UNODC
United Nations Office on Drugs and Crime

National Institute of Social Defence (NISD)

A Trainer's Manual

on drug use prevention, treatment and care for street children

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Acknowledgments

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Contents

Abbreviations

- **ABI:** Activity-based intervention
- **AIDS**: Acquired Immuno deficiency Syndrome
- **BCC:** Behaviour Change Communication
- **CWC:** Child Welfare Committee
- **DIC:** Drop-in-Centre
- **GOI:** Government of India
- **Hep C:** Hepatitis C
- **HIV:** Human Immuno Deficiency Virus
- **ICPS:** Integrated Child Protection Scheme
- **JJB:** Juvenile Justice Board
- **MDGs:** Millennium Development Goals
- **MSJE:** Ministry of Social Justice and Empowerment
- **NCDAP:** National Centre for Drug abuse Prevention
- **NDPS Act:** Narcotic Drugs and Psychotropic Substances Act.
- **NFE:** Non-Formal Education
- **NGO:** Non Governmental Organisation
- **NISD:** National Institute of Social Defence
- **NLM:** National Literacy Mission
- **N/S :** Needle / Syringe
- **ORW**: Outreach worker
- **PE:** Peer Educator
- **SJPU:** Special Juvenile Police Unit
- **SOP:** Standard Operating Procedure
- **STI:** Sexually Transmitted Infections
- **SUD:** Substance Use Disorder
- **WHO**: World Health Organisation

Foreword

The street children are one of the most deprived and vulnerable section of our society. They are particularly vulnerable to drug abuse. We need to take urgent steps to ensure their health, safety and education.

Recognizing this, the National Centre for Drug Abuse Prevention (NCDAP-NISD) under the aegis of the Ministry of Social Justice and Empowerment, and the United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA) have joined hands in developing this manual titled ***"A Trainers manual on drug use prevention, treatment and care for street children".***

I hope that this manual will serve as a tool for empowering (through training and capacity building) service providers working in the drug treatment and rehabilitation centers in India. With a network of over 300 such centers in India, I am optimistic that we would soon be in a good position to reach out to the vulnerable street children with basic information on drug use and problems associated with drug use, so as to ensure that they don't fall victim to substance abuse.

I would like to express NISD's gratitude to UNODC for partnering in this endeavor to develop this training manual and hope that initiatives such as these continue to be taken on the basis of lessons learnt and cumulative weight of scientific evidence, in this regard.

(Chaitanya Murti)
Director, NISD

Preface

The United Nations estimates the population of street children worldwide at 150 million. South Asia is home to a large number of these street children with India having the largest number in the world. Estimates range from 10-21 million mostly concentrated in the major metropolitan and urban areas. Poverty, abuse and lack of care drive vulnerable children to the streets, which without protection, supervision, guidance or care by responsible adults become their homes.

Drug use among the street children is common, not only in India, but also in other parts of the world. Although, the problem is well known, little scientific evidence is available in terms of the extent and pattern of the problem. The challenge to respond to this is complex as there is very little understanding about possible treatment and intervention options for street children who use drugs. Further, there are few organizations working with street children that have attempted to deal with their drug use; similarly very few organizations of those involved in drug use prevention, treatment and care have attempted responding to the psycho-social or health needs of street children. Thus effective models for replication are unavailable. Lack of understanding of the issues on both sides coupled with weak capacities to respond has been a major barrier.

There is an opportunity for India to respond comprehensively to address drug use among street children. The Government of India, through the Ministry of Social Justice and Empowerment (MSJE) supports over 300 drug treatment and rehabilitation centres in the country. The cadre of service providers within those centres can be engaged through training and capacity building initiatives to initiate a comprehensive response for street children on drug use.

It is a great honour for the United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA) to have developed in partnership with the National Centre for Drug Abuse Prevention (NCDAP -NISD) under the Ministry of Social Justice and Empowerment, the present "***A Trainers manual on drug use prevention, treatment and care for street children***".

I am confident that this training manual will enable service providers at the grass-root level to engage with street children especially in hard to reach settings and that this process of engagement will ultimately lead to the development of effective intervention models at the national and international levels for the benefit of many street children in need worldwide.

Cristina Albertin
Representative
UNODC South Asia

About the manual

There is little understanding on drug use prevention, treatment and care issues among the agencies engaged in service provision for street children. Similarly there is lack of understanding about the needs of the street children among agencies providing drug related services. There is also a lack of capacity among the service providers on both ends on providing evidence based services leading to the drug use related services provided to street children not meeting their specialised needs. There are little evidences and very little guidelines/SOPs to help/guide services to structuralise suitable interventions.

This manual is also an attempt to bring together the service providers from both the drug sector as well as those engaged with street children to have common understanding regarding the stakes and chart the way forward.

Keeping all these issues in mind the manual aims at providing a guide to structured training of trainers from the various regions of the country to help build a cadre of trainers who can subsequently train service providers in their respective regions.

How to use this manual

The manual is to be used by the trainers who would conduct training on Drug use Prevention Treatment and Care for the street children. MSJE supported drug treatment centre staff and those working among street children will be trained using this manual.

The trainers are expected to initially read the entire manual and make themselves familiar with the topics on which they have to conduct sessions. The manual also provides a list of sessions to be conducted with methodologies for each. The trainers are expected to use these methodologies and the power point presentations provided for each session (wherever applicable) for conducting the sessions.

The accompanying CD has all the power point presentations for ready reference and use when conducting training.

Programme Schedule

		Day 1
Session No.	Time	Session
	8.30 – 9.00	Registration
	9.00 – 9.30	INAUGURATION
	9.30 – 10.15	Introduction and Ice Breaker, ground rules and pre training evaluation
	10.15 – 10.30	Tea break
1	10.30 – 11.45	Vulnerabilities of street children
2	11.45 – 13.00	Extent & pattern of drug use among street children in India
	13.00 – 14.00	Lunch
3	14.00 – 15.15	Impact of Drug Use on the street children
	15.15 – 15.30	Tea Break
4	15.30 – 16.45	Impact of drug Use on the street children (continued)
	16.45 – 17.00	Feed back
		Day 2
Session No.	Time	Session
	8.30 – 9.00	Recap of the previous day
1	9.00 – 10.15	Primary prevention among street children
	10.15 – 10.30	Tea break
2	10.30 – 11.45	Primary prevention among street children (continued)
3	11.45 – 13.00	Experiences of drug use prevention in India
	13.00 – 14.00	Lunch
4	14.00 – 15.15	Education of street children for drug use prevention
	15.15 – 15.30	Tea Break
5	15.30 – 16.45	Drug refusal skills for street children
	16.45 – 17.00	Feed back

		Day 3
Session No.	Time	Session
	8.30 – 9.00	Recap of the previous day
1	9.00 – 10.15	Medical management of drug use among street children
	10.15 – 10.30	Tea Break
2	10.30 – 11.45	Outreaching the street children
3	11.45 – 13.00	Outreaching the street children (continued)
	13.00 – 14.00	Lunch
4	14.00 – 15.15	Brief interventions
	15.15 – 15.30	Tea Break
5	15.30 – 16.45	Motivation enhancement
	16.45 – 17.00	Feed back
		Day 4
Session No.	Time	Session
	8.30 – 9.00	Recap of the previous day
1	9.00 – 10.15	Relapse prevention
	10.15 – 10.30	Tea Break
2	10.30 – 11.45	Relapse prevention (continued)
3	11.45 – 13.00	Risk reduction
	13.00 – 14.00	Lunch
4	14.00 – 15.15	Family counselling
	15.15 – 15.30	Tea Break
5	15.30 – 16.45	Family counselling (Continued)
	16.45 – 17.00	Feed back

		Day 5
Session No.	Time	Session
	8.30 – 9.00	Recap of the previous day
1	9.00-10.15	After care for street children
	10.15-10.30	Tea Break
2	10.30-11.45	After care for street children (continued)
3	11.45-13.00	NGO networks and networking
	13.00-14.00	Lunch
4	14.00-15.15	NGO networks and networking (continued)
	15.15 – 15.30	Tea Break
5	15.30-16.45	Government schemes for street children
	16.45-17.00	Question hour & Feed back
	16.30-17.00	Valediction

Chapter 1

Vulnerabilities of street children in India

Definition and issues

Three types of children belong to the category of street children.

- Children on the street, who spend most of their time on the street and have regular contact with their family,
- Children of the street, who come from their home but maintain contact with their family, and
- Abandoned children, who have broken all ties with their families and live completely on their own (UNICEF 1986)

Critique of the definition

Studies undertaken by various researchers to understand the lives of street children revealed that these categories are fluid and children keep moving in and out of them (Aptekar, 2000). Another important issue is to note that often the two terms, street and working are used interchangeably. By dint of the issue of defining 'street child', data on street children across the world is disputed and contested (UNICEF 2011).

Situation of street children in India

Situational studies commissioned by UNICEF in the 90s generated data and literature on the condition of street children in different cities of India. Apart from the UNICEF's conservative figure of 11 million street children in India, another study has estimated "314,700 street children in metros such as Bombay, Kolkata, Madras, Kanpur, Bangalore and Hyderabad and 100,000 in Delhi alone". Even though the 'number' is disputed by considering the issue of definition, it is now considered a major source for understanding the magnitude of street children India (UNICEF 2011).

Profile of street children

Situational studies in India have found that an overwhelming majority of children on the street is either living or maintaining contact with their family. This fact is very apparent from study by Rita Panicker and Praveen Nangia in 1992 (the study found that only 14.9% of children alone stay on streets without any ties with family) and the latest work done by Save the Children 2011, states that 90% of children have contact with families.

While analysing the gender break-up, it has been observed that girls are less visible on the streets in comparison to boys. The latest study done by Save the Children (2011) identifies 20.5% street girls in Delhi.

Street children are a part of unorganized labour sector and support themselves or families by engaging in rag picking, selling magazines, news papers, books, popcorns, water and nick knacks etc on trains, buses and traffic signals, working as helpers at shops, small tea shops, cleaning cars and other vehicles etc. A section of children also survive by begging.

Street children generally congregate at railway/metro stations, bus terminals, vegetable markets, large wholesale market areas, traffic signals, around places of worship etc for their survival.

With reference to the major reasons for being on the streets, poverty and lack of opportunity are the most revealed factors by the situational studies conducted in cities like Bangalore, Kolkata, Pune, Chennai , Mumbai and Delhi.

Issues affecting street children: an overview

Major issues affecting street children are;

- Basic Needs-Shelter, safe drinking water and toilet facilities are still the basic issues faced by children in their everyday lives on the street. Due to lack of permanent place for residing, children find it difficult to keep their belongings. It is the reason why street children of Mumbai spend their entire days of earning each day (D'Lima, and Gosalia Rima 1992). Consequently, the problem leads to insecurity, anxiety within the children and incidents of abuse on the street (Rashmi Agrawal 1999).

- Health hazards-Street children suffer from bronchitis, asthma, tuberculosis due to continued exposure to dust and other pollutants. Several kinds of skin diseases like scabies and ulcers are common among street children (Rashmi Agrawal, 1999). They also have poor dental hygiene. Children working as porters and rickshaw pullers often suffer from spinal disorders. Use of drugs like correction fluid, glue, thinner, cough syrups, pain killers, paint, gasoline, psychotropic drugs lead to long term health problems. Sexual abuse and commercial sexual exploitation of children put them at high risk of STIs and HIV/AIDS.

- Violence and incidence of abuse-studies conducted in different cities in India have highlighted the violence of police and other law enforcing authorities on street children. Children report extortion, harassment and physical atrocities and unexplained detention by the police. Human Rights Watch/Asia's investigation in cities like Bangalore, Delhi, Mumbai and Chennai revealed incidents of detention; unimaginable torture and cruelty on the child in custody, resulting even in death (Human Rights Watch, 1996).

- Incidence of sexual, emotional and physical abuse either by parents, guardians and relatives or police, law enforcing authorities, adults, who know children, strangers, peer group and employers have been reported by street children (GOI 2007; ASK 2005 and Save the Children 2011).

- Education-Studies show that an overwhelming majority of street children have been excluded from educational institutions or never been a part of formal education system. Poverty, knowledge background of the child, nature of work, unfavorable attitude of parents and employer, the context, where the child lives and inadequate response of the state restrict children to start or continue their studies either in formal or non-formal education system. The series of situational analyses conducted in different cities find that street children give maximum preference to education and training for a better livelihood. The study of Poornima Tiwari finds that out of the total 54.4% of the children have expressed their inclination to do any kind of semi-skilled job in future (2006).

- As a growing problem, the phenomenon of street children is a matter of grave concern in India. To ameliorate their vulnerability in the changing scenario, it is essential to understand the situation of street children.

Training session

Vulnerabilities of street children (Day 1 Session1)

Objectives of the session:

To orient the participants on the profile and major issues affecting street children in India.

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Laptop/ computer and LCD projector

Methodology of conducting the session:

Interactive discussion using the presentation (Day 1 Session 1- Vulnerabilities of street children)

Chapter 2

Extent & pattern of drug use among street children in India

Extent of drug use in street children

The World Health Organisation (WHO) mentions that globally up to 90% of the street children use some kind of drugs, with wide region wise variation. The highest drug use is reported in Brazil, where drug use and street gang culture have been burgeoning. In India, no definitive nationwide data is available on the prevalence of various drugs in this group. A review of all published literature (both scientific and newspaper articles) showed that most data is available from big metropolitan cities in India, with data from small towns and villages being conspicuously absent. 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 are absent in smaller cities.

The following table (Table 1) summarises the magnitude of the drug use in various parts of India from selective studies and compares them with Brazil for world reference.

Table 1: Summary of magnitude of drug use in street children

Authors and year of study	Place of study	Sample Size	Method of collection	Drug use	Commonest drugs
Pagare, 2004	Delhi	115	Night shelter for street children (Prayas)	57.4%	Nicotine 54%, Alcohol 50%, Inhalants 25%
CHETNA[1], 2008	Delhi	63	Market, railway station, religious places (CHETNA)	73%	Inhalants
Benegal, 1998	Bangalore	321	NIMHANS[2] out patient in collaboration with BFSWC[3]	70.1%	Smoking tobacco 53%, Inhalants 33.7%
Joshi H, 2006 (ASAG[4])	Ahmedabad	153	15 of 43 ward of the city, 2001 census based data	85%	Tobacco 60%, Inhalants
Karmakar, T (1998)	Kolkata	2416	Street based interview	39.3%	54.2% females addicted to depressants and 42% males addicted to cannabis.
Asian Age (2006)	8 Railway platforms from New Delhi to Bhopal	684	Children at railway platform	45%	Inhalants, followed by cannabis, alcohol.

CHETNA[1]: Childhood Enhancement Through Training and Action
NIMHANS[2]: National Institute of Mental Health and Neuro Sciences
BFSWC[3]: Bangalore Forum for Street and Working Children
ASAG[4]: Ahmedabad Study Action Group

Authors and year of study	Place of study	Sample Size	Method of collection	Drug use	Commonest drugs
Gaidhane, et al (2008)	Mumbai	163	Street Based	80.98%	Looked into sexual abuse but no details of drug use
Forster LM, 1996	Brazil, city of Porto Alegre	105	Street interview	70%	Tobacco 58%, Cannabis 40%,Alcohol 25%, Inhalant 4%

It becomes apparent from the above table that drug use is very high among these marginalised children.

Pattern of drug use in street children:

Socio-demographic profile:

Age: The mean age of street children taking drugs has been found to be about 13 years (range 10–17 years). The age composition reveals that more than half of the street children are of somewhat older age (15 to 17 years). Small children aged 8 to 10 years made less than 10% of the total in most studies. However, drug use in street children has been found to occur in very young children sometimes. There are reports of children less than 10 years of age using drugs.

Sex: In most of the studies, the drug using street children were exclusively or mostly boys. Even in studies attempting to enumerate street children, most were found to be boys. This seems to be a global trend as in most of the cities of the world, street children are predominantly male.

Education: 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. Most children had only primary level of education.

Occupation: The majority worked as unskilled labourers. A rapid situation assessment study conducted by the National Drug Dependence Treatment Centre, AIIMS, Delhi in association with six NGO partners (Butterflies, CHETNA, Don-Bosco Ashalayam, Prayas, Project Concern International (PCI) & Salam Balak Trust) and funded by WHO (India) found that compared to non-drug using street children, drug users were more employed, presumably to support their drug habit (Table 2).

Table 2: Employment status of drug users (Inhalant users) as compared to drug non-using street children in Delhi (NDDTC, 2009)

Employment Status	Drug users (%)	Drug non-users (%)
Currently employed full time	61	41.9
Currently employed part time	33	22.6
Currently not employed	4	9.7
Not known	2	25.8

Close to 30% of the children near railway stations were engaged in collecting empty plastic water bottles from the trains. Rag picking, i.e. collecting and selling plastic and metal scraps in the junkyards, driving pedal rickshaw and loading – unloading of goods from one place to another were among the other major economic activities in which street children were engaged. A street child spends on an average almost 8 hours a day working for livelihood. Their occupation is significantly related to their drug 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 or a huff of inhalant. Rag pickers generally visit sites twice a day; once in the morning and then in the evening and therefore they can avail longer hours of rest in between, which they spend by taking drug, gambling, wandering around or indulging in criminal activities like pick-pocketing. Children engaged in roadside food stalls had fewer rest periods during the day and generally took drugs in the evening and often with adults. However, the study by the National Drug Dependence Treatment Centre, AIIMS reported that almost one third of inhalant users reported using inhalants throughout the day.

Street children 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 drug use. With time, drug use takes precedence over other activities like self-care and eating and money earned is spent immediately for procuring the drug.

Majority of the street children have to buy their own food. However, all children had (or knew) access to free food, which is distributed at religious places (Mandir/Masjids) and even in some restaurants (Fakir Restaurants). The disturbing fact is that these children spend a substantial portion of their earnings on drugs rather than on food.

Age of Initiation of Drug use: The minimum age at starting drug use in studies was as low as 5 to 7 years of age. The mean age of onset of drug use reported by the patients was 9 years. Data also revealed the gateway phenomenon of progression of drug use. Most of the smaller children start off with tobacco use and when they are a little older, they start using inhalants. By the time they are older, 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 smack. According to the Bangalore study the mean age [SD] of initiation of drug use are as follows (Table 3).

Table 3: Age of initiation of various drugs in street children according to one specific study at Bangalore (Benegal, 1998)

Initiation of drug use	Mean age of initiation
Age at onset of tobacco use (smoking)	10.76 years
Age at onset of tobacco use(chewing)	10.79 years
Age at onset of Inhalant use	11.53 years
Age at onset of Cannabis use	12.79 years
Age at onset of Alcohol use	13.16 years
Age at onset of Opioid use	13.16 years

Type of drug use: Chewing of gutkha and tobacco seemed to be most common among the street children as this addiction was reported by nearly 60 – 90% of them. Around half of the children are also, reportedly, addicted to solvent sniffing in the form of sniffing of adhesive glue, petrol, gasoline, thinner and spirit in most of the studies. Older children also consume alcohol which is available in polypacks costing Rs.15 to 25. Charas and smack appears to be used less often by street children as they are costlier. Most of them also used multiple drugs like

tobacco, country liquor and cannabis in addition to inhalants. In the CHETNA study, 47% of the children were addicted to at least three or more drugs. In the study by the National Drug Dependence Treatment Centre, AIIMS the ever use of other drugs in inhalant using street children is shown in table 4.

Table 4: Use of various drugs in inhalant using street children (NDDTC, 2009)

Type of drug	Ever using other drugs (%)
Inhalants	100
Tobacco (smoking / chewing)	86
Cannabis (Bhang, Charas, Ganja)	63
Alcohol	44
Pharmaceutical preparations (tablets,	8
cough syrups, injections etc.)	
Opium (Doda, phukki)	4
Heroin (Smack, brown sugar)	3

Effects of Drug use: Most of them took to drugs as a way of street life or to remain in the peer group. When asked specifically about how they feel after taking the drug the commonest answer was that they feel relaxed and happy. Relief of boredom, hunger, depression, fear 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.

Risk factors of drug use in street children: When these studies tried to look into the risk factors of drug use in street children, they found that the rural or urban background of the child, the native state, age of the child and his educational level before coming to the streets had no bearing on the drug use pattern. The following risk factors have been reported in many studies.

Abandoning Home: The primary risk factor of drug 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 drug use and the more difficult it becomes to rehabilitate them. Studies based on observation homes report slight decrease in drug use as compared to before coming to the observation home or in comparison to children living on the streets. All antecedent stressors that are instrumental in the child's leaving home are the risk factors of street drug use.

Two-thirds of the children reported that they left home because of domestic violence and conflict in their family, along with physical abuse by family members. Drug use in fathers, marital discord in parents and assault of spouse and children during intoxicated states by parents were other significant risk factors.

For girls, a number of factors within the domestic sphere push them onto the streets, many of which are related to low income. Heavy domestic chores within the family, domestic violence, incest and abuse within house are most commonly cited reasons. Rape or sexual abuse of a girl often results in social victimization, which forces them to abandon home. Trafficking of girl child by own family member is becoming a disturbing trend in many states of the country. Once on the streets, most girls living in and around platforms and station often go into the 'protection' of the older youth, or other inhabitants of the station. Very often, however, this 'protection' comes at a price of street sex and introduction to drug use.

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 drug use is often reported as the most important influence for initiation of drug use and criminal behaviour in street children in many studies. A new member is often offered the correction fluid by the older members as a part of indoctrination into the group. Drug using children are significantly 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 street children face. Major life events occur in their lives without them having any control over the situation. Drug use is often an attempt to cope with the pain and to assist in the period of adjustment.

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, tobacco (Biri, Guthka) is universally available and so universally used. Even though misuse of typewriter fluid is obvious, the strong business earning of this licit drug keep the supply abundant in most roadside shops and permits indiscriminate selling to street children (who may have never used or seen typewriters).

This chapter tries to make the reader aware that drug use is an alarming problem in Indian street children and needs urgent intervention. It tries to provide the reader the basic understanding of the patterns and risk factors of drug use in these children which will empower the reader to develop skills and strategies for helping such children.

Training session

Extent & pattern of drug use among street children in India (Day1 Session 2)

Objectives of the session:

- To familiarize with the extent of drug use in street children
- To understand the pattern of drug use, socio-demographic profile and risk factors related to drug use in street children

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board /Marker pens
- Laptop/ computer and LCD projector

Methodology of conducting the session:

The participants should be asked to share what they know about extent of drug use, common drugs used by street children, socio-demographic profile of street children who use drugs, risk factors. Followed by an interactive discussion using a power point presentation **(Day 1 Session 2- Extent & pattern of drug use among street children in India).** Each slide should be preceded by eliciting information from the participants. If the participants are from different regions of the country, the similarity in drug use as well as any regional variations should also be discussed and highlighted.

Chapter 3

Impact of Drug Use on the street children

The use of drugs has ramifications on the physical, psychological and social aspects of an individual. The effect largely depends on

- Type of drug being used: different types of drugs will have specific effects on the individual. This is described in detail below
- The manner of use of a particular drug: the way in which the individual uses the drug also has bearing on the impact. For e.g., if an individual uses a particular drug through injection route, the impact will be far severe as compared to the oral route of use of drug; the impact also depends on whether the individual is using the drug daily or occasionally. Finally, the short term effect and the long term effects of an individual drug are also different.
- The physical status of an individual: if the individual is of growing age (e.g. adolescence), the impact would be severe. Other conditions often associated with street children, for e.g., malnutrition, poor hygiene increases the adverse impact of drugs on the children

Type of drugs:

Drugs can be divided (classified) in many ways.

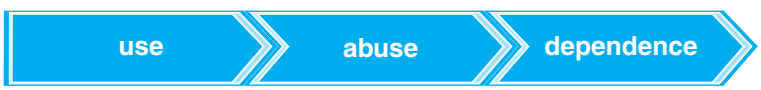
a) Depending on the chemical class, the drugs can be divided into: alcohol, cannabinioids, opioids, sedative/hypnotics, cocaine, amphetamines and other stimulants, hallucinogens, volatile substances, tobacco, and multiple drug use

b) Depending on the type of effect the drugs produce on the individual, drugs are divided into three main types:
   - Depressants: depress or slow down the functions of the brain – e.g. alcohol, opioids, sedative/hypnotics
   - Stimulants: stimulates or excites the functions of the brain – e.g. cocaine, amphetamines
   - Hallucinogens: produce distortions in sensations (the way we hear, smell, feel) – e.g. LSD, ketamine, phencyclidine

c) Depending on the availability and legal status of the drug: legal (e.g. alcohol, tobacco) or illegal (e.g. cocaine, ketamine, LSD). Some of the drugs are branded as illegal by international rules and regulations (e.g. heroin, cocaine, amphetamine), while the legal status of some of the drugs may be determined by the existing laws of the country (e.g. alcohol, tobacco).

Pattern of drug use

Drugs can be used in many ways. After the initial use of a drug, the individual may continue his on and off use of drug, depending on the effect of the drug perceived by the individual as well as other factors. During this on and off use, the individual may develop adverse effect of the use of drug. If the individual continue to use inspite of adverse effect, the pattern of use is termed as 'abuse'. Finally, if the individual takes the drug regularly and becomes dependent on the drug, this is termed as 'dependence syndrome'.



a) Abuse: a pattern of use of drug in which the individual continues to use drug despite having experienced harms associated with the drug. These harms can be in physical, psychological, social or legal domains.

b) Dependence: a group of physical, behavioural and cognitive disturbances which appear upon repeated use of the drug, and in which the use of the particular drug assumes greater importance for the individual than other values and behaviours. Thus, dependence has a number of features: tolerance, withdrawals, craving, difficulty in controlling the drug use, preoccupation with drug use, and continued use despite harm/knowledge of harm.

There are several criteria laid down to describe the various patterns mentioned above. These criteria have been standardized for uniform understanding and definition by international bodies such as World Health Organisation (WHO).

The impact of the drugs on an individual can be short term or long term. The immediate effect of a drug depends on the chemical properties of the drug and the individual's psychological makeup. All the drugs produce euphoria or a profound sense of well-being due to their actions on particular parts and receptors of the brain. Additionally, most of the drugs either produce drowsiness or excitation depending on their chemical type. Finally, all the drugs produce a decrease capacity to respond to one's surroundings and a loss of judgement.

The long term use of drugs has an impact on a number of spheres of an individual's functioning. The various spheres which drugs have an impact on include:

Though these spheres are distinct, impact on one sphere would also have an effect on other spheres of functioning of the individual affected. This leads to a complicated picture, in which an individual affected by drugs continues to suffer on many fronts in his drug-using life.

Training session

Impact of Drug Use on the street children (Day1 Session 3 & 4)

Objectives of the session:

- To familiarise the participants with various factors related to the impact of drug use on individuals
- To educate the participants on the various stages of drug use in an individual's life and the effect of drugs related to the stages of drug use
- To enhance the knowledge of the participants on the various effects of drug use on street children

Duration of session:

One hour and fifteen minutes (2 hour and 30 minutes)

Materials/Aids required:

- LCD projector
- Laptop for power point presentations
- Chart papers for group discussion

Suggested methodology for conducting the session:

- Interactive discussion using a power point presentation **(Day 1 Session 3- Impact of Drug Use on the Street Children)**
- Group work

Chapter 4

Primary prevention among street children

Premise of drug use prevention

"An ounce of prevention is worth a pound of cure"

The primary targets of any drug use prevention programmes are the risk and protective factors. The goal of these programmes is to build new and strengthen existing protective factors and reverse or reduce risk factors in the target group. Primary prevention is defined as a preventive strategy which aims at reducing the risk factors and preventing the development of the disease.

In this case, the disease is 'drug use and drug dependence'. In order to understand the strategies to be employed in prevention of drug use among street children, an accurate understanding of the risk factors and the protective factors and their relationship in the assessment of the overall risk is essential.

Risk of drug use:

Various factors which constitute the special reality of the lives of street children expose them to the risk of drug use and abuse. The relationship between these various factors have been described in the Modified social stress model: (Programme on Substance Abuse, WHO, 1993)

$$\text{Risk for Drug Use} = \frac{\text{(Dis)stress} + \text{Normalization of Drug Use} + \text{Drug Effect}}{\text{Attachments} + \text{Coping Strategies} + \text{Resources}}$$

The risk of drug use is increased by level of perceived distress, the image that the use of the drug has in the community, and the effects that the drug produces in the consumer after consumption.

The risk is decreased by positive attachments that the child may have, the possession of adequate coping strategies and skills, and resources of help, which serve as protective factors.

Risk factors	Protective factors
√ **Stress:** • Major Life Events (eg: loss or death) • Stresses and strains of day to day life (needs, exploitation and abuse) • Life transitions-(constant mobility, peer relationships. role strain)	√ **Attachments** • Contact with family • presence of adult mentor • stable peer non drug using relationships

√ **Normalization of drug use** The term normalization refers to the extent to which a particular drug using behaviour may be considered "normal" in a given society or subculture. √ Drug experience A particular drug is more likely to be used if the subjective experience of using that drug is an experience, which was desired	√ **Coping strategies and skills** • Problem solving • Assertiveness • Communication skills • Decision making √ Resources • Information • education • health • recreation

Models of primary prevention:

In discussing the methodology of primary prevention for drug use among street children, the main focus would be to potentiate and enable protective factors and reduce the risk factors.

Approach to interventions among the street children

The population we are dealing with are mainly street children, alienated from the mainstream, independent in nature. Any method of intervention that is direct, instructive would be regarded as judgemental and boring.

Activity based interventions are effective in being fun, ability to evoke and sustain interest and encouraging children to reflect, discover the message on their own.

The key element of activity-based intervention (ABI) is based on the premise that activities and actions initiated by children are more likely to attract and hold a child's attention and as a result maintain their involvement.

Reduction of Risk factors:

Dealing with stresses of street life:

The realities of street life and its stresses are grave, persistent and most of the time unremovable. However, the distress associated with it can be addressed if children are given an opportunity to share their feelings and ventilate their distress.

The psychological profile of children living on the street is such that they avoid thinking about negative consequences of their actions or habits since it is distressing. They lack long term plans and live for 'here and now'.

Hence by providing children with alternate opportunities to bond over, which are healthy, a new sense of identity and belonging can be created.

Also organizing children into activities which help them reflect on their own on the potentially hazardous consequences of their unhealthy behaviour helps overcome to some extent the risks of street life.

Strengthening protective factors:

Protective factors moderate the effect of risk factors. Presence of more than one protective factor potentiates each other and strengthens the effect

Attachment:

It has been proven that children who have stable relationship with an adult are less likely to take use drugs as a coping mechanism. They also value the opinions and reinforcement from the families which are consistent.

Hence providing children at least one secure adult attachment could serve as a protective factor against drug use.

Adaptive Coping skills:

It has been found that children who possess better coping skills are better able to deal with stressors of life and have a lower risk of drug use.

- √ Life skill training is a key component in bettering coping skills
- √ Life skills are abilities for adaptive and positive behaviour that enable children to deal effectively with the challenges of their daily life.

Experience in India

Various Non Governmental Organisations have been working in the area of drug use and street children providing detoxification interventions and after care services.

While these are not preventive programmes, it is important to recognize that there is a significant overlap between drug use prevention and intervention in the drug use abstinence relapse cycle.

A.

The Society for Undertaking Poor People's Onus for Rehabilitation (SUPPORT) is a voluntary organization working with street youth and children to prevent drug use and HIV/AIDS in Mumbai.

It runs a residential rehabilitation and vocational training program for youth and children, after detoxification, to mainstream them into society. This program also deals with educational component.

Sharan is another initiative which in collaboration with sub partner SUPPORT, implemented a project in Delhi and Mumbai on detoxification of drug-using street youth and children.

Salaam Baalak Trust is another NGO working in the same area with programme components consisting of education, health, mental health, life skills, performing arts, games, vocational training, and job placement.

Indeed, programmes like these mainly focus on providing resources like education, health support, recreation, vocational training etc which serve as preventive factors for drug use.

B

The Action Programme initiated by the Forum for Street and Working Children in conjunction with the National Institute of Mental Health And Neurosciences was implemented in Bangalore.

The experimental brief intervention was a low cost intervention which consisted of a single viewing of an animated video film "Gold- tooth "made by the Street Kids International and two or three 'workbook sessions. Workbook sessions were conducted by street educators who were trained in the use of the relevant techniques. Using projective techniques, groups of children were encouraged to interpret an open - ended series of images, in the light of their own experiences.

This allowed the children to review their maladaptive responses to day to day stressors and their drug use. Further sessions were utilised to generate, from the peer group, alternative adaptive strategies that the children could use for the same situations.

C

Another project as part of the WHO Biennium funds conducted in collaboration with AIIMS, Delhi and NIMHANS, Bangalore involved an intervention package comprising six sessions. It was delivered in groups of 5-10 children over 2-3 days. The themes of the six sessions were:

1. Functional analysis of pro-social activities and drug use behaviour
2. Motivation enhancement and harm reduction
3. Life skill Training (drug refusal skills)
4. Health management
5. Money management
6. Relapse Prevention

Education

Drug use related

Education plays an important part of Primary prevention. By providing appropriate information resources about various aspects of health and well being, it promotes health and helps prevent development of behaviours and practices detrimental to one's health and safety .

The street children seldom identify health as a major concern. They often regard themselves as invulnerable, focused on the 'here and now' and not on long term consequences. Hence, they do little or nothing about their health and do not have adequate information on what to do at times of need. These children also lack information about existing resources and often pick up misleading or erroneous information from their peers. Hence, educating these children about health management is very vital in any drug use prevention programmes.

However, any attempt that is direct and instructive is bound to fail for these children. Encouraging children to explore these areas and reflect through activities is an efficient and proven method of health education.

Money related

Children on the streets also lack a systemic planning and future orientation. The majority of the children do not save the money they earn. At times of need and when not working they manage their expenses by snatching from others, stealing or begging. It is also noticed that children who earn more are more likely to use drugs and spend almost all their earnings on drugs.

Hence, one of the strategies in prevention of drug use is by reducing the available ready cash in their hands by teaching them aspects of money management and saving.

Drug refusal skills

Children who are taught refusal skills are more likely to make positive choices and refrain from engaging in high-risk behaviours. Helping children set limits for themselves and say "no" to outside pressure increases their self confidence. When children learn to stop and consider the consequences before responding to a question as well as a variety of ways to say "no" they become more accomplished at refusing to participate in harmful activities.

Training session

Primary prevention among street children (Day2 session1 & 2)

Objectives of the session:

- To orient the participants on the model of primary preventive intervention
- To familiarize the participants with some of the techniques that can be used with street children for preventive intervention

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology of conducting the session:

An interactive session with the participants using the power point presentation **(Day2 session1 Primary prevention among street children)**

The facilitator explains the primary prevention model and then when discussing the activities a service provider can do with the street children for primary prevention he/she first explains the activity detailed on the power point slides and then invite volunteers from the participants to demonstrate it. The facilitator in discussion with the rest of the participants provides suggestions for improving upon it.

Training session

Experiences of drug use prevention in India (Day2 session3)

Objectives of the session:

- To orient the participants on the experiences of primary preventive intervention efforts in India

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Laptop/ computer and LCD projector

Methodology of conducting the session:

An interactive session with the participants using the power point presentation **(Day2 session2 Experiences in India)**

Training session

Education of street children for drug use prevention (Day2 session4)

Objectives of the session:

- To orient the participants on the importance of education in primary prevention and familiarises them on some activities that may be used when intervening with the street children.

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

- Using the power point presentation **(Day2 session3- education),** the facilitator explains the importance and role of education in primary prevention and then invites volunteers to demonstrate the 'activities' detailed on the slides. The facilitator in discussion with the rest of the participants provides suggestions for improving upon it.

Training session

Drug refusal skills for street children (Day2 session5)

Objectives of the session:

- To orient the participants on the experiences of primary preventive intervention efforts in India

Duration of session:

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology of conducting the session:

- An interactive session with the participants using the power point presentation followed by a role play by the participants as detailed in the power point presentation (Day2 session4 -Drug refusal skills)

- (This chapter has been adapted from the 'Peer based intervention in out of school adolescents – an intervention module for out of school children' - under the WHO Biennium activities for year 2008-09).

Chapter 5

Reaching out to street children

Street children are heterogeneous in terms of type-some having home & family while others none, varying in age and sex. They are usually highly mobile in search of food, jobs and fun- making it difficult to reach them consistently. The groups are never homogeneous in terms of levels of drug use and other high risk practices too making reaching out critical. Like other areas of service provision these children will require sensitive and child friendly handling. Never being threatening & judgemental is the key to effectiveness.

What is outreach planning?

Outreach planning is a process using various tools that facilitate individual level planning and follow up of service uptake, based on individual risk and vulnerability profiles of street children. Outreach planning gives a visual picture of the site /area. It helps to understand the reach of general & programme services (if started) among street children, identify and monitor problem areas.

Objectives of outreach planning:

- √ To identify the number of street children in each area
- √ To facilitate effective child tracking for service access & behaviour modification
- √ To collect information for effective action plans
- √ To enhance participation of street children in programme planning

Outreach planning process:

There are six basic stages in the outreach planning process

1. Social mapping
2. Spot analysis
3. Contact mapping
4. Risk/vulnerability assessment
5. Work plan
6. Individual level tracking (monitoring)

1. Social mapping

A social map is a map showing places:

1. where street children live /congregate and
2. where services for street children are available

The purpose of a social mapping is to establish a dynamic understanding of street children for complete coverage through outreach in the intervention site.

Social mapping is useful to:

- √ Learn about locations where street children live
- √ Identify places where street children often go-get together (including work) and reasons for doing so
- √ Identify which services are available for street children, their locations, availability & accessibility
- √ Services include: referral, health care, education, vocational etc.

2. Spot analysis

Once the social map is constructed,

- √ Hotspots mapped will be divided among outreach workers (ORW)
- √ The assigned ORW will lead his/her team of peer educator (PE) and key informants (street children belonging to that hotspot) to the location
- √ Information will then be collected on:
  1. Number of street children in the spot
  2. Profile of street children: age group, sex, typology (types of drugs being used heroin/ brown sugar / cannabis / inhalants pharmaceutical drugs, etc.)
  3. Timing of drug use procurement congregation

After collection of the above information, the ORW and PE team will share this information with the other team members through a presentation or discussion.

3. Contact mapping

- √ Aim: to help participants map contacts they have with street children in each spot and plan for outreach based on these contacts
- √ Use the spot analysis to derive number of street children in a particular spot
- √ The assigned PE / ORW will list out the number and names of all street children (within the target group) known by each ORW and PE of the assigned site.

4. Risk/Vulnerability assessment:

The ORW / PE should collect following information from each street children post mapping, the risk/ vulnerability parameters should, at the minimum, include:

1. Types of drug used
2. Frequency of use
3. Sharing of N/S or other injecting equipment (if injecting)
4. Sexual behaviour: frequency of sexual intercourse, protected /unprotected sex (if sexually active)
5. Sensitivity about disclosure

5. Work plan

The next step is to develop a work plan to optimise scaled coverage by PE so as to address needs of the street children. Using information from the social mapping and risk/ vulnerability assessment of street children, outreach teams should plan a target for outreach to the street children of each area. These work plans should be documented in order to focus activities. Weekly plans should be made to ensure optimum coverage and service

uptake. Plans should be in coordination into other activities designed to increase street children's engagement or service utilisation.

6. Individual Tracking (Monitoring)

Information of day-to-day outreach and other service delivery provided to street children should be recorded in ORW/ PE log book /diary, daily contacts by PE and ORW should be documented within 48 hours of contact for quality data. These paper formats should be used to update individual tracking grids weekly.

Steps in conducting outreach

- √ Step 1: Building rapport with the street children and their care givers and general community in the setting
- √ Step 2: Delivering services in the field; referrals to DIC and other services as available and applicable
- √ Step 3: Creating child friendly and enabling environment for effective delivery of and access to services
- √ Step 4: Documenting and analysing collected data for re-planning/re-strategising outreach

Conclusion

- √ Outreach (planning and conducting) is the most important activity of a street children programme
- √ Outreach requires careful planning and coordination among staff
- √ The quality of outreach determines outcome of the programme
- √ Constant monitoring and re-planning (of outreach) is required to reflect & address the changing patterns & needs of street children

Training session

Outreaching the street children (Day3 session 2 & 3)

Objectives of the session:

- To help the participants understand the concept of outreach, the need of planning for outreach among the street children
- To familiarise the participants with the planning process for outreach in the context of the street children

Duration of session:

Two hours and thirty minutes (2 hour and 30 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

- An interactive session with the participants using the power point presentation (Day2 session5 –Outreach planning)
- Follows up by dividing the participants into 4 groups and asking them to list out the steps in planning outreach
    - Railway Platform
    - Around Traffic Signal
    - Around a temporary slum
    - Around a religious place.

Chapter 6

Brief orientation to medical management of drug use among street children

Treatment of drug use disorders in adolescents especially in street children is a difficult endeavor due to issues such as accessibility of interventions, lack of social support, lack of suitable medications being some of the roadblocks.

This chapter will aim to familiarize the reader to some crucial issues in management of Subtance Use Disorder (SUD) in street children.

Drug use disorder in street children:
The types of psychoactive drugs street children use can be many and varied. The following are some of the common drugs used by street children as documented in different studies. A basic knowledge of these drugs and their effects will help in planning treatment more effectively.

Alcohol:

Alcohol is a depressant which depresses some aspects of brain activity. Substances containing alcohol include the following: wine, beer, spirits.

Opioids:

Drugs in this group may act as analgesics (they relieve physical pain) and brain depressants. They may be synthetic or made from opium poppy. The following drugs are examples of opioids: heroin (street heroin called brown sugar) opium, pharmaceutical opioids such as codeine (such as in some cough mixtures), dextropropoxyphene capsules, buprenorphine (which is usually injected as a street drug).

Cannabis:

The cannabis plant grows in many parts of the world. Preparations containing different concentrations of cannabis are consumed.
Bhang: paste of leaves of the plant or dried leaves
Ganja/Marijuana: the leaves and flowers of the marijuana or hemp plant.
Charas/Hashish (oil and resin): these forms of cannabis are made from the resin of the different parts of the plant

Inhalants:

Inhalants include a wide range of easily available products including aerosols, volatile solvents and gases. The following substances can all be inhaled: ink eraser fluid, petrol, glue, paint thinners etc.

Sleeping tablets:

Drugs in this group are used to reduce anxiety and produce sleep. Common examples are diazepam (commonly known by the trade name calmpose), nitrazepam (commonly known by the trade name nitravet), alprazolam (commonly known by the trade name alprax).

Pattern of drug use:

Drug use patterns vary among street children and may not be constant over time. Street children usually pick drugs which are easily available and which are inexpensive. Some of the maladaptive patterns of drug use which are associated with increased physical and psychological risk are defined below.

Intoxication:

Intoxication is a temporary state that follows the use of one or more drugs resulting in a change in the person's alertness, thinking, perceptions, decision making, judgment, emotions, or behaviour. An intoxicated person is more likely to suffer from burns, suffocation, seizure, poisoning, overdose, sudden death etc. They may also be involved in accidents, violence and unsafe sex. Intoxication is highly dependent on the type and dose of drug and is influenced by an individual's level of tolerance and many other factors. It is not always clear when street children are intoxicated as intoxication with different drugs has different signs and symptoms. Cannabis can produce symptoms of psychosis (manifested as confusion, abnormal behaviour and suspiciousness that may be prolonged or transient). In general, an intoxicated person will have the following common signs; they may be drowsy, have trouble in thinking and speaking and talking to them may be difficult. Their eyes may be congested/dilated, they may laugh inappropriately (sometimes in response to hallucinations) and they may become aggressive.

Withdrawal:

When a person stops taking a particular drug that he or she has been using regularly, he/she may experience adverse effects known as withdrawal symptoms. Opioids, alcohol and sleeping tablets can cause withdrawal symptoms which can be very severe if not medically managed. The most dangerous withdrawals are from alcohol/sleeping tablets which can lead to seizures and delirium. Unless young people have been using large amounts of alcohol for a long time, they rarely need to be treated for alcohol withdrawal in a medical setting. However the dependence to sleeping tablets develops much faster with continued use for more than 6 weeks duration. Inhalants and cannabis are drugs which do not cause specific withdrawal signs or symptoms or if they do occur, they are mild in nature.

Drug	Withdrawal symptoms
Inhalants	No or mild withdrawal symptoms
Cannabis	No or mild withdrawal symptoms (anxiety, restlessness)
Alcohol/sleeping tablets	Anxiety, tremors, vomiting, sweating, convulsion, delirium (confusion & hallucinations) –withdrawals for alcohol rare in children as it requires continued heavy use for several years duration but the dependence for sleeping tablets develops much faster with continued use for more than 6 weeks duration
Opioid	Muscle cramps, running nose, watering from eyes, vomiting, diarrhoea, sleep difficulty, restlessness

Harmful use/abuse:

Harmful use is a pattern of drug use that results in damage to physical or mental health. Most physical harms experienced by street children following the use of drugs occur as a result of intoxication; hence health damage can also occur with experimental and occasional use. Other harms result from the way in which the drug is used. Injecting drugs is particularly dangerous because it can lead to an overdose or it may increase the risk of hepatitis, HIV and other infections from contaminated needles and syringes. Smoking drugs can result in disorders of the respiratory system and burns. Inhalants are particularly toxic and cause intellectual and memory impairment and can potentially cause liver and renal damage.

Dependent use:

This is a pattern of drug use in which the user has a strong desire to take the drug and cannot control its use. Thus drug use gains priority over other activities for the user. Long-term use increases tolerance as their body adjusts to the drug so that the same amount of drug no longer produces the effect. They may also experience physical withdrawal reactions if he or she goes too long without the drug. Presence of withdrawals also depends on the nature of the drug that was being used as certain drugs lead to predominantly psychological dependence only (such as inhalants) while others have very prominent physical withdrawals (such as heroin, sleeping tablets). Users who are dependent may continue to use drugs despite very serious consequences. They may spend more and more of their day involved with drugs.

Note that opioid and sleeping tablets cause withdrawal symptoms, while drugs like cannabis and inhalants do not cause clear-cut prominent withdrawal syndrome

Assessment

A comprehensive assessment forms the backbone of a management plan. It can be carried out by different group of qualified people including trained health worker/counsellor/paramedical staff/general practitioner/psychiatrist/psychologist depending upon the available resources. Some of the important things to be kept in mind while conducting an assessment are:

Assessment

- Background: age, gender, cultural background.
- Drug use-nature of drugs used, frequency, quantity, duration, last use, history of withdrawal symptoms, previous attempts at treatment
- Sexual and reproductive health including history of high risk behaviour and history suggestive of sexually transmitted diseases
- Physical health and injuries.
- Mental health and psychological trauma.
- Family and social.
- School and vocation.
- Unlawful behaviour.
- Recreational and cultural activities.

Management:

A street child may require various levels of intervention from basic primary health care to residential treatment in a facility. Referral to different services would depend on the current status and the goals. This requires assessing the severity of drug use including quantity and frequency, last use, nature of drugs used and associated physical or mental health problems.

Setting a goal:

Goal setting is an important component of assessment and case management. Goals should be negotiated with the street child. The goal should be specific and observable, and broken up into short-term, achievable targets. Plans should be reviewed regularly, and updated to take into account the changing nature of street life, the current availability of resources and services, developmental issues, and the fluctuating motivation of the child.

Goals of treatment

Abstinence
Reduction of harm
Improvement of health, social, occupational functions
Improved quality of life

Setting:

The tables below outline the various settings where drug use can be managed.

- √ Intensive treatment in a health facility
- √ Residential environment
- √ Street based setting
- √ Drop-in centre

Referral to medical facility is required in the following instances-

- In case of severe intoxication
- Expected withdrawal symptoms based on knowledge about drugs used
- Symptoms suggestive of health damage-physical or mental
- Associated physical or psychiatric illness

The common symptoms that may require referral for mental health problems are:

- Behavioural abnormalities
- Presence of sustained sadness of mood/crying spells
- Any suicidal ideas/behaviour
- Increased aggressiveness and tendency to harm others
- Abnormal beliefs including undue suspiciousness

Note: Some of these symptoms may be transiently present when intoxicated and may not require referral.

Care of intoxication/overdose:

Alcohol/Inhalant/Cannabis:

The basic steps in management of intoxication are based on principles of first aid and are outlined below

- Protect vital signs by monitoring ABCs, or Airway, Breathing, and Circulation
- Treat hypoglycemia
- Electrolyte and fluid balance to be checked
- In severe cases referral to tertiary care center may be required for additional support.

Opioids:

Opiate intoxication is classically characterized by the triad of pinpoint pupils, depressed respiration and coma. A suicidal or accidental overdose of opioids is an emergency and should be referred to nearest medical center with emergency support. If opioid overdose is suspected, the antagonist naloxone must be immediately administered. This is both diagnostic and therapeutic. If consciousness improves and pupils dilate it confirms the diagnosis of opioid intoxication. Such timely intervention can sometimes be life-saving.

Care of withdrawals/detoxification:

The goal of detoxification is to provide safe and humane withdrawal from drug(s) dependence. The procedure for detoxification will depend upon the type, combinations and pattern of use of drugs in question.

Drugs which require medical setting and supervision for detoxification are:

- Opioid
- Sleeping tablets
- Alcohol (in cases where dependence manifested by withdrawal symptoms has developed)

For other drugs, medical assistance may however be needed to ease the withdrawal process.

Long-term treatment:

Treatment for drug use should preferably be prolonged over several months irrespective of the setting where it is being carried out. In cases, where a child is admitted to a medical facility for various reasons, the psychosocial intervention should continue even after discharge from the medical facility.

A number of pharmaceutical agents have been well researched and in use for long term management of drug use disorder in adults. Deterrent (medication that produces reaction with alcohol) and anti-craving agents for alcohol, agonist/substitution treatment (medication with effect similar to the drug being used) and antagonist treatment (medication that blocks the effect of the drug if the drug is taken by a person who is stabilized on the medication) of opioid dependence are accepted approaches. All these approaches for long term treatment are still in their early stages and have not been well researched in adolescents. The mainstay of long term treatment in young people as of now remains psychosocial intervention.

Conclusion:

Management of drug use disorder in street children involves a combination of both pharmacological and intensive psychosocial treatment. Medical management of common drugs of use such as alcohol/opioids or inhalants currently focuses upon immediate care, especially problems like intoxication/overdose and withdrawals. Immediate care requires assessment and referral to appropriate setting for management of these conditions. Gaps in research and

knowledge still exist in long term pharmacological treatments and need to be further explored. Assessment and management of medical and psychiatric co morbidities are vital to a successful outcome.

Training session

Medical management of drug use among street children (Day3 session 1)

Objectives of the session:

- To understand what is drug use disorder and issues pertaining to street children.
- To conceptualize and formulate a rational treatment plan for the patient.
- To understand basics of medical management of common drugs of use in street children

Duration of session:.

One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

An interactive session with the participants using the power point presentation **(Day2 session4 -Drug refusal skills)**

The facilitator asks questions after each section to ensure that the information imparted has been retained. Key questions include:

1. How are the various drugs distinct from each other?
2. Which drugs lead to prominent withdrawals that can be distressing?
3. Which drugs can lead to seizures during withdrawal?
4. Which drugs do not need medication for detoxification or treatment of withdrawal symptoms?
5. In which conditions would one need to take a street child to a medical facility for treatment?
6. Can drug use be treated while the child is living on the streets?

Chapter 7

Psychological interventions for early detection and treatment

Drugs are used for the direct 'benefits' (including the perceived one's) they provide through their action on the brain (e.g. sense of pleasure/euphoria) and also through the brain's action on other parts of the body (e.g. reduction of physical pain caused due to trauma or hardship). They are also used for their indirect benefits (increasing ability to take risks-due to impairment of judgement, become more 'courageous' due to lowering of inhibition through action on the inhibition centre on the brain). These benefits coupled with the fear of 'costs' -again both direct (pain/discomfort of withdrawal) and indirect (loss of companionship of drug using peers, social position among the drug using group) drive the decisions to continue using.

Brief Interventions:

Brief interventions are aimed at helping people in identifying current or potential problems of drug use and motivate those at risk to change their behaviour to prevent use, reduce/cut/stop use or encourage seeking more intensive treatment for harmful/dependent drug use. Brief Interventions can indeed be very brief intervention of single sessions beginning from 5 minutes to those of 15 to 30 minutes.

Brief interventions need to be personalised, supportive and non- judgemental. There is strong evidence for the effectiveness of brief interventions in primary care settings for alcohol and tobacco, and growing evidence of effectiveness for other drugs.

Motivation enhancement

Changing drug using behaviour is not easy, especially if the use has been prolonged. It is a behaviour change that requires one to be motivated for the change. The 'benefits' of drug use coupled with the fear of the 'costs' of stopping/cutting drive the progression of continued use making it difficult to stop in spite of knowing/realizing the harms of it. The street child needs to be motivated to overcome these fears of losing the benefits as well as to bear the costs. He/she will not only need to be motivated to take the plunge but also continue to remain motivated to take the necessary actions till the desired goal is reached.

It needs to be remembered that motivation is dynamic, keeps changing - increasing as well as decreasing the requisite change can only be brought about through a social interaction (e.g. between a street child and a counsellor).

Those using drugs go through various phases before making the behaviour change and ultimately sustaining it.

Stage	Description	Example
Pre contemplation	Not yet acknowledging that there is a problem behaviour that needs to be changed.	Golu, a street child who uses inhalants does not think that he has a problem using it.
Contemplation	Acknowledging that there is a problem but not yet ready or sure of wanting to make a change.	Golu, understands that his inhalant use is causing him various problems but does not know how to reduce/stop.
Preparation	Preparing for change.	Golu has talked to a peer educator about where to find help regarding his inhalant use.
Action	Changing behaviour.	Golu has enrolled in DIC for treatment of his inhalant use.
Maintenance	Maintaining the behaviour change.	Golu has stopped using inhalants and is attending relapse prevention sessions regularly.
Relapse	Returning to older behaviours and abandoning the new changes.	Golu has stopped visiting the DIC, has again started inhalant use and sharing in the same pattern as before.

Through motivational enhancement techniques the counsellor helps the client to move from one stage to another. So it is important for the counsellor to know the various strategies that help in motivating the client to move through the different stages. The counsellor uses the following strategies during interview.

Feedback

This involves providing feedback to the client regarding the ACTUAL negative consequences the client has faced in the past as well as those he/she continues to face presently due to drug use. 'Preaching' about possible or potential consequences he/she may 'suffer' in the future is avoided.

Decision balancing

The client is helped to compare ('weigh') two different situations: the benefits & costs of cutting/stopping drug use against benefits & costs of continuing drug use. Thereafter encouraging the client to take the decision whether to change or stay the same.

Developing discrepancy

Here, the client is helped to compare his/her life with his/her non drug-using peers or with those who have successfully changed their behaviours. Additionally, a comparison can also be made between the status of the client as it stands today (e.g. the money he/she has to spend and the things he/she has to do for earning the money/getting the drug) and his/her likely status had he/she not been taking drugs. Yet another way to increase motivation through this technique would be to encourage the client to compare his status in the future in two imagined situations – if he/she succeeds in changing his/her behaviour vis-à-vis he/she does not change the behaviour.

Supporting self-efficacy

Many drug users hold this notion that it is impossible for them to change their behaviours; "You know, I have been sniffing glue for so many years now. It is impossible for me to change myself." In such situations the important thing for the counsellor to do is to instil the hope in the client ("change is possible") and confidence ("you can do it"). This can be done by taking examples of others who have succeeded in doing so- if possible from his/her peer groups e.g. the peer educators.

Relapse prevention

Drug use is a chronic disease prone to relapse like many other chronic conditions. For example a person suffering from diabetes will go through ups and downs with his/her blood sugar level going up and down –sometimes worsening and may be put in critical conditions needing greater care including hospitalisation. The worsening of condition may be caused by changes in practice, lifestyle or medication. In case of diabetes- stopping/irregular exercise, eating foods with higher sugar content or missing doses of medication or combination of all may cause the relapse. Thus, though commonly associated with drug use relapse occurs in many other disease and like many other chronic one's which cannot be cured but only managed may be aggravated through change in behaviour, practice, lifestyle.

'It is not difficult to quit but very difficult to stay quit' - the most difficult part of the 'change' is in maintaining it –in remaining abstinent. A number of factors – both internal and external, play a critical role in determining whether the individual continues to remain abstinent or relapses back to drug use. The most important determining factor is the way in which the individual client handles or deals and reacts to these factors.

Drug use is a learnt behaviour- every time one uses drugs- he/ she is rewarded either through gaining pleasure or reduction of pain. This 'reward' remains recorded in the brain and pushes the user to seek it again and again- compelling him/her to continue using. Along with drugs and their effects –the brain also records the places of use, the people used with, time of use and the situations of use etc. and associate them with the actual effects of the drug used. These act as cues and trigger off craving for drugs when exposed to them. This continues even when the user stops drug use pressurizing him/her to return to drugs. The level of compulsion (craving) varies from person to person, drug to drug and also duration of use. These 'triggers' are evidenced to play a major role in relapse. Exposure to them creates high risk situations which the drug user finds difficult to handle due to lack of coping skills leading to relapse.

Relapse is a process and not an event. When an individual after abstinence restarts use he/she goes through stages before reaching the pattern of earlier full blown use. The initial stage of drug intake after a period of abstinence is called as **'slip'.** These may be occasional/intermittent events of drug use without the reappearance of withdrawal, tolerance or other signs and symptoms of harmful use/ dependence. This is followed by **'lapse'** when the frequency and quantity of drug use is increased- may show tolerance and withdrawal but yet to reach the full blown state. **'Relapse'** is to be regarded as full blown with the return to the previous pattern of drug use and the subsequent reappearance of the signs and symptoms characteristic of the individual's drug dependence'.

Relapse prevention includes the following steps:

- Assessment of high risk situations and triggers
- Planning to cope /deal with high risk situations and triggers
- Developing skills to cope/deal with high risk situations and triggers

The assessment of high risk situation and trigger can be done through functional analysis of various drug using episodes and the associations by analysing the following:

1. Situation (including people, place, time), thoughts, feelings and sensations -before drug use

2. Drug using behaviour and practice
3. Effects/consequences- after drug use

This can be followed up with analysis and ranking of the triggers as applicable to the individual using External, Internal trigger analysis tools. These analyses should be done through discussions with the street child helping him/her identify them as potential risks in recovery.

Once the triggers are identified the counsellor and the street child should discuss the plans to deal or cope with them. It should be remembered that exposure to some of the triggers can be avoided while others (the unavoidable ones) will require to be dealt/coped with. The counsellor should remember that the list of unavoidable ones for street children will be very long when compared to those of the child with a protective home and family. The street child is almost always exposed to drugs and drug sellers, drug using peers, money to procure drugs is also easy to 'earn'. Thus, the street child will need to rely more on coping skills than on avoiding to maintain recovery. For developing coping skills, the counsellor may use **direct instruction** – guide the client on preparing a specific strategy to each high-risk situation, and the client is asked to practise it. Alternatively, the client can be exposed to the situation through imagery or in controlled situations and be asked to practise the behaviour to be adopted. This is called as **behavioural rehearsal**. This can also take place in a group setting, and the other group members may guide the client and suggest how to handle the particular situation.

Counselling for risk reduction

A street child who uses drugs may not be immediately ready to seek treatment and stop drug use right from the time he is contacted by the outreach worker or his/her opening up/confiding in the counsellor. He or she will take time to go through the various stages before taking action towards abstinence. It is important to keep the street child safe from the associated risks as much as possible. While, this will help the street child take his/her steps without being pushed, it will also provide greater opportunity to build trust between the counsellor and the client by enhancing confidence in each other.

The risks for a street child using drugs are various:

- Risks due to effects of the drugs
  - Intoxication/Hallucinations - crossing the road, using in under construction/abandoned buildings
  - Impairment of judgement and performance-working on machines, riding bicycles
- Risks due to the mode of use
  - Smoking –causes damage to the respiratory tract
  - Injecting – causes damage to the veins, abscess, may lead to infections- HIV, Hepatitis B, C

Once the risks are identified through risk assessment interviews with the client the counsellor should inform him/her about them and also about the consequences in a non threatening/non-frightening manner. The counsellor together with the client should explore the possible options for risk reduction using evidence based information.

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

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

Family counselling:

Family plays a very important role in drug use of an individual. The role of family can be both positive as well as

negative or a combination of both affecting the drug use of an individual. While poor parenting, domestic violence may be the reasons for the child being on the street, they may also have affected drug use by the child ultimately leading him/her on the street. Many of the street children may not be having any connection with their biological family, some may be having only poor ties while others may have families also staying on street and/or using drugs –with little or no influence over the children. A street child may be having an elected family–a biologically unrelated group of young people only or with some adults bonding together somewhat like a family.

Irrespective of the family structure -some members may be protective to the child while others may be risk factors. Thus making it very important for service providers to have a thorough understanding in the role/s the family members may be playing in the treatment/recovery, care and support of the child. This can be done through detailed interviews with the child and the family member/s, combined with additional information from the outreach workers who visit them in the community settings.

In case of family members serving or having potential to act as ' protective factors' or playing supportive role in seeking treatment and recovery- should be involved as much as possible. In case of families acting as risk factors due to their own drug use and other behaviours- counsellors should use discretion in limiting their roles as appropriate.

In case of conflicts that might affect the treatment/recovery of the child - the counsellor should try to help the drug user and the family resolve it by bringing the two together and helping them seek solutions to the problem/s.

Training session

Brief interventions (Day 3 session 4)

Objectives of the session:

- To familiarise the participants with the tool (Assist) & techniques of Brief Interventions

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector
- Printed copies of the Assist forms to be distributed to the participants before the session.

Methodology for conducting the session:

1. The facilitator makes a short presentation using the power point presentation **(Day3 session4- Brief interventions)** to acquaint the participants with the Assist tool and technique.
2. Request two participants to volunteer for role play. One playing the client (referred by the hospitalising where he/she was admitted after an accident under the influence of inhalants) and the other the counsellor.
   Request them to use the tool for the interview and subsequent feedback based on the findings.

Training session

Motivation enhancement (Day3 session5)

Objectives of the session:

- To familiarise the participants with the tools and techniques of counselling for motivation enhancement

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector
- Printed copies of the Cost Benefit Analysis form to be distributed to the participants before the session.

Methodology for conducting the session:

1. Ask the each participant to note down within 2 minutes:
   a. One activity they like doing and do it regularly
   b. One activity they do not like but also do it regularly

Ask the participants –'why do you do the activity that you like and note the responses on a chart paper. Then go to individual participants and ask them –what is the activity they do not like but do regularly and what are their reasons for continuing to do it regularly? Probe the answers to find the 'rewards' they receive either through avoidance of some pain, discomfort, complications etc or indirectly some 'pleasure'.- note down the findings in two columns of benefits gained and costs avoided. Share the findings with the participants to highlight how all activities are 'reward' oriented. Draw an analogy with drug use- how one continues to use drugs in spite of knowing /realising the costs of it but cannot stop/cut due to the fears of withdrawal and other associated losses. (20 minutes).

Make a short presentation to orient the participants on the motivation enhancement techniques using the power point presentation **(Day 3 session 5- Motivation enhancement) (20 minutes)**

2. Invite 2 volunteers for a role play. While one plays the counsellor the other plays the role of the client (a street child dependent on inhalant or cannabis not thinking of doing anything about his/her drug use). (20 minutes)
3. Provide feedback to the volunteers, clarify issues (if any) and wrap up.

Training session
Relapse prevention (Day 4 session1 & 2)

Objectives of the session:

- To orient the participants to the counselling techniques for relapse prevention

Duration of session:

- Two hours and thirty minutes (2 hour and 30 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector
- Printed copies of the Functional Analysis, Trigger Questionnaire forms to be distributed to the participants before the session.

Methodology for conducting the session:

1. Share the issues and problems related to relapse and the various techniques used for its prevention using the power point presentation of (Day3 session 4 &5 -Relapse prevention)
2. Invite 2 volunteers for a role play. One plays a client (just finished his/her detoxification phase) and is being counselled for relapse prevention. Request them to use the various techniques and tools just shared with them.
3. Provide feedback to the volunteers, clarify issues (if any) and wrap up.

Training session
Risk reduction (Day4 session3)

Objectives of the session:

- To orient the participants on the need for risk reduction counselling and the various components of it

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

Divide the participants into 4 groups and assign each group one at risk type of street child:

1. a street child who regularly uses oral opioids and also injects when in crisis
2. a street child who sells odd items at street traffic crossings and is dependent on inhalants
3. an adolescent female street child whose mother is alcohol dependent
4. a street child who works at a high way eatery (dhaba) and drinks leftover alcohol.

The groups are requested to discuss the drug related risks of each and list them on chart papers and suggest measures to address those (30 minutes). The groups are then requested to present their findings to all the participants. The facilitator encourages the participants to provide feedback on the findings, the effectiveness and feasibility of the suggested measures.

The facilitator wraps up the session with the power point presentation (Day4 session1-Risk Reduction)

Training session

Family counselling (Day 4 session 4 & 5)

Objectives of the session:

- To orient the participants on the basic components of family counselling and the techniques of conducting family counselling sessions for street children

Duration of session:

- Two hours and thirty minutes (2 hour and 30 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

1. Share the issues related to the family in drug use and dependence and the various techniques used to help them help the client in drug use prevention treatment and care using the power point presentation
2. Invite 2 volunteers for a role play. One plays a client's (receiving treatment at the centre) father/mother.

   Request them to use the various techniques and tools just shared with them.
3. Provide feedback to the volunteers, clarify issues (if any) and wrap up.

Chapter 8

After care for street children

Recovery process does not end when a child completes a drug treatment (detoxification) program. Support and care is the key to a complete and healthy recovery from drug dependence. After care can occur in a variety of settings, such as periodic outpatient after care, relapse/ recovery groups, self help groups and mid way/half way homes. Children especially those on the streets with very little or no family support and constant exposure to easy drugs and drug using peers are very vulnerable, thus, in need of greater care and support.

Street children usually are malnourished. If using drugs their main focus is on drug procuring, using and overcoming withdrawals from it forcing them to concentrate all efforts and resources towards it. Thus street children who use drugs mostly suffer from malnourishment leading to reduced immunity further adding to ailments. Sexual activity is common among street children, some may be having STIs or other reproductive tract infections complications.

There may be underlying physical conditions (often manifested in pain) and psychological complications prior to drug use which may have caused the child to be on the street. In many cases drug use is a form of self medication to deal with these issues and may also be in turn be the reason for the child to be on the street. Whatever the case, these discomforts remain hidden/ unnoticed during drug use but may start surfacing with the stoppage of it. Remaining unattended, all these will be major causes for distress for the child. Lacking knowledge and means to access services for these will remain as major risks for relapse.

Providing requisite services directly and indirectly related to relapse prevention and sustainable recovery are regarded as after care services.

The following services are some of the requisite ones:

a. Follow up services-including follow up visits, outreach etc
b. Relapse prevention services –including counselling, recovery group meetings
c. Drug free shelter
d. Nutrition
e. General health care
f. Counselling for other psychological issues
g. Specialized care (mental health, STIs etc)

What services are needed?	When to provide?	Who will provide?	What will be the mode of delivery?	What will be the mode of delivery?
1. Follow up services	Needed as an on going service, preferably during treatment (if treatment is being provided as outpatient or on site) and post treatment phase	Outreach teams	By visiting the field, using a tracking system	Documenting and tracking very important
2. Relapse prevention counselling	During outreach with focused counselling	Treatment providers and counsellors	Through counselling at treatment centre ,IEC material	To be monitored and observed closely
3. Recovery group meetings	After treatment and counselling	Groups like NA and support groups	Formation of groups at different areas or places, networking with recovery groups	Very comfortable and free access available
4. Drug free shelter	After treatment	Drug treatment providers, Govt. services	Mid way homes	Stay should be extended beyond 15/20 days
5. Nutrition	During and after treatment	Treatment centres, mid way homes	Through DIC's, mid way homes	Can be tied up through religious/charitable institutions
6. General health care .	During and after treatment	Govt.hospitals, treatment centres, mid way homes	Hospital OPD,PHC, Service provider	General medicines can be supported through pharmaceutical companies
7.Counselling for other psychological issues	After treatment	Psychologist, trained /qualified counsellors	In house settings, counselling centres	Tied up through existing counselling groups
8. Specialized care (mental health, STIs etc)	During and after treatment	STI clinics, mental health hospitals and clinics	Hospital OPD, mobile STI services	

Training session

After care (Day5 session1 & 2)

Objectives of the session:

- To orient the participants on the need for after care and the various components of it

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

Divide the participants into 8 groups and assign each group one area of service. Ask the groups to answer the following questions in relation to their service:

1. When to provide?
2. Who will provide?
3. What will be the mode of delivery?
4. Comments/remarks (if any)

The groups are then requested to present their findings to all the participants. The facilitator encourages the participants to provide feedback on the findings, the effectiveness and feasibility of the suggested measures.

The facilitator wraps up the session with the power point presentation (Day5 session 1 -After care)

Chapter 9

NGO networks and networking

Even though one should refrain from generalizing about what signifies a network, there are a few common characteristics, which appear to be generally applied. Networks are created for very different reasons and entail various structures depending on the goal(s) intended to be achieved within the network. Networks can include either formal or informal structures and vary in member contribution and benefits. Networks evolve and change over time. Their purpose, functions, value propositions, and structures may change. Their membership may change; people and organizations come and go. And, along with the possibility of adaptive change, networks seem to have a maturation process.

The simplest definition of a network is that it is a set of "nodes and links," of connections between things (e.g., networks of canals and roads between cities, or of computers, cells, or nerves). This is a very broad statement, however, and, as Duncan Watts observes, not especially helpful in the analysis of particular cases. The networks this manual emphasizes on is what social scientists call social networks –systems of social ties that link people to one another.Social networks result from the intertwining of individual initiatives within specific social contexts – and include the personal networks of colleagues, friends and acquaintances with which we are all familiar. The networks that are of concern to the civil sector are social networks, but of a particular type, drug user networks being one such type.

NGO networks: Definition

"Groups of **individuals and/or organizations** with a **shared concern or common interest,** who **voluntarily contribute** to knowledge, experience and/or resources for shared learning, joint action and/or to achieve a **shared purpose or goal** and who **rely** on the network to **support** their own goal".
Benefits of network membership:

a) Need for access to knowledge, information, expertise and financial resources (donor attraction)
b) Need for coordination of knowledge, information
c) Increase the organizations' efficiency, outreach and impact
d) Strengthen the organizations' advocacy capacity
e) Increased influence in policy formulation at national and international levels
f) Increase the organizations' visibility of issues (overcoming isolation)
g) Develop shared practices and shared learning
h) Increasing the profile or legitimacy of member NGOs and their needs
i) Mitigate risks
j) Need for support and solidarity
k) New ways of understanding and intervening in complex circumstances (shared diagnosis, analysis and strategic coordination of action
l) Expanding opportunities to start projects

There are however also a number of risks associated with network membership.

Risks involved with network membership:

a) Loss of autonomy- NGOs need to consider how much interdependency they are prepared to commit to before joining a network
b) Loss of responsibilities
c) Requirements of membership
d) Unclear accountability structures
e) Domination of the most active members
f) If poorly constructed and managed, networks can translate into more work rather than a reduction
g) Loss of identity if poorly represented
h) Inappropriate leadership
i) Networks based on individuals and personal contacts risking lost benefits when individuals leave
j) Placing attention at the network level may take time and energy from the grassroots or local levels

Networks and Networking:

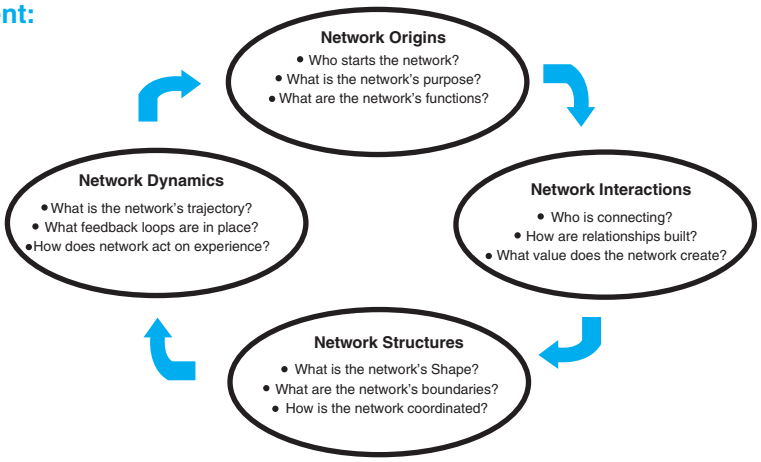
The essential activity in networks is the practice of networking. While the term 'networking' is also open to a wide range of interpretations, the essence of networking is communication. In contrast to organizations, "the core business of networks are not so much the manufacture of products and/or the provision of services, but social learning, communication, and the making of meaning".

Networking, thus, is "the process resulting from our conscious efforts to build relationships with each other to further [a certain cause]. Networks are the more or less formal, more or less durable relational patterns that emerge as a result of such efforts".

As a voluntary mechanism for learning and communication among autonomous participants a network depends upon the inputs given by its members. If there are no contributions, then there is no networking and, hence, no network.

Networking can be done in a number of ways and for a wide range of purposes. Sometimes networking is occasional and rather informal; sometimes the activity of networking can lead to the creation of an organization. Sometimes continued networking is preferred either because the participating NGOs are keen to maintain their independence or because it is deemed more efficient in relation to stated objectives. Irrespective of what your networking may lead to, remember that much can be achieved by networking, but not everything. Make up your mind about what you want to accomplish by participating in a network. Cooperate initially on those issues where you have a shared idea and leave other topics for the time being. Allow network participation to cost but be cautious in matters like the management of funds and representation.

Framework for Network Development:



Network Structures:

As interactions occur within networks and are repeated, patterns of linkage appear. These structures enable interactivity by, for example, routing the flow of information through particular people in a network or creating multiple pathways for exchange among members. One structural phenomenon in growing networks is the creation of hubs—nodes that are more connected, have more links, than other nodes, and become more influential in the network. Hubs are created because early nodes in a network have more time than latecomers to form links with new nodes and because new nodes tend, prefer to link to more connected nodes. This is why it is said that as networks expand, the rich (more connected) nodes get richer.

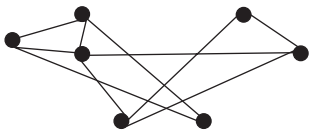
Moreover, some structural arrangements (a specific pattern of nodes and links) are better suited to some network functions than others. For example, the tasks of both mobilization and diffusion are typically best served by a multi-tiered branching structure in which flows between center and periphery are more easily achieved. In contrast, the task of combining capacities is better achieved in a small dense cluster (which can be highly organized) than in a larger multi-channel network.

Network structures make revealing pictures.

- When many nodes connect to a single node, a **Hub-and-spokes** or star structures is created. Each of the spoke nodes has one link, while the central node is linked to all other nodes.

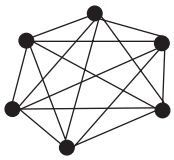
Hub-and-Spokes
(Eureka)

- When many nodes connect to each other in various configurations, a **Many Channels** structure is created. Each node may have several links through which it can reach other nodes.



Many Channels
(Lawrence Community Works)

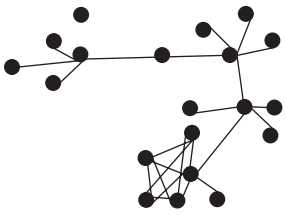
- When a number of nodes are all connected to each other, a **Dense Cluster i**s created. Each node is connected directly to all of the other nodes.



Dense Clusters

(VT Smart Growth Collaborative)

- When hubs connect to one another, either directly or through spokes, a **Branching or Multi-Tiered** structure is created. Nodes may have fairly long paths, through central nodes, to reach each other.



Branching

(Boston Parents) Organizing

What are the network's boundaries?

Like any territory, networks have boundaries beyond which there are no linked nodes. Boundaries define who is in and who is out of the network; they limit connectivity. The terms of network membership established through eligibility rules, fees, alignment with network identity, etc. create boundaries. But boundaries can be more or less

porous. And the liveliness that exists at the edge of a network can be an important factor in producing desired network effects.

How is the network coordinated?

As a network develops, it begins to need a certain amount of coordination and infrastructure to support its members' activities and to tend to the network's business.

The coordination tasks of the network broadly include:

a) Coordinating member activities, like a "traffic cop" that helps with routing so that congestion doesn't occur.
b) Developing and maintaining a management information system for the network
c) Orienting new members.
d) Monitoring the health of the network.

Advantages of networking

A rather new phenomenon, especially in the NGO sector, is that networks are beginning to form as mechanisms to enable members to seek, mobilize and improve relations with international agencies and donors. Another recent phenomenon is the establishment of networks as 'platforms of action' which NGOs are then using to create new alliances, policy spaces and ways of negotiating with both development and policy communities. Due to the newness of this phenomenon, there are as yet no available studies on how networks are affected by these new tasks or of how effective they are in these new pursuits.

The word 'networking' refers to the activity of communication and exchange - primarily of information. If there is no exchange then there is no network and networks cannot function if they simply consist of passive recipients of information. But even when communication is multi-directional and networking runs smoothly, networks need time to mature, five to seven years is frequently mentioned. Partly this is so because it is often difficult to pinpoint the benefits of networking and partly because the benefits of networking are not always those intended.

Networks often tend to be exclusive, a kind of selective brotherhood. As such, they may just as well prevent the spread of information and communication as facilitating it. Nevertheless, networks – seen as communication mechanisms and learning devices - when more open and successful, can "promote the exchange of ideas and information between individuals and groups who would not otherwise communicate with each other" (Nelson & Farrington 1994). They have the potential to "enable the accelerated, more comprehensive, development of new knowledge and the mobilizing of new issues" among members. Hence, networking can - but does not necessarily - "promote cross-fertilization, a spilling-over of ideas across sites and sectors, and creative ways of addressing them". Experience shows that there are a few conditions that need to be fulfilled for networks to be so successful. There are also a number of pit-falls to be avoided.

Training session

NGO networks and networking (Day 5 Session 3 & 4)

Objectives of the session:

- To understand the basics and concepts of NGO networks and networking.
- To understand the nuances, process and types of networking for NGO service providers.
- To understand and formulate a rational networking plan for NGOs.

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes) X 2 sessions

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector

Methodology for conducting the session:

1. An interactive session with the participants using the power point presentation
2. Presentation of 2 video clips which emphasize on the environmental factors and linked vulnerabilities of a street child
3. Discussion based on the 2 video clips
4. The facilitator asks questions after each section to ensure that the information imparted has been retained. Key questions may include-
5. What is a network?
6. What are the different kinds of networks you have heard of?
7. Why is it important to network?
8. What is networking?
9. Who do you network with at the community level and why?

In the end (and following the presentation of the 2 videos) participants would be asked to :

- Identify "gaps in services" for street children
- Identify services/organizations/institutions/places to network with
- Develop a networking plan for ensuring access to basic health and related services for street children in the community settings.

Chapter 10

Government schemes for street children

The Constitution of India recognizes the vulnerable position of children and their right to protection. Article 15 the Constitution guarantees special attention to children through necessary and special laws and policies that safeguard their rights. The Right to equality, protection of life and personal liberty and the right against exploitation is enshrined in Articles 14, 15, 16, 17, 21, 23 and 24.

While protection is a right of every child, some children are more vulnerable than others and need special attention. The Government recognizes these children as 'children in difficult circumstances', characterized by their specific social, economic and geo-political situations. In addition to providing a safe environment for these children, it is imperative to ensure that all other children also remain protected.

Child protection is integrally linked to every other right of the child. Failure to ensure children's right to protection adversely affects all other rights of the child. Thus, the Millennium Development Goals (MDGs) cannot be achieved unless child protection is an integral part of programmes, strategies and plans for their achievement. Failure to protect children from issues such as violence in schools, child labour, harmful traditional practices, child marriage, child abuse, the absence of parental care and commercial sexual exploitation among others, means failure in fulfilling both the Constitutional and International commitments towards children.

Vulnerable Children:

All children due to their age are considered to be at risk for exploitation, abuse, violence and neglect.

But vulnerability cannot be defined simply by age. Though age is one component, Vulnerability is also measured by the child's capability for self-protection. The question that arises is, are children capable of protecting themselves. A child's vulnerability comes from various factors that hinder a child's ability to function and grow normally. Hence self-protection is more about the ability of the child to lead a healthy life within a child protection system; the ability to protect themselves or get help from people who can provide protection. The term vulnerable children refer to an age group that is considered at risk.

Children in need of care and protection is defined as a child who :

- Doesn't have a home or shelter and no means to obtain such an abode
- Resides with a person(s) who has threatened to harm them and is likely to carry out that threat, harmed other children and hence is likely to kill, abuse or neglect the child.
- Is mentally or physically handicapped, or has an illness, terminal or incurable disease and has no one to provide and care for him/her.
- Has a parent or guardian deemed unfit or unable to take care of the child.

- Is an orphan, has no family to take care of him/her, or is a runaway or missing child whose parents cannot be located after a reasonable search period.
- Is being or is likely to be sexually, mentally, emotionally or physically abused, tortured or exploited.
- Is being trafficked or abusing drugs
- Is being abused for unthinkable gains or illegal activities
- Is a victim of arm conflict, civils unrest or a natural disaster

"UNICEF views vulnerable children as those who are abused, exploited, and neglected. Child protection is derived out of the duty to respond to the needs of vulnerable groups of children. UNICEF outlines the following groups as vulnerable: Children subjected to violence, Children in the midst of armed conflict, Children associated with armed groups, Children affected by HIV/AIDS, Children without birth registration, Children engaged in labour, Child engaged in marriage, Children in Conflict with the Law, Children without Parental Care, Children used for commercial sexual exploitation, Female children subjected to genital mutilation / cutting, and Trafficked children.

Vulnerable Children Related Issues:

Vulnerability of children leads to and is further created by the socio-cultural, socio political and socio-religious situations they are in. A child who is forced or born into a situation or discriminated group is at risk of abuse, neglect and exploitation.

The lack of a protection system either due to mis-implementation of national laws and programmes or the absence of protection policies and legislation also renders children vulnerable. Following is a discussion of various protection issues concerning children.

- Abuse and Violence
- Street Children
- Children Living with AIDS
- Child in Armed Conflict
- Girl Child
- Child Marriage
- Children with Disabilities
- Children affected by Drug Use
- Birth Registration
- Missing Children
- Children in Conflict with Law
- Child Labour
- Child Trafficking
- Children without Parental care
- Child Health and Nutrition
- Early Childhood (Children below six)
- Children of Schedule Caste and Schedule Tribe Families
- Children in Poverty

Within care, support and rehabilitation services the scheme will also provide CHILDLINE services, open shelters for children in need in urban and semi-urban areas, offer family based solutions through improving sponsorship, foster-care, adoption and after-care services, improve quality institutional services, and general grant-in-aid for need based/ innovative interventions. Within statutory support services the scheme calls for the strengthening of CWCs, JJBs, SJPUs, as well as seeing to the set up of these services in each district. Beyond this ICPS also outlines the need for human resource development for strengthening counselling services, training and capacity building, strengthening the knowledge-base, conduct research studies, create and manage a child tracking system, carry out advocacy and public education programmes, and monitoring and evaluation of the scheme.

Training session

Government schemes (Day 5 session 5)

Objectives of the session:

- To familiarise the participants with the existing government schemes that can be used to support programmes for street children
- To help the participants plan services for the street children by using the existing related government schemes

Duration of session:

- One hour and fifteen minutes (1 hour and 15 minutes)

Materials/Aids required:

- Flip-charts / chart paper/ white-board
- Marker pens
- Lap top/ computer and LCD projector
- 5 Sets of printed copies of the government schemes.

Methodology for conducting the session:

- ? Divide the participants into 5 groups and request them to identify additional services required to help in the recovery and rehabilitation of the street children. (15 minutes)
- ? Distribute the 1 set of the printed copies of all the schemes to each group. Request each group to identify the additional services listed by them that can be provided using these schemes. (15 minutes)
- ? Also ask them to list the steps they have to take towards accessing these schemes
- ? Request each group to present their findings. Ask the participants from other groups for any queries or clarifications.

Appreciate the effort provide feedback to the participants, clarify issues (if any) and wrap up.

Government of India schemes for street children

Name of the programme/scheme	An Integrated Programme For Street Children
Name of the Ministry / Department/Institution	Ministry of Social Justice and Empowerment
Objectives	Provision of shelter, nutrition, health care, sanitation and hygiene, safe drinking water, education and recreational facilities and **Protection against abuse and exploitation of destitute and neglected street children**
Target Group	Street children particularly those without homes and family ties especially vulnerable to abuse and exploitation such as children of sex workers and pavement dwellers (excluding those living with their parents).
Pattern of Assistance	Under the Scheme financial assistance would cover up to 90 percent of the cost (not exceeding Rs. 15 lakhs per annum) of the project (100 percent of the cost in case of Union Territory and Ministry itself if it takes up any activity) to take up, inter-alia following activities: - City level surveys on destitute and neglected children. - Establishment of 24 hrs drop-in-shelters for children with facilities for night stay, safe drinking water, bathing, latrines, recreation etc. - Non-formal education programmes imparting basic literacy. - Programmes providing facilities for training in meaningful vocations. - Programmes for occupational placement of destitute children. - Programmes aimed at mobilising preventive health services and providing access to treatment facilities. - Any other programme consistent with the Rights of the Child and/or covered under the JJ Act.
Implementing Agencies	State Governments and Union Territory Administrations/ Autonomous bodies set -up by Government under a statute or as a society registered under the Societies Registration Act, 1860 or otherwise / Educational and other institutions of the like local bodies and cooperative societies/ Registered Non-Government organizations.
Eligibility Conditions	Having relevant aims and objectives laid down, not being run for profit of an individual or a group of individuals, registered for a period of two years and having a duly constituted managing body.
Procedure for applying	Application in prescribed format, recommended by the State Government, should be sent to: Deputy Secretary/Director (CW) Ministry of Social Justice and Empowerment 'A' Wing, Shastri Bhavan, New Delhi- 110001 Tele: 23381843 Fax: 23384918

Name of the programme/scheme	Programme Of Assistance For Innovations In Child Development And Welfare - National Children's Fund
Name of the Ministry / Department/Institution	National Institute of Public Cooperation & Child Development,Department of Women & Child Development, Ministry of Human Resource Development.
Objectives	Welfare of children, including rehabilitation of destitute children, particularly pre-school age children.
Target Group	Children, especially those belonging to Scheduled Castes/Scheduled Tribes and other backward classes.
Pattern of Assistance	Financial assistance to the voluntary organisations is a one time grant limited to 90% of the approved estimated cost of the programme/project and not exceeding Rs. 1,00,000/-.Some of the activities assisted under NCF are (i) vocational training intailoring, sewing, printing & composing, motor mechanics, TV & radio repairing, handicrafts & leather goods making and motor winding; (ii) Health care and recreational facilities, (iii) Study/Coaching Centre after school hours; (iv) Non-formal education; (v) Library facilities; (vi) Purchase of vehicles/genset, Production of films, Construction of low cost buildings, etc.
Implementing Agencies	National Children's Fund (NCF) through 5 voluntary organisations registered under an appropriate Act.
Eligibility Conditions	Registered for at least two years or a regularly constituted branch of a registered welfare organisation. It should have the requisite financial, physical and personnel resources,managerial skills and experience to initiate innovative and experimentalchild welfare/development activities.The financial position of the organisation should be sound so as to beable to raise additional funds to continue the aided activities after the grant is fully utilised for a period of five years.
Procedure for applying	Application in the prescribed proforma in duplicate accompanied by necessary documents, should be sent to: The Secretary-Treasurer National Children's Fund C/o: National Institute of Public Cooperation & Child Development, 5, Siri Institutional Area, Hauz Khas, New Delhi-110 016 Tel: 26963002, 26963204 Fax: 26851349, 26515579

Name of the programme/scheme	**Scheme For Assistance To Voluntary Agencies For Non Formal Education For Elementary Age Group Children Under The Programme For Universalisation Of Elementary Education**
Name of the Ministry / Department/Institution	Department of Education, Ministry of Human Resource Development.
Objectives	To develop the programme of non-formal education for meeting The educational needs of out of school children.
Target Group	Children in the age group of 6-14 years who are unable to attend formal schools.
Pattern of Assistance	Assistance will be given as grants on a cent percent basis for NFE both at the primary and middle stages. Some specific activities for grants are as under: • Running of non-formal education centres in the field. • Non-formalisation of the formal education system. • Resource development, including development of curricula, teaching/learning material, production of instructional materials, development of evaluation techniques etc.
Implementing Agencies	Registered Non-Government Organisations and Public Trusts; Companies registered under Section 25 of the Companies Act, 1956; Non registered agencies/social activists/groups with a bonafide certificate from Collector / Deputy Commissioner; autonomous bodies set up by Central/State Governments for abolition of child labour working in the educationally backward states.
Eligibility Conditions	The organisation should be in existence for 3 years, have a properly constituted managing body, be in a position to secure the involvement, on voluntary basis, of knowledgeable persons for furtherance of programmes and should not discriminate against any person on the ground of sex, religion, creed, caste etc.
Procedure for applying	The proposal, in prescribed format, through the State Department of Education should be sent to: Director (NFE) Department of Education, Ministry of Human Resource Development, Shastri Bhavan, New Delhi –110001 Tele: 23386278, 23381355, 23382947

Name of the programme/scheme	Scheme For Assistance For Experimental And Innovative Programmes For Education At The Elementary Stage Including Non-formal Education
Name of the Ministry / Department/Institution	Department of Education, Ministry of Human Resource Development.
Objectives	To disseminate the findings in respect of methods, processes and outcomes in respect of various programmes of experimentation and/or innovation and to provide financial and administrative support to the selected agencies for activities undertaken by them.
Target Group	All children in the country, particularly children of habitation without schools, working children and girls who cannot attend whole day schools.
Pattern of Assistance	Assistance on cent percent basis will be given for well-designed field projects, development of learning materials, instructional/learning aids and other aspects of technical resource development, training, creation of infrastructure for taking up experimentation/innovative programmes, conducting seminars to promote innovation and other activities for dissemination of the outcome of experimentation/innovative programmes.
Implementing Agencies	Registered Non-Government Organisations and Public Trusts; Companies registered under Section 25 of the Companies Act, 1956; government agencies; educational institutions; and panchayati raj institutions
Eligibility Conditions	The organisation should be in existence for 3 years, have a properly constituted managing body, be in a position to secure the involvement, on voluntary basis, of knowledgeable persons for furtherance of programmes and should not discriminate against any person on the ground of sex, religion, creed, caste etc.
Procedure for applying	The proposal, in prescribed format, through the State Department of Education should be sent to: Director (NFE) Department of Education, Ministry of Human Resource Development, Shastri Bhavan, New Delhi –110001 Tele: 23386278, 23381355, 23382947

Name of the programme/scheme	**Assistance To Voluntary Agencies In Adult Education Under National Literacy Mission (NLM)**
Name of the Ministry / Department/Institution	Department of Education, Ministry of Human Resource Development
Objectives	• To involve voluntary agencies towards total eradication of illiteracy. • To educate children between 9 to 14 years for whom no non formal education facilities exist. • To ensure maximum participation of women and persons from backward and weaker sections and making them aware of their legal and social rights through literacy.
Target Group	Persons in the **age group of 15-35 years and children between9-14 years for whom no non-formal education facilities exist.**
Pattern of Assistance	Assistance on cent percent basis for running the literacy programmes as well as administrative costs in accordance with norms of the scheme.
Implementing Agencies	Registered Non-Government Organisations and Public Trusts; Companies registered under Section 25 of the Companies Act, 1956; Non registered agencies/social activists/groups with a bona fide certificate from Collector/Deputy Commissioner.
Eligibility Conditions	The organisation should be in existence for 3 years, have a properly constituted managing body, be in a position to secure the involvement, on voluntary basis, of knowledgeable persons for furtherance of programmes and should not discriminate against any person on the ground of sex, religion, creed, caste etc. Not have been set up by State Government/UT Administration including State Social Welfare Advisory Boards, Municipalities, Panchayati Raj Institutions, Government Corporations/ Committees.
Procedure for applying	The proposal, in prescribed format, through the State Department of Education should be sent to: Under Secretary (Voluntary Agencies) Department of Education, Ministry of Human Resource Development, Shastri Bhavan, New Delhi –110001 Tele: 23383213

Further reading

1. Are Colombian Street Children Neglected? The Contributions of Ethnographic and Ethnohistorical Approaches to the Study of Children. (1991)

2. 'Non Tobacco Substance Use, Sexual Abuse, HIV and Sexually Transmitted Infection Among Street Children in Kolkata' conducted by National Institute of Cholera and enteric Diseases (2010), Media Voice, December 2010.

3. 'Police Abuse and Killings of Street Children in India', Human Rights Watch/Asia, 1996, p.2.

4. A World View of Street Children in the Year 2000, (2000) available at http://www.sjsu.edu/facility/aptekar/download/streetchildrenfinland.pdf accessed on 15th January 2011.

5. Adolescent Drug Abuse: Analyses of Treatment Research-NIDA Research Monograph 77 1988- www.archives.drugabuse.gov/pdf/monographs/77.pdf.

6. Aptekar.L, (1989) Colombian Street Children: Gamines and Chupagruesos.

7. ASK (2005) Situational Analysis of the Children on the Railway Stations in Delhi, Haryana: ASK.

8. Bangladesh Shishu Adhikar Forum (2000) State of child Rights in Bangladesh, Dhaka: Bangladesh Shishu Adhikar Forum.

9. Benegal V, Bhushan K, Seshadri S, Karott M, Drug Abuse Among Street Children in Bangalore: A project in collaboration between the National Institute of Mental Health and Neurosciences, Bangalore and the Bangalore Forum for Street and Working Children, 1998.

10. Benegal, Vivek, Shekar P. Sheshadri, Prabhat K. Chand, Lakshamana. G and Subodh, B.N, (2008-09) Inhalant Use among Street Children in Bangalore, NIMHANS Bangalore: WHO.

11. Childhood Enhancement Through Training and Action (CHETNA), Use or Abuse? A study on the substance abuse among street and working children in Delhi, CHETNA, 2008, New Delhi.

12. D'Lima, and Gosalia Rima (1992) Street children of Bombay, New Delhi: National Labour Institute

.

13. Gaidhane A M, Quazi S Z, Waghmare L, Shanbhag S, Zodpey S, Joharapurkar SR, Substance abuse among street children in Mumbai, Vulnerable Children and Youth Studies, 3(1), 42 – 51, 2008.

14. Galanter M and Kleber HD, eds. The American Psychiatric Publishing Textbook of Substance Abuse Treatment. 4th ed. American Psychiatric Publishing Inc. Washington, DC, 2008.

15. GOI (2007) Study on Child Abuse: India 2007, New Delhi: Kriti. http://www.childlineindia.org.in/cr-drug-abuse.htm accessed on 10th February 2011.

16. Mac Fadyen, Lori (2005) Voices from the Street: An Ethnography of India's Street Children. A Case Study of Delhi, New Delhi: Hope India.

17. N.B, Patel and Bansal RK (2010) 'STI Profile and Treatment Seeking Behaviour of street Children in Surat', National Journal of Community Medicine 2010, Vol-1, Issue- 1.

18. National Drug Dependence Treatment Centre. Inhalant Use among street children in Delhi - A Situation Assessment, Report submitted to WHO (India) and Ministry of Health and Family Welfare, Govt of India, 2009.

19. Pagare D, Meena GS, Singh MM, Saha R, Risk Factors of Substance Use Among Street Children from Delhi, Indian Pediatrics, 41, 2004

20. Panicker Rita and Desai Kalpana (1993) Street Girls of Delhi, New Delhi: National Labour Institute.

21. Panicker, Rita and Parveen Nangia (1992) Working and Street Children of Delhi, New Delhi: National Labour Institute.

22. Phillips, W.S.K (1994) Street Children in India, New Delhi: Rawat Publications.

23. Poonam Sodhi Garg (2004) Street Children: Lives of Valour and Vulnerability, New Delhi: Reference Press.

24. Rashmi Agarwal (1999) Street Children, New Delhi: Shipra Publications.

25. Save the Children (2011) Surviving the Streets, New Delhi: Save the Children.

26. Street Children in the Developing World: A Review of Their Condition, available at http://wwwsjsu.edu/faculty/aptekar/download/crossculturalresearch.pdf. (1994)

27. Tiwari, Poornima, 'Life on Streets', Indian Journal of Paediatrics, Vol-74, March 2007.

28. UNICEF, Consortium for Street Children. available at http://www.streetchildren.org.uk/_uploads/resources/Street_Children_Stats_FINAL.pdf last visited on January 5, 2011.

29. Veale, Angela (1992) Towards a conceptualization of street children, Dublin: Trocaire Development Review.

30. Weinberg NZ, Rahdert E, Colliver JD, Glantz MD (1998) Adolescent Substance Abuse: A Review of the Past 10 Years. J. Am. Acad. Child Adolesc. Psychiatry, 37, 3:252 – 260.

31. Weinberg NZ, Rahdert E, Colliver JD, Glantz MD (1998) Adolescent Substance Abuse: A Review of the Past 10 Years. J. Am. Acad. Child Adolesc. Psychiatry, 37, 3:252 – 260.

32. Working With Street Children: A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs. (2000) Published by WHO.

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