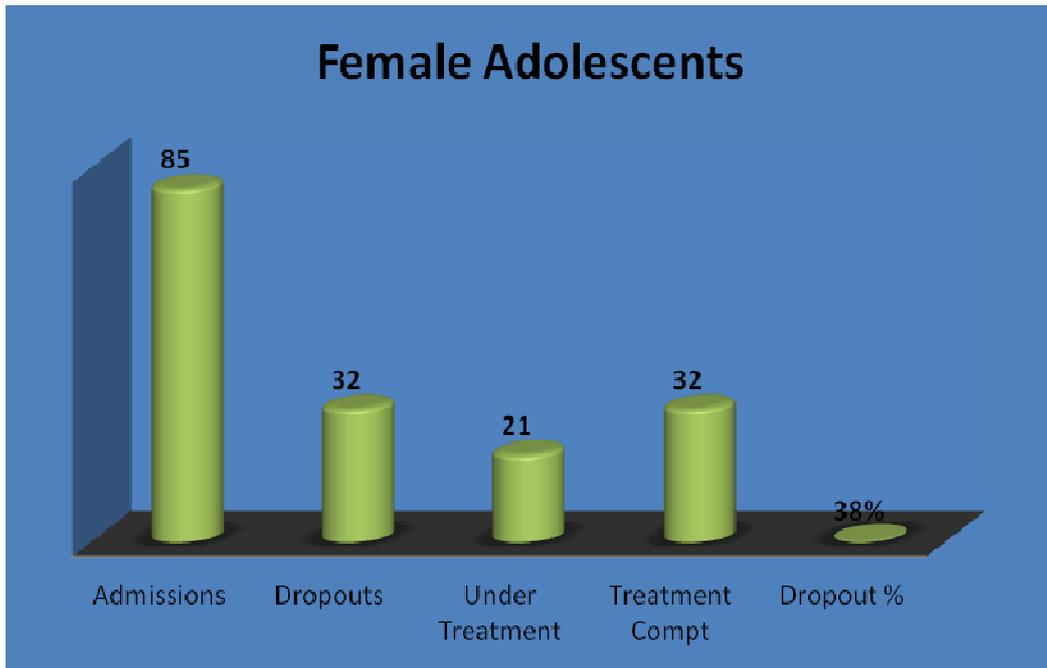


### **Residential Drug Treatment Services June 2012 to December 2013**

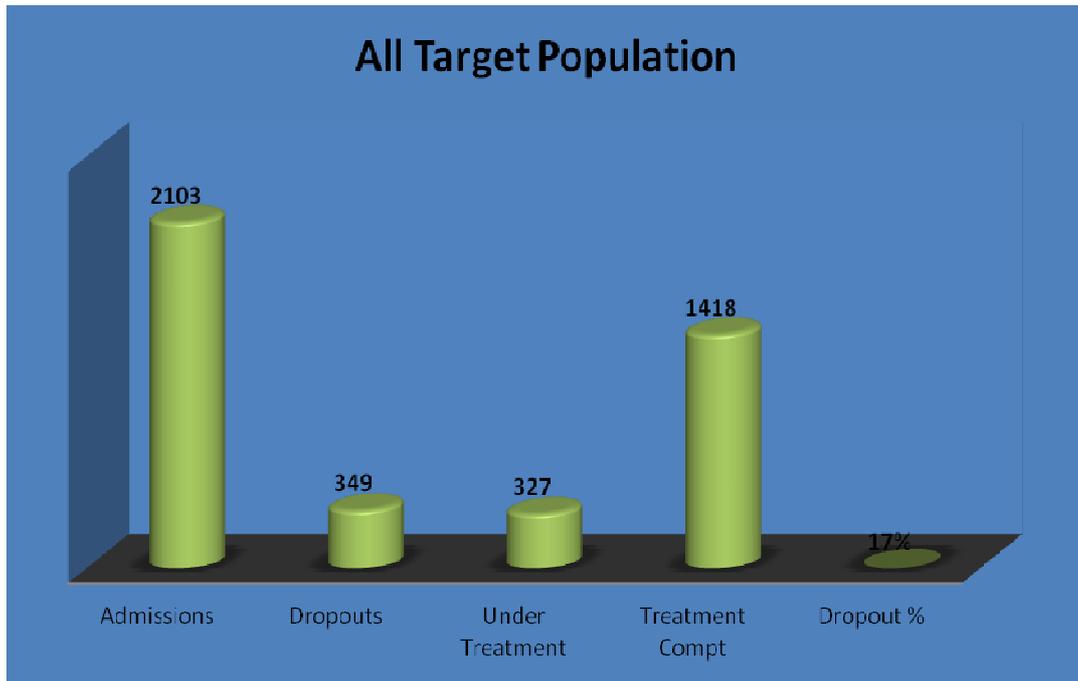
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