Drug Abuse: News-n-Views

A Newsletter brought to you by the National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi

Issue : March 2009 **Theme : Drug use among Street Children**

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Editorial

Dear readers

In this issue of our newsletter, Drug Abuse: *News-n-Views,* we discuss the theme, "Drug Use among Street Children."

'Street children' are visible everywhere – selling books, picking rags, polishing boots. Yet people have little idea of what their lives are like, what choices they make, what they like and how they see their future. They are often treated as a 'problem of the society', which requires a solution. In the last two decades, the subject of 'street children' has captured enormous attention.

This issue is especially important for a predominantly young country like India, which has the largest number of street children in the world. Among many problems being faced by the street children – poverty, deprivation, malnutrition, lack of facilities for survival, violation of rights – a major problem is substance use. Many studies have highlighted the high prevalence of substance use in this population. Though there are many conceptual issues involved in defining street children and most studies conducted on this population have methodological variations, it can be safely concluded that abuse of various psychoactive substances is a widespread phenomena among street children. The literature on this topic has been summarised and discussed in our article: *Street Children and Substance Use.*

One of the major difficulties in studying and helping this population is its inherently mobile nature. It is not easy to access and engage street children; even more difficult is accessing and engaging *substance-using* street children. They remain a hidden population in many ways, rarely entering into the social consciousness.

As reviewed in the article mentioned above, the substances preferred by this population are those which are relatively easily available. While tobacco remains the drug of choice for initiation, a large number do graduate to using other drugs such as inhalant preparations, progressing eventually to illicit ones like cannabis or heroin. This issue of widespread use of inhalants by the street children, unfortunately, has not received the required attention. It appears that inhalant use is fast becoming the norm among this population. Mr. Sanjay Gupta, a child-right activist presents a brief summary of a study conducted on this issue titled, *Use or Abuse*?. Certain findings of this study – conducted among street and working children in Delhi – are indeed striking. It has been reported that inhalant drugs (known on the street as 'solution') are very easily available, not only on the stationery stores but also in common grocery shops and even pan shops! The dimensions of the 'solution' market also appear to be mind-boggling. The estimated turn-over of commonly available typing correction fluid – if the methodology of the researchers is correct – runs into lakhs of rupees daily!

Typing correction fluids are most popular among street children as inhalants (*brand name has been erased*)

A major obstacle in controlling this problem would be the legal status of inhalants. Most products commonly used as inhalants – glues, correction fluids, petroleum products etc. – are not categorised as narcotic or psychotropic substances and consequently are not controlled. However, their propensity to be abused is now increasingly being recognised both by the researchers (*Basu et al, Indian J of Med Sciences, 2004*) as well as by the media (*Times of India, 26 Jun 2007; merinews.com, 2 Mar 2008*). In the face of this evidence, some policy changes must be made in this regard to regulate the availability of these products to the vulnerable population. An example is the Chandigarh administration, which – after finding a link between abuse of these drugs by children and criminal activities – imposed a ban on sale of correction fluid to minors (*Times of India, 7 Oct 2006*).

It is a well known fact that supply reduction strategies alone are not effective in curbing the problem of drug abuse. Despite the best efforts at regulating the supply of inhalants, there will always be a substantial number of children and adolescents who will require help in quitting use of drugs and remaining away from them. Dr. Anju Dhawan has discussed this issue at length in her article: *Inhalant Use among Street Children: what can be done*? The virtual absence of pharmacotherapy for treatment of dependence on inhalant drugs remains a challenge for the future research. Till then, search should be on for finding effective, feasible and acceptable non-pharmacological interventions to help inhalant using adolescents. The NDDTC, AIIMS, with support from WHO (India) has recently initiated a pilot project to develop a psycho-social intervention package for inhalant using street children. The project is being implemented simultaneously at New Delhi and Bangaluru (by NIMHANS), in collaboration with NGOs working with street children.

Another issue worth considering is the association of substance use with the risk of spread of HIV and other infections. Street children, by virtue of their social and economic deprivation are a vulnerable group to be abused sexually or to engage in consensual high-risk activities. Substance use in this group renders it even more vulnerable and poses a special challenge for interventions. Dr. Suruchi Pant – referring to her own experience in dealing with this issue in various South Asian countries including India – has discussed this aspect in her article: *Reaching out to substance using street kids*.

Do keep writing to us.

Happy reading,

B. M. Tripathi

Atul Ambekar

STREET CHILDREN AND SUBSTANCE USE

KOUSHIK SINHA-DEB, ATUL AMBEKAR, B. M. TRIPATHI
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In the last two decades or so, the subject of 'street children' has captured enormous attention.

The difficulty in dealing with the subject is the conceptual problem of definition: Whom do we call as street children? The frequent use of the term 'street children' has rendered it a generic meaning, encompassing all the children found on the streets either working or living. Other terms such as 'children without families', 'high risk children', 'abandoned and destitute children', 'children in need of care and protection' and 'children in especially difficult circumstances' are also commonly used to refer to street children.

One of the first definitions is: Street children are those for whom the street (in the widest sense of the word) more than the family has become their real home, a situation in which there is no protection, supervision or direction from responsible adults. UNICEF, in the past, used two differentiating subcategories: 'children on the streets' and 'children of the streets'. Children 'on' the street refer to those who just use the street as their workplace but have regular contact with their families. Children 'of" the street live, work and sleep in the street. However, even these distinctions had their inherent limitations. Hence, currently, UNICEF has been grouping all working children, whether working on city streets or elsewhere, as 'working children'. It uses the term 'street children' to refer to the smaller number of largely abandoned children and youths for whom the city streets are home. In India, 'street children' have been categorized into three groups based on the relationships and contact with families: Children with their families, children who live with their family and work on the street, children who live and work on the street (Behura and Mohanty, 2002).

The next major hurdle in studying problems of street children is the fact that there is no easy way to survey them. By definition they roam on roads rarely having any permanent address. Substance-using street children are even more unreachable because of the factors like fear, stigma, and their substance using behavior.

Street children in India :

According to UNICEF (estimates of year 2002), 100 million children live and work on the streets of the cities of the world: 40 million in Latin America, 25- 30 million in Asia, and 10 million in Africa.

India has the largest number of street children in the world. Though most of population is still rural, India is urbanizing rapidly, leading to a rapid growth of slums and shanty towns. India also has a huge at-risk young population with 40% being under the age of 18 years. All these factors have resulted in an explosion of street children in the country.

The 2001 Census estimated that eighteen million children lived and worked in India's urban slums (huts, pavements etc), which under the government's definition qualified them as street children.

Substance abuse in street children

Substance abusing street children being a hidden population, there is no definitive data on the prevalence of various substances in this group. The WHO has estimated that up to 90% of the worlds street children abuse some kind of drugs.

A review of all published literature (both scientific as well as 'grey') showed that most data is available from big metropolitan cities in India. While this is partly reflective of the growing phenomenon of urban slums resulting in more street children being in big cities, it in no way implies

that the phenomenon of drug use in street children is not there in smaller cities. There is an urgent need to fill these gaps in our knowledge as the substance use pattern and risk factors in small cities may be markedly different for street children. Though, all the available studies had methodological limitations, some broad findings do emerge on this issue, which have been summarised below.

The National Household Survey on Drug Abuse, surveyed 40,697 males of whom 8,587 were children (aged 12-18 years). Of these, 3.8% were using Alcohol, 0.6% Cannabis and 0.2%were using Opiates. Though this survey looked into the substance use pattern of children *living in houses* it provides a yardstick for comparing the substance use in street children. Similarly, of people who reported to the treatment centres for their drug use problem only 5% were below 20 yrs. However, almost 70% of these drug users have initiated substance use before the age of 20 years. This implies that most drug users start early (i.e. in childhood / adolescence) but remain hidden from all intervention efforts.

"…Most drug users start early (i.e. in childhood / adolescence) but remain hidden from all intervention efforts"

In comparison in community/street surveys as many as 70% - 85% the children reported that they were addicted to one substance or another. For example in a Bangalore study, of the 281 children assessed 197 were Drug users and 84 were Non users. More specific findings emerging from the review of literature are as follows:

"…Most street children take drugs as a way of street life"

Socio-demographic profile: The mean age of street children taking substances have been found to be 13.33 ± 2.29 (range 10–17 years). In most of the studies, the substance using street children were exclusively or mostly boys. Indian street girls interviewed were often employed in 'beedi' factories and had a place to stay, were more often picked up by NGOs and put in home (as it was perceived that they had better chance of recovering and more threat from sexual abuse on the streets and hence could be accommodated under various programmes). However, most studies found that a large proportion had been pressed into commercial sex work as soon as they landed up on to the streets.

Most of these children are school dropouts (as high as 90%). Their education had stopped when they left home, or they drop out of school when they are forced to go to work by family members. The majority worked as unskilled labourers. Many are engaged in collecting empty plastic water bottles from the trains. Rag picking, driving pedal rickshaw and loading – unloading of goods are the major occupations. A street child spends on an average eight hours a day working for livelihood. Their occupation is significantly related to their substance use behaviour. For example, bottle pickers after attending a train can have a rest while waiting for another train to arrive, which is the commonest time for a smoke of a huff of inhalant. Even with eight hours of work the street children earn significantly more than they can spend immediately which leads to more chance of substance use.

Additionally, they operate under constant fear that the money that they earn or save from their earnings would be stolen or snatched away. Thus they tend to spend the entire money they earn immediately, for food, cinema or substance use. With time, substance use takes precedence over other activities like self care and eating and money earned is spent immediately for procuring the substance.

Most children have access to free food, which is distributed at religious places and even in some restaurants. The disturbing fact is that this has given an opportunity to the children to spend a substantial portion of their earnings on drugs rather than on food.

Age of Initiation of Substance use: The minimum age at starting substance use in studies has been found to be as low as 5.5 to 7 years. Data also reveal an interesting 'gateway' phenomenon of progression of drug use. Most of the smaller children (around 10 – 11 years) start off with

tobacco use and when they are a little older they graduate to use of inhalants. By the time they are 13 years, the use of inhalants tapers off and alcohol supersedes inhalants as the drug of choice. This is around the same time that the children experimented with the illicit drugs like cannabis and brown sugar etc.

Type of substance use: Chewing of gutkha and tobacco seemed to be most common among the street children. Around half of the children are also, reportedly, addicted to solvent sniffing in the form of sniffing of correction fluid, adhesive glue, petrol, gasoline, thinner and spirit. Many also consume alcohol. Some children, also report using Charas and smack though they are costlier.

Effects of Substance use: When street children are asked about why they use drugs, their answers are mostly non-specific and vague. Most of them take drugs as a way of street life or to remain in the peer group. When asked specifically about how they feel after taking the substance, the commonest answer was that 'they feel relaxed and happy.' Relief of boredom or hunger or depression and frustration, wanting to feel good, to keep awake or get to sleep or to dream may be some of the functions served by drug use.

"...Drug use in children forms just one of the many elements which contributes to their High Risk Lifestyle"

Complications of Substance use: An interesting finding is that, compared to the western literature in Indian substance using street children the complications of substance use appear to be minimal. Though admittedly, data available from India on this issue is really scanty, nevertheless even in studies looking into street inhalant users, none of the street children had any physical stigmata of inhalant abuse. Studies looking into comorbid psychiatric disorder or hematological and biochemical profile also did not find any major abnormalities. However, one study from Bangalore found that the use of 'solution' was related to occurrence of (a) Tingling and numbness, (b) possible S.T.D.s, (c) stomach problems and (d) headache.

The harmful effects of substance use as perceived or named by children were lung problems like "burning of lungs" and tuberculosis, some stomach ailment like stones, rupture and bloody vomiting, cancer, blackening of teeth, rupture of cheeks, closing of heart and death.

Risk factors of substance use in street children:

Abandoning Home: The primary risk factor of substance use in street children is the very fact that they are living on the streets away from home. The longer their duration of stay on the roads the greater is their chance of falling to substance use and the more difficult it becomes to rehabilitate them.

A large majority of the children report that they left home because of domestic violence and conflict in their family, along with physical abuse by family members. Substance use in fathers, marital discord in parents and assault of spouse and children during intoxicated states by parents are another significant risk factor.

Though western literature describe both "push and pull" factors for living on the streets. Pull factors like excitement and glamour of living in great cities; hope of raising own living standard; and financial security and independence are rarely reported by Indian street children.

Peer behaviour: Peer group and media were the most important influences for initiation of drug use and criminal behaviour in some studies. When a new member is introduced in the group, he is offered the correction fluid brought by the older members. Drug using children have been found to more likely to perceive drug taking as beneficial, less likely to consider drug use as dangerous and have a significantly larger drug using peer group.

Stress: There are many levels of stress that the children face. Many report having gone through Major Life Events. Drug use is often an attempt to cope with the pain and to assist in the period of adjustment. Also for children on the streets the everyday problems encountered are far more grave, persist over time and cannot be easily resolved. Such Enduring life strains force them to seek out drugs.

Life transitions: Street children need to be continually adapting to new situations - moving between communities/ cities with disruption in peer relationships and the need to adjust with a new group of peers. Drugs are used to facilitate acceptance among the new peers and deal with the discomfort associated with the transition.

Normalization of drug use: The term normalization refers to the extent to which a particular drug using behaviour may be considered "normal" in a subculture and how that subculture reinforces that belief. Amongst street children therefore inhalants, such as typewriter correction fluid ("solution"), petrol, glues which are cheap and easily available are widely used as a part of life. Availability of a drug also fosters normalization. Of the licit drugs (Biri, Guthka) are commonly available and are used. Even though misuse of typewriter fluid is obvious, the strong business earning of this licit substance keep the supply abundant in most roadside shops and permits indiscriminate sell to street children (who may have never used or seen typewriters).

High Risk Behaviour: One of the major realizations from the studies is that drug use can not be viewed in isolation. Drug use in children forms just one of the many elements which contributed to their High Risk Lifestyle. Majority of the studied street children had self reported Delinquent behaviour. This included stealing, fighting, rape and self directed aggression. Almost all of the male children have been found to report one or more incident where they had either been forced into, or paid for, or offered drugs in exchange for sex. A nexus between street children and local commercial sex workers has been found, many of whom abuse alcohol and drugs. Children frequently acted as pimps or go – betweens in exchange for money, drugs, shelter or sexual favours. The sexually active children, by and large, report having sex in intoxicated states and not using condoms, despite knowledge of condom use. Intoxication made them careless or daring.

Intervention strategies for drug use in children: Published data on intervention for drug using children in India has been minimal. Only one study from Bangalore attempted structured intervention on drug using street children: an experimental "brief intervention", divided over two or three sessions, aimed at sensitizing groups of selected children and teaching them Life skills. The results appeared to be promising.

However, most authorities on the subject believe that isolated treatment interventions for substance use will rarely be successful in this population. They have no felt need for leaving substances and being habituated to a life without rules they rarely adjust to the structured routine of a hospital stay. A "Problem Oriented" approach in the community focusing on their current difficulties may be more effective in bringing them to mainstream. The felt need of street children are varied and include, Night shelter, Clothes, Medical treatment, Toilet and bathroom, Education, Food, Regular employment and Financial assistance

Thus the review of literature on pattern, prevalence and risk factors of substance use among street children suggests that any intervention plan for substance using street children should be based on the following general principles:

- Adult attachment appears to reduce chances of drug use. Future interventions should involve an adult mentor system, where each child is tied-in with an adult educator.
- Peer educators appear to be the major influence on the street child's learning. Intervention programmes would require training and utilizing older children to sensitize, protect, recruit and counsel younger children.
- Decreased cash liquidity and encouragement to save decreases the chances of drug abuse. Advice to children on savings, as well as providing resources for banking may be helpful.
- Life skills training with a focus on general problem solving appears to have some validity as a brief, cheap, easy to administer method which leads to demonstrable behavioral and attitudinal change.
- Attention to sexual and general health and nutrition needs to be part of any drug prevention package in

this population. It is quite clear that drug use is merely one of the elements in this interacting matrix of risk and a piecemeal approach to any one element is unlikely to succeed.

- Sensitizing junior police personnel and training them to provide protection to children instead of exploiting and brutalizing them as a matter of course would form an important part of this strategy.
- A system of identity cards for the children would, among other things, legitimize their street presence and provide some measure of accountability and protection.
- Night schools and more importantly vocational training centres would allow children to both work and learn
- Community awareness-raising activities which would also seek to educate among others, pharmacists selling off -the –counter- drugs (illegal without prescription) or stationery shop owners selling type-writer correction fluid indiscriminately.

Looking to the future

Some government ministries / departments have in place, schemes for the welfare of street children, which fund NGOs on programmes related to street children. The joint government / NGO project CHILDLINE, a 24-hour, free, emergency telephone hotline in 29 cities, have been used by more than one million children in past 5 years. The National Initiative for Child Protection campaign launched in 2000 has helped in sensitizing a broad range of people across police, healthcare, judicial, education, labour, transport, media and corporate sectors. However, much needs to be done.

Old-fashioned approach of institutionalising street children in custodial care (often through juvenile justice system) is not an appropriate or effective intervention. There is an urgent need to develop Community-based models with an emphasis on the contact / outreach programme (trust and relationship building) linked to 'Contact Centres' (access to services) in the vicinity of their stay / work. As the children live in groups, working with the group is often more appropriate than working on a one-to-one basis. Steps for promotion and protection of street children's rights by sensitizing allied systems such as the police, education, health, judicial system, media etc is necessary. Finally participation of street children themselves in decision-making and formulating intervention strategies is greatly undervalued at present and should be looked into (*koushik.sinha.deb@gmail.com*).

Did you like this issue of Drug Abuse: *News and Views ?* Do you have something to tell us? Your suggestions and feedback are valuable to us.

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USE OR ABUSE ?

A study on the substance abuse among street and working children in Delhi

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A study was conducted among street and working children in Delhi by our organisation, Childhood Enhancement Through Training and Action (CHETNA). There were four main objectives: to understand the lifestyle of street and working children, to explore the causes and factors behind substance use among this population, to assess the magnitude of substance use among this population and to understand the health aspects of drug abuse.

The sample for this exploratory study was comprised of 63 boys in the age group of 8-18 years, recruited from seven different areas of Delhi, which included market places, railway stations and religious places. Various techniques used for data collection were: participatory observation, interview schedules, focussed group discussions, and case studies.

Most children were found to earn their livelihood by polishing shoes, rag-picking, selling toys or newspapers, working as porters and helpers in dhabas and hotels etc. Some were also involved in begging. Majority of the children (62%) were found to work for 8-12 hours per day. Most of them were migrants belonging to Bihar, UP or other states and came to Delhi hoping to find a job and earn money. Most did manage to find some shelter and three or more meals per day. Just about half were illiterate.

A majority in the sample – 73% - were addicted to one drug or another. Most were using 'solution' (street name for typing correction fluid). The usual mode of intake was, pouring the 'solution' on a rag and then sniffing it. The important factors found behind the drug taking habit were: Peer pressure, to relive stress, to increase work-efficiency and for pleasure. The various sources from where children get their drugs include: Pan shops, petty shops, stationery shops and from drug peddlers. While most were earning money, the income was spent mostly on drugs. The extent of dependence on drugs was reported to be so much that many children, in case of non-availability of money, resorted to borrowing, begging or stealing.

Of major concern was the finding that a majority – 65%, were not aware of the health hazards of drugs. This became more alarming in the light of the fact that more than half of these children were suffering from one or other health problems. Importantly however, a large majority, close to 87%, expressed desire to quit taking drugs, but were not aware of the means to do so.

The study also attempted estimating the size of the 'solution' (i.e. the correction fluid) market in Delhi. The researchers estimated that the turnover of the correction fluid market in Delhi ranges anything between Rs. 27,75,000 to as high as Rs. 63, 38,000. Obviously, the manufacturers and marketers of correction fluid are making a lot of money at the expense of heath of the future of our nation.

The findings of this report should be seen as an eye-opener by all of us. Clearly, as highlighted here, the sad state of these children smashes our claims of being a modern and progressive city.

(Full report is available upon request, chetna@vsnl.net)

Reaching out to substance using street kids: Realities and programme priorities for South Asia

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South Asia – one of the most densely populated regions in the world – is home to 1.4 billion people, or roughly one-fifth of the global population. The region's impressive technological and economic advances of the last decade have not always reached the general population, leaving millions living in poverty with inadequate health care.

"Child poverty and deprivation in South Asia are among the worst in the world.."

South Asia also has 584 million children, the largest number of people under the age of 18 of any region of the world. Child poverty and deprivation in South Asia are among the worst in the world, affecting as many as 330 million children or 57 per cent of the child population.

Vulnerabilities of street children

Street children constitute a marginalized group in most societies. Exposed to some of the worst forms of insecurity and abuse, they have no homes to go to for protection and no one to depend on for love and care. The continuous exposure to harsh environments and the nature of their lifestyles make them vulnerable to substance use and this threatens their mental, physical, social and spiritual wellbeing. Most of these children use alcohol and other psychoactive substances.

Street kids are exposed to numerous problems. Exclusion from primary education; stigma and discrimination; exposure to unprotected sex, sometimes in exchange for food, protection or money or as a result of violence and exploitation by peers and adults; illicit drug use; low self-esteem; emotional disorders; poverty (linked to day-to-day existence which makes them vulnerable to violence, petty crime, conflict with the law, abuse, neglect and commercial sex work).

Living in a risky environment often facilitates a careless attitude towards danger and a desire for instant gratification that comes from a lack of hope and optimism. This, in turn, results in impulsiveness and risk-taking behaviours. Some aspects of street life such as extreme mobility, low knowledge and awarerness, recreational sex, lack of adequate responsible adult protection and supervision compounds their risks and vulnerabilities.

Lifestyle:

Street children live a transitory life style and are vulnerable to inadequate nutrition, physical injuries, substance use, and health problems including sexual and reproductive health problems. These factors reduce the effectiveness of interventions that target street children. In addition, these children do not access services as they view health and social services with suspicion and are often confronted with discrimination.

Although street children support themselves in many different ways, they need the assistance of caring adults and services provided by government or non-government organizations. Despite peer solidarity and support through charitable services, street children experience high rates of morbidity, disability and mortality.

HIV among kids in South Asia

Very little data is available on street children living with HIV/AIDS in this part of the world, since data on this group is not disaggregated out of data for 15-19 year olds that are usually collected by national surveys; street children per se (unlike 'sex workers' and 'injecting drug users' etc.) are not 'core transmitters' and therefore are not specifically tested to determine levels of HIV.

"..substance users are more likely to engage in risky sexual behaviour.."

The latest HIV/AIDS estimates indicate that there were 36,000 new infections among the region's children (0-14 years) in 2005, and that out of the 100,000 children living with HIV/AIDS, 30,000 were in need of anti-retroviral therapy (ART) but less than 100 were receiving it.

Factors that facilitate HIV transmission among street children

Street children are vulnerable to STI/HIV primarily due to the following reasons:

- Consensual sexual contacts with multiple partners
- Forced sex
- Substance abuse and related risky behaviours such as injecting drug use.

Many street children, child sex workers and working children are also using different drugs, which are associated with their risk behaviour patterns. Substance users who are injecting are at risk of contracting HIV and can pass it on to their sexual partners. In addition, the substance users are also more likely to engage in risky sexual behaviour, due to their intoxication. Street children spend a lot of time in settings where casual sexual encounters occur (street corners, lonely places such as warehouses, taverns etc.) Their risk of acquiring blood borne diseases, STIs and HIV, is heightened by the fact that they often have sex with persons who practice risky behaviours like multiple sexual partners or those sharing injecting equipment.

Engaging with substance using street children: Major Challenges

Intervening with substance using street kids is challenging. Interventions, even where available are often not directed at addressing the needs and risks of substance using kids. Substance using street children are a hidden population and therefore hard to reach. They are sexually active and sexually exploited at a very early age and some have multiple sexual partners. They are stigmatised by society for being drug users as well as street children. Agencies, which work with street children, often do not have mechanisms in place to address the needs of substance use among street children. Since the target group is very mobile it is difficult to carry out follow-ups and complete any intervention with street kids. Additionally, many street children use solvents or 'inhalants' which, unfortunately are not considered to be important enough to address.

There is a lack of a comprehensive package of services for addressing HIV prevention for street kids (child friendly services like voluntary counselling and Testing Centres, appropriate outreach etc., are often missing). Motivating kids to go for detoxification (where available) is also very

challenging since many of the treatment services are not geared to provide services to this group in a child-friendly manner.

Reaching out to substance using kids

In order to reach out to street kids effectively, a community based peer led intervention can be suggested. The intervention could be designed to bring about a change at four levels:

1. Individual
2. Interpersonal (between self and other persons in the social network of the drug using street children, norms of a 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)

Such as approach has been employed in a UNODC project titled, "Prevention of spread of HIV amongst vulnerable groups in South Asia." The project reached out to more than 10,000 street children in South Asia through 14 pilot interventions which were implemented by NGOs. The project has developed a handbook for use by outreach workers. The project also conducted a quick baseline KAP vulnerability survey amongst 1,313 street children in South Asia. The survey found alarming levels of risks and vulnerabilities among street children in South Asia.

Based on the experiences gained in the project it can be safely recommended that any prevention strategy for street kids should address the following:

- Create awareness on risks associated with drug use and HIV- Delivering 'key messages' on safe behaviours, drugs, HIV and life skills using peer driven mechanisms (increase risk perception and risk reduction).
  - Develop a child friendly communication package to address the same
- Make drug treatment centres 'child friendly', approachable, accessible and create more 'child friendly' outreach services (using peer led mechanisms).
- Train service providers from various NGOs working with street and working children on appropriate knowledge, attitude and skills to address drugs, HIV.
- Equip service providers with necessary knowledge and skills to identify substance use among street children.
- Connect substance using street children to treatment and rehabilitation facilities (including vocational services).
- Provide better referral/ linkages between NGOs working with street children, drugs and HIV.

It is important to note that in order to design any intervention or programme to address the needs of substance using street kids, a holistic approach is recommended. This should take into account basic needs like food, clothing, shelter, and access to basic health services etc (*suruchi.pant@unodc.org*).

More details about the UNODC's approach and the project are available from the authors upon request.

Inhalant Use among Street Children: What can be done ?

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Drug abuse has been found to be very high among street children in different parts of the world including India and is an almost universal phenomenon in this population. Also, the onset of drug use occurs at a very young age in this group. The pattern of drug use is also different from other drug users with abuse of inhalants (substances with vapors that produce psychoactive effects) being more common. The most common inhalant that is used by street children in Delhi is typing ink eraser fluid (popularly called fluid and contains toluene).

Challenges posed by inhalant abuse among street children

In terms of health damage, inhalants are one of the most hazardous substances that are abused. This combined with their easy accessibility and low cost makes them particularly problematic. Acute intake is associated with an increased risk of accidents, cardiac arrhythmias and sudden death. Chronic inhalant use is known to cause impairment in multiple systems and body functions: hearing, vision, heart, lungs, liver, kidney, hematological, neurological damage including peripheral neuropathy and brain damage leading to effects ranging from mild cognitive impairment to dementia. They can cause heart failure, kidney and liver failure. They produce dependence manifested by craving (such that drug use may sometimes take priority over food) and withdrawal symptoms (sleep disturbance, nausea, tremors, and irritability) lasting several days.

A major constraint, not only in India but all over the world, is a lack of treatment-models with proven effectiveness for management of inhalant abuse as well as lack of trained manpower that has familiarity with issues related to management of inhalant abuse. Neither treatment facilities for other substance use nor the treatment models used for management of alcohol and other substance use work very well for inhalant users. Many countries have separate treatment facilities for inhalant users.

Adding on to that, the challenges posed by any drug use in street children are many. These include the difficulty in treating street children while they are living in an environment where drug use is a norm and an environment where behaviour is often determined by the behavioural patterns of the peers in the absence of parental supervision. As reported in a multicentre study conducted by WHO in 1991 that included ten cities from different countries including India, there is a connection between the problems of life on the street and the effects that street children desire from substance abuse. At least in the early stages, the abuse of substances by street children takes place in an effort to be functional on the streets. However, it is known that the substances often do not produce the effect the street child wants and they leave the child with even less emotional, financial and health resources than before. Use of substances may occur to relieve boredom and add excitement, offer entertainment in absence of recreational facilities, remove loneliness and promote socializing, provide a sense of connection with other users and overcome social isolation; it helps to reduce hunger pains, fear, feelings of shame, depression, hopelessness, physical pain. It facilitates sleep in spite of the noise and overcrowding on the streets, increases energy to work and alertness towards any potential attacks and also makes it easier to steal money to meet the requirements for food or drugs. It is also used as self-medication in the absence of access to health services. Many of the above mentioned effects were also reported in focus group discussions with street children and key informant interviews of staff of NGOs working with street children in an ongoing study funded by WHO (India) on development of intervention for inhalant abuse among street children. This study is being currently carried out by NDDTC, AIIMS in collaboration with six NGOs: Salam Baalak Trust, CHETNA, Butterflies, Prayas, Don Bosco, and Project Concern International.

Health services in general are underutilized by street children. These services are perceived to be unfriendly and inaccessible. As street children have poor access to health services, organizations that provide treatment for substance abuse are often not able to reach them. Community outreach with this population requires a very sustained and prolonged commitment. Services that provide treatment to adult substance users including through community outreach may be unable to reach this population. The NGOs working with street children do have easy access to them. These NGOs also find that optimum utilization of their services by the street children is often hindered by chronic substance abuse or dependence particularly inhalant abuse in this key population.

Assessment and treatment of inhalant abuse among street children

The setting in which any inhalant user should be treated is preferably inpatient setting. It is often felt that removing the street child from the substance using environment is the first essential step to initiate intervention. However, children who are not interested in leaving the street life, even temporarily, are often those most addicted to inhalants. To be able to reach out to them, the services should be need-based and comprehensive with focus on meeting their needs such as food, a place to bathe, recreational facilities etc. Discussion on drug use related issues would have to be determined by the preparedness of the child. Even continued contact with a service provider without initially addressing the drug abuse related aspects may be very important. Later this relationship of trust provides an entry point to initiate intervention. To allow this to happen, the services may often have to be flexible and tolerant to children coming to them even under the effect of inhalants. A peer advocate system also facilitates entry into treatment but needs supervision.

"Pharmacological interventions have a very limited role to play in the management of inhalant abuse"

Inhalant abuse researchers and experts concur on the following critical elements in treating the patients:

Treatment in the early phase

- During physical examination, several medical complications must be assessed such as: (1) central nervous system damage; (2) renal (kidney) and hepatic (liver) abnormalities (3) the possibilities of cardiac arrhythmia and pulmonary (lung) distress; and (4) hearing and vision assessment and (5) nutritional deficiencies.
- Neuropsychological impairment is usually present in the inhalant abuser. Determining whether these problems predate or are the result of inhalant abuse is often difficult to decide. However, it is important to assess the presence of any learning difficulties that may interfere with the treatment process or contribute to disruptive behavior. Neurological examination and neuropsychological testing should be considered early in the treatment process. It is also important to repeat the testing in several months to assess improvement. It is not known conclusively whether neurological damage from inhalant abuse is reversible or not.
- Initial interventions should be very brief (15 to 30 minute sessions), informal and concrete. Walking and talking sessions would probably result in the development of rapport and encourage interaction. The inhalant abuser's attention span and complexity of thinking are greatly reduced in the early stages of treatment. Thus, cognition should be continually assessed to decide their changing level of functioning.
- Pharmacological interventions have a very limited role to play if any in management of inhalant abuse or dependence.
- Because chemicals are stored in the fatty tissue of the body, the inhalant abuser may experience residual effects of inhalants for quite some time. This could include altered mood and dullness of intellectual functioning. Consequently, the detoxification period will need to be longer than the typical drug abuser, i.e.

several weeks not days. The "typical" 28-day treatment stay is probably too short a time to realistically expect change. Treatment time is uncertain and typically requires many months. Intensive aftercare and follow up are essential to rebuild life skills and re-integrate the patient.

Long term Intervention

- Treatment programs should be prepared to engage the inhalant abusing street child in an extended period of supportive care marked by abstinence from inhalants.
- The most common and urgent need of the street children is stabilization of their living situation. Change of environment is considered to be desirable as there are high chances of relapse in the same environment. The strategy could be repatriation or sending back to the family or to a shelter home.
- Since many of the street children live with their families on the streets, a thorough assessment of family stability, structure and dynamics must be a major component of any treatment program addressing the inhalant abuser.
- Treatment should also focus on therapeutic intervention with the family providing drug education, parenting and social bonding skills. Alcohol and other drug abuse are common for siblings and parents of inhalant abusers and if present they should be addressed. There is a high probability of poor communication and possible physical, emotional and psychological abuse occurring in the families, which should be addressed. However, often intervention with the family is not carried out.
- The exploration of peer group dynamics is very important. Treatment goals that are realistic can help the child break the bonds with their negative peer group and replace it with a more positive peer group. This may sometimes involve change of environment altogether.
- Non-confrontation and an emphasis on developing basic life skills are recommended. Pro-social activities including alternative sources of recreation, non-formal education and vocational training avenues or job placement options need to be explored. A case management approach is often required by addressing medical, family, educational, vocational, recreational and legal issues (referral to shelter homes / addressing delinquent behaviour).

These children often exhibit disruptive behaviour as they have poor social skills and impulse control. The patient should be in the care of one or two staff persons who gain experience in managing inhalant abuse. Knowledge of the staff about various aspects of abuse of inhalants is a pre-requisite. Since relapse is common, the treatment should encourage reentry into treatment in case of relapse.

Treatment models for substance use among street children

The WHO ten-city multicentre study aimed to facilitate the work of existing agencies which provide services to street children with a focus on improving strategies for prevention, assessment and management of drug problems. Many of the issues related to substance use among street children have been discussed in the ten manuals that were produced from this study. The *Modified Social Stress Model* (1993) was discussed in these manuals. It incorporates environmental, psychological, social and cultural variables which may influence drug use. This model is suggested to assist in the development of interventions. The six components of this model were: Stress, Normalization of behavior and situations, Effect of behavior and situations, Skills, Attachments and Resources. It is believed that all components of the model influence the chances of a given risk behaviour such as substance abuse. The first three factors mostly increase the risk and the last three have mostly a protective influence. Intervention in one or more of these components can produce the desired change. The interventions can be based

"Since relapse is common, the treatment should encourage reentry into treatment in case of relapse"

on what is feasible in the local situation. These interventions can be at the level of the individual, family, community or even at the national level. Some of the examples cited are-

- **Stress:** individual/group counseling to reduce stress at drop-in-centres, treatment of substance abuse in the parent, help-lines, bringing legal action against people who commit violence against street children
- **Normalization of behaviour and situation**: awareness programmes to change the norms, peer-based programmes, reducing availability of a substance
- **Effect of behaviour and situations:** providing information on health damage through awareness programmes at mass, group or individual level through counselors or peer leaders
- **Attachments:** mentorship by staff or peer educators, family interventions to enhance bonding and supervision, peer support programmes
- **Skills:** training in life skills, vocational training, job-finding skills
- **Resources:** increasing access to pro-social activities including recreation, non-formal education, drop-in-centres, shelter homes, night shelter or day care facilities

The interventions that have been reported for drug-using street children are few and include only a handful of studies. These interventions include: motivation enhancement through motivational interviewing, skill-focused interventions, broad spectrum health intervention program in a residential care facility, peer-based interventions, community reinforcement approach and family therapy. A study on Community Reinforcement Approach (CRA) showed significant reduction in drug use, depression and social stability in those who received CRA as compared to treatment as usual. Life-skill based approach has also been found to be effective in a few studies. Studies have shown that peer based interventions often work better than adult-led interventions. Data on brief motivational intervention is conflicting. While one study found it to be effective, another report no significant change. It is often believed that a brief intervention alone is unlikely to produce sustained change. A study on ecologically based family therapy also showed that it was effective. However since these studies are very few in number, they all need to be replicated.

Prevention of inhalant abuse in street children

The strategy that is adopted quite effectively by many NGOs in Delhi includes reaching out early to runaway children and intervening before they get engulfed in the peer networks where drug use starts inadvertently. These NGOs usually remove the children to their shelter homes or drop-in-centres and then repatriate them if possible. Peer leaders and outreach workers provide the initial intervention. Besides this, messages about health damage due to inhalant use to the children on the street are routinely provided.

Conclusion

The treatment of inhalant abuse / dependence is a challenging area and needs interaction between experts working with street children and those working in the area of substance abuse. There are also several grey areas where more research needs to be conducted to enable provision of effective interventions for this population.

Events and Announcements

NDDTC conducts Training for paramedical staff

Recognizing that the paramedical-staff too can play an important role in the treatment of substance use disorders, NDDTC, with support from the Ministry of Health and Family welfare, conducted training for paramedical staff in two districts of the country, Morigaon (Assam) and Meerut (U.P.). Various categories of paramedical staff – ANMs, ASHA workers, health-educators, nursing personnel etc. – were trained on identifying the substance users and enhancing their motivation to seek help. The trainings were conducted in a participatory manner with resource persons from the NDDTC. These trainings were part of the project, 'enhancing substance use treatment services at the district level' being implemented jointly with the local district administration. The training is expected to substantially enhance the levels of treatment seeking in these two districts.

Survey on Drug Abuse situation launched

A survey has been launched in the district Meerut (U.P.) by the NDDTC, AIIMS in collaboration with the district Administration. The survey will broadly follow the methodological principles of a 'Rapid Situation Assessment' research design. A four member research team – recruited especially for the survey – has been trained. The team will collect data from various sources including key informants as well as many drug users themselves. The report of the survey – expected by August 2008 – will provide important insights for development of a district-based substance use control programme at Meerut.

Forthcoming Events

April 18 -23, 2009
INTERNATIONAL HARM REDUCTION CONFERENCE
Bangkok, Thailand
www.ihraconferences.net

May 07-09, 2009
9TH ANNUAL ADOLESCENT HEALTH CARE CONFERENCE
Boston, USA
www.contemporaryforums.com

May 16-21, 2009
162ND ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION (APA) 2009
San Francisco, USA
www.psych.org

June 11-12, 2009
SUBSTANCE MISUSE: BRITISH ASSOCIATION FOR PSYCHOPHARMACOLOGY (BAP)
Bristol, United Kingdom
www.bap.org.uk

June 17-20, 2009
6TH CONGRESS OF PAEDIATRIC ASSOCIATION OF SOUTH ASIAN COUNTRIES
Colombo, Sri Lanka
www.srilankacollegeofpaediatricians.com

June 20-25, 2009
32ND ANNUAL SCIENTIFIC MEETING OF THE RESEARCH SOCIETY ON ALCOHOLISM
San Diego, USA
www.rsoa.org

August 3 – 4, 2009
FIRST INTERNATIONAL CONFERENCE ON ALCOHOL AND HIV IN INDIA
Mumbai, India
http://www.alchivconf2009.in/home.asp

September 23-26, 2009
2009 ANNUAL MEETING OF THE INTERNATIONAL SOCIETY OF ADDICTION MEDICINE (ISAM)
Calgary, Canada
www.isamweb.org