Co-funded by
the European Union

A manual on drug prevention and promotion of
youth health and wellbeing in the context of youth work

Youth Drug Prevention

What's inside

About this manual 1
The project 1
The manual 2
The consortium 2
Manual glossary 3
CHAPTER-1. Drugs and young people's well-being 4
1.1. Difference between drug use and drug abuse 5
1.2. Drug abuse and youth well-being 6
1.3. Drug characteristics and classification 7
1.4. Drug addiction and substance abuse disorder 9
1.5. Drug addiction recovery and rehabilitation 10
CHAPTER-2. Social research on drug abuse among youth 12
2.1. Context and objective 13
2.2. Methodology and limitations 14
2.3. Research insights and results 14
2.4. Participants' perspective analysis 19
2.5. Discussion and conclusion 20
CHAPTER-3. Drug consumption among young people 22
3.1. Socially accepted drugs, illegal drugs 23
3.2. Alcohol, tobacco, drug abuse in youth 24
3.3. Effects of alcohol, tobacco, and drug abuse 25
3.4. Alcohol addiction: a substance use disorder 27
3.5. Youth against drug and substance use 27
CHAPTER-4. Drug prevention through youth work 29
4.1. Youth-based organisations in drug prevention 30
4.2. Drug prevention interventions in youth work 31
4.3. Impact pathway to drug prevention 33
4.4. Community and media-based interventions 34
4.5. Youth engagement and participation 36
CHAPTER-5. Design and delivering of youth drug prevention training 38
Manual references 45

About this manual

Youth Health Literacy
Project Reference: 2021-2-MT01-KA220-YOU-000049937

Co-funded by the European Union

This manual has been co-funded with support from the European Commission. Its content reflects the views only of the author and the Commission cannot be held responsible for any use which may be made of the information contained herein.

The project

For a healthier Europe, promoting good health is an integral part of Europe 2020, the EU 10-year economic-growth strategy. Health policy is important to Europe 2020 objectives for smart and inclusive growth because keeping the people informed, healthy, and active has a positive impact on the future of the EU. There is growing evidence that health and literacy are closely linked, and therefore, influence other parameters of life such as poverty, inequality, discrimination, power relations, and income levels. Hence, health literacy is a strategy which contributes to the improvement of community's health, participation, and wellbeing where health is the basic human right that guarantees people autonomy and responsibility for their own health, and wellbeing. But despite its immense benefits, health literacy remains a challenge for the European public health. Research findings show that more than a third of the EU population face difficulties in finding, understanding, evaluating, and using information to manage their health, especially sexual and mental health. Whereas according to the World Health Organisation, health education interventions have formative character, since they manage to integrate both cognitive and attitudinal processes that allow behaviour modification, and become a conscious, rational, and voluntary action.

Thus, in this project, we sought to create a partnership aiming to strengthen partners' capacity to develop a youth work that can meet the health literacy needs of our targeted groups through inclusion and diversity; by using the approaches that offer potential for reaching out to and engaging targeted groups. From previous projects, efforts were falling short on these aspects, and thus, failing in meeting the needs of our targeted groups in the longer term perspective. Though each project focused a lot on needs assessments among the targeted groups, there was no room for impact measurement to see whether social change was happening. To meet those needs, the consortium and the targeted groups benefited from applying the Impact Pathway, Participatory Action Research, and Rights-Based Approaches in project's implementation. Project partners met their needs by strengthening their own capacities through research, experiential learning, and by sharing good practices on how programming a Youth Health Literacy Intervention must be rights-based; youth and their rights to health must be at the centre of such an intervention. Whereas the project targeted groups participated in community-based interventions to transform their health literacy problems into the human right language that abides to the EU's youth health policies.

The manual

Youthhood is recognised as a period for onset of behaviours, conditions that not only affect youth health outcomes limited to this period, but also lead to adulthood health outcomes. Unhealthy behaviours such as smoking, drinking, or illicit drug use that often begin in youth hood are closely related to increased morbidity and mortality in young people and represent major public health challenges. Poor academic performance, increased youth unemployment, poor health and well-being, accidents, suicide, mental illness, and decreased life expectancy; they all have drug misuse or abuse as a common contributing factor that have a major impact on the youth, families, communities, as their effects are cumulative, contributing to costly social, physical, mental health problems.

Hence, this manual conducted consultations with youth on the role and contribution of youth work to planning, designing, and implementing effective and friendly youth-centred interventions to prevent drug abuse among the young people. The manual starts by addressing youth drug prevention information and continues presenting findings from youth consultations on drug prevention such as: smoking, tobacco use, alcohol use, drug use, and combined substance abuse. The manual further looks into how family, school, and community-based prevention interventions are the most effective in reducing various drug use among the youth. Moreover, the manual presents media-based prevention interventions, such as campaigns being also effective because of their fidelity, scalability, and sustainability. Among the interventions for alcohol use, the manual sees school-based alcohol prevention interventions as being associated with reduced frequency of drinking among youth. For drug abuse, the manual claims that a combination of school, community, and media-based interventions based on a combination of social competence and social influence approached through youth work in the context of non-formal education, show more protective effects against drug abuse. And thus, a combination of school, community, and media-based drug prevention interventions that focus on the social competence and social influence is an effective approach in addressing substance abuse.

The consortium

Author: National College "Ienăchiță Văcărescu"

One of the top of Dambovita county's learning establishments. Under the attentive guidance of exceptionally professional teachers , the students develop their skills and creativity, as well.

Contributor: TERRAM PACIS

Established in 2010, a human rights, non-profit organisation in special consultative status with The United Nations Economic and Social Council. Through education and training we facilitate youth build a universal culture of human rights.

Contributor: Comitato d'Intesa

Created in 1977, gathers associations operating in different sectors such as: youth policy, interculturality, sustainable development, social solidarity, assistance of persons with special needs and support a healthy way of life.

Contributor: Ministry for Gozo

An important public body that caters for Gozo, especially Gozitan Youths, and has connections all over Europe. It is a hub for innovative European Youth Education. Learners who are associated with this setup are youth in Malta and Gozo.

Contributor: Universidade Atlântica

Created in 1996 as a public interest institution that focuses on the creation, transmission, and diffusion of knowledge, sciences, and technology through the articulation of studies, teaching, research, and experimental development.

Manual glossary

- ***Health literacy:***
  Refers to the personal skills and social resources needed by an individual to access, understand, apply, and use information and services to make health decisions, as well as the ability, capacity to communicate, affirm, and implement those decisions.

- ***Youth health literacy***
  Refers to the degree to which youth have the capacity to obtain, process, understand, and apply the most basic health information which is needed to make appropriate health decisions.

- ***A health literate youth:***
  Refers to the young person who has the ability and capacity of placing their own health and well-being and that of their family and community into context, understanding which factors are influencing them, and knowing how to address them.

- ***Youth wellbeing:***
  Refers to how youth are doing and how they feel about their lives. A low wellbeing has been linked to poor mental health outcomes, which can lead to various mental health conditions such as depression and anxiety.

- ***Drug use:***
  Is often referred to as a single episode of use of a substance both for medicinal and/or recreational purposes.

- ***Drug abuse:***
  Referred to as a problematic use of alcohol or drugs which differs from individual to individual as an abuser often overlooks the consequences of drugs due to compulsion or extreme desire to continue using.

- ***Drug addiction:***
  Is defined as a chronic, relapsing disorder characterised by compulsive drug seeking and use despite adverse consequences.

- ***Youth drug prevention:***
  Seeks to prevent or delay the start of drug use; deter drug misuse or abuse; and prevent or reduce drugs' effects on youth health and well-being.

- ***Drug prevention intervention:***
  Seeks to enhance protective factors and reduce risk factors; strengthen skills to resist drugs, problem-solving skills, and social competencies; and target youth and give special attention towards identifying the youth who are most at risk.

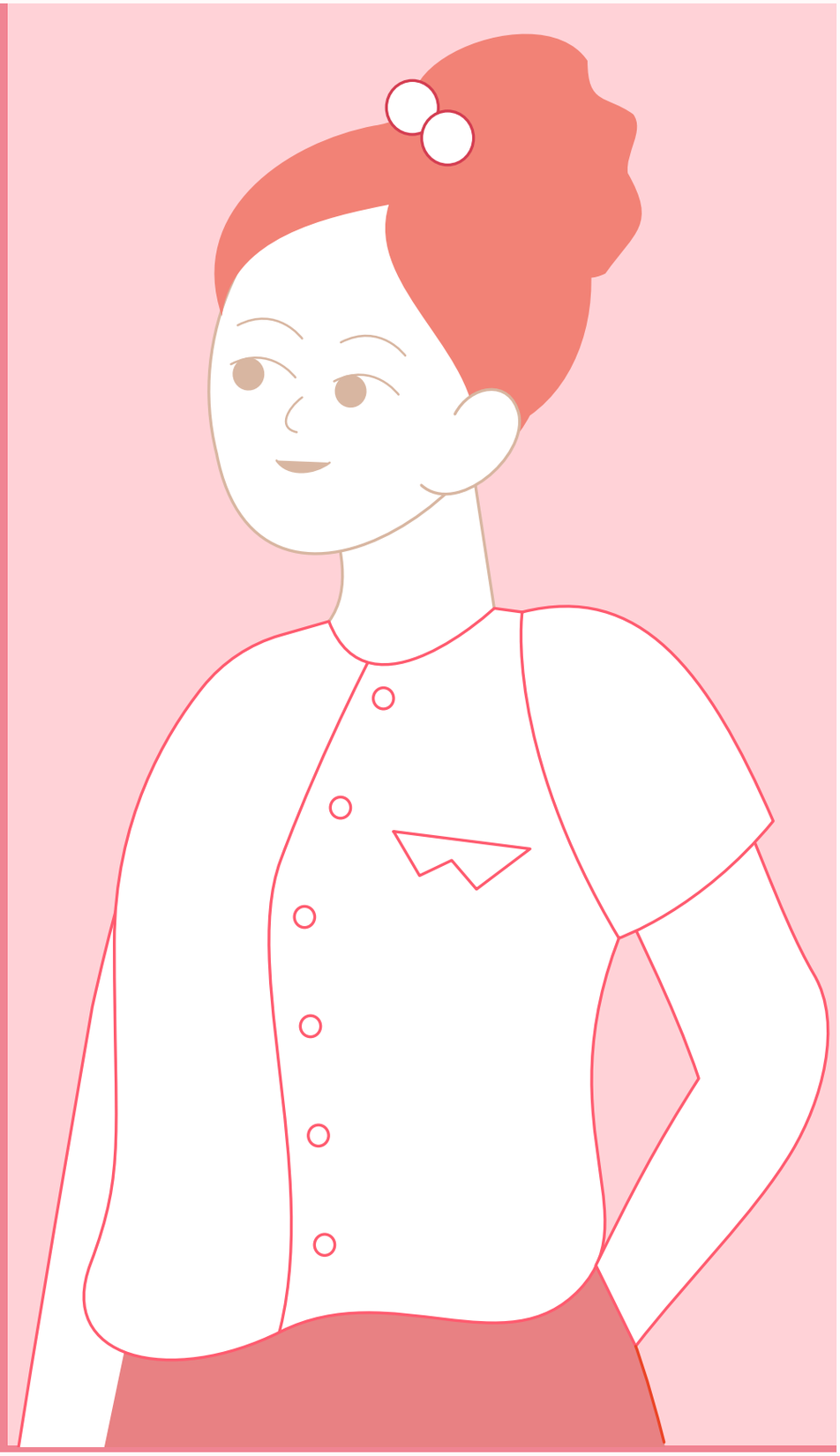
- ***Drug prevention in youth work:***
  Seeks to develop media, school, and community-based drug prevention programmes aimed at strengthening youth-centred activism; improving youth's behaviours, attitudes, and narratives toward drug abuse prevention; and raising awareness on protective factors as well as how to reverse or reduce risk factors among youth.

- ***Youth drug prevention:***
  Refers to organised efforts to transfer youth health knowledge and develop youth health skills, attitudes, and the competences, which encourage positive youth health behaviours that contribute to high level of health literacy among youth.

- ***Drug prevention intervention's audience:***
  Universal interventions are designed for the general population, such as all students in a school; Selective interventions target groups at risk or subsets of the general population, such as poor school achievers or children of drug abusers; and Indicated programmes are designed for people already experimenting with drugs..

CHAPTER-1

Drugs and young people's well-being



1.1. Difference between drug use and drug abuse

It can be difficult to tell the difference between drug use and drug abuse. Drug use and drug abuse terms are often used interchangeably, although abuse and use carry different meanings. As youth workers involved in the field of youth drug prevention, it is therefore helpful to be aware of such differences as this can help with improving the young people's knowledge about how and when the use of a substance can become problematic and what a person can do. And indeed, understanding the problematic use of a substance has been a significant area of focus in the field of psychology and rehabilitation. Much of the research around problematic use of alcohol and other drugs examine the levels of impact the substance may have on an individual's life. Hence, to understand how drug use can transition to drug abuse, it is relevant to examine the patterns and consequences of the use of drugs. It is also important to understand the substance use of choice, as each substance carries its own distinct characteristic and traits that can affect users differently. Research shows a strong connection between the number of negative consequences and severity of drug use abuse. So, for drug use prevention efforts to contribute to protective factors against drug abuse it is important to define drug use and drug abuse as distinct terms.

- Drug use is often referred to as a single episode of use of a substance both for medicinal and/or recreational purposes. Though substance of choice varies from person to person, some of the most commonly used drugs include alcohol, tobacco, marijuana, caffeine, ibuprofen, etc. while the use of alcohol, tobacco, and other various drugs carry a sense of normalcy within society. For example, alcohol is often used frequently during celebrations, various rites of passages, and even during family dinners. Prescription drug use, similarly, can be effective for the treatment of ailments, especially when used as prescribed by a doctor. The question is: when does drug use transition into something more serious like drug abuse or addiction?
- Drug abuse is often referred to as the problematic use of alcohol or drugs. It differs from individual to individual as an abuser often overlooks the consequences of drugs due to compulsion and/or extreme desire to continue using. So, the one distinguishing marker is often the frequency of use in combination with the level of desire and/or control. Drug use refers to the experimentation, low frequency, and/or irregular use of alcohol and drugs. On the other hand, drug abuse refers to regular or compulsive urges to use alcohol and drugs. Generally, drug abuse alters an individual's lifestyles and influences psychological dependency on a substance. Drug abuse is not strictly limited to illicit substances. It can also be prescribed medications and legal drugs like alcohol or marijuana. A problematic pattern of drug use carries the potential of leading to drug abuse and even more so to addiction.

So, even though identifying problematic behaviours can be difficult, it is very important to understand the reasons for using the drugs in the first place. Whereas drug use is often an innocent pass-time and have fun episode; by contrast, drug abuse has a strong behavioural and emotional component. It has more to do with the emotional and mental impact that an individual desires to experience when engaging in substance use behaviours. Because of the strong connection between substance use and emotions, it is hence imperative to explore the various reasons why a person may be using drugs. Common reasons a person may utilise a substance include:

- Recreational pastime
- Celebration or major event
- Relaxation or Boredom
- Social acceptance
- Rebellion or Enhance performance.

Many of these reasons do not necessary nor immediately raise red flags or suggest that a possible drug abuse is indeed occurring. Instead, some of these reasons simply highlight situations where a person may be more inclined to actively seek illegal and/or legal substances like alcohol, cocaine, marijuana, and more. Then, there are more serious implications that may suggest an underlying issue that may cause a person to find relief through substance use:

- Depression; Anxiety; or Trauma
- Life stressors at home or work
- Relationship turmoil
- Severe physical pain
- Self-medication
- Sleep problems, or Grief.

1.2. Drug abuse and youth well-being

Youthhood is recognised as a period for onset of behaviours and conditions that not only affect youth health outcomes limited to this period but also lead to adulthood health outcomes. Unhealthy behaviours such as smoking, drinking, or illicit drug use that often begin during youthhood are closely related to an increased morbidity and mortality among young people and represent major public health challenges. And poor academic performance, increased youth unemployment, a poor health and well-being, accidents, suicide, mental illness, and decreased life expectancy all have drug misuse as a common contributing factor that have a major impact on young people, families, and communities, since their effects are cumulative, and contribute to more costly social, physical, and mental health problems. Several factors enhance the risk for initiating and continuing substance abuse including socioeconomic status, quality of parenting, peer group influence, etc. which all have negative effects on youth health and well-being. Youth well-being is about how young people are doing and how they feel about their lives. Low well-being has been linked to poor mental health outcomes, which can lead to mental health conditions such as depression and/or anxiety. Hence, *poor youth well-being* not only impact their relationships with their family and friends, but also how they feel about and interact with the world around them. So, *high youth well-being* integrates mental health *(the mind)* and physical health *(the body)* which result in more holistic approaches to disease prevention and health promotion.

Drug abuse, is a regular and compulsive urge to abuse tobacco, marijuana, alcohol, and/or drugs that is linked to poor well-being among youth, and which not only impact their relationships with their family and friends but also how they feel about and interact with the world around them. That is, youth who persistently abuse substances experience an array of problems, such as academic difficulties, and health-related problems including mental health, poor peer relationships, involvement in violence and development of risk and aggressive behaviours. Additionally, these have consequences for family members, the community, and the entire society.

- Academics: Declining grades, school absenteeism, and other school or out of school activities, and increased potential for school drop out are problems associated with adolescent substance abuse. Cognitive and behavioural problems experienced by youth who abuse alcohol and drug may interfere with their academic performance.
- Physical health: Injuries due to accidents such as car accidents, physical disabilities and diseases, and the effects of possible overdoses are among common health-related consequences of adolescent substance abuse. Disproportionate numbers of youth involved with alcohol and other drugs abuse face an increased risk of death through suicide, homicide, accident, and illness.
- Mental health: Mental health problems such as depression, apathy, developmental lags, withdrawal, and other psychosocial dysfunctions are frequently linked to substance abuse among adolescents. Substance-abusing youth are at higher risk for mental health problems than no-abusers, including depression, conduct problems, personality disorders, suicidal thoughts, attempted suicide, or suicide.
- Peer problems: Substance-abusing youth often are alienated from and stigmatised by their peers. Youth who abuse alcohol and other drugs also often disengage from school and community activities, depriving themselves, their peers, and communities of the positive contributions they might otherwise have made.
- Family problems: In addition to personal adversities, the abuse of alcohol and other drugs by youth may result in family crises and jeopardise many aspects of family life, sometimes resulting in family dysfunction. Both siblings and parents are profoundly affected by alcohol and drug abuser youth. Substance abuse can drain a family's financial and emotional resources.
- Social and economic consequences: The social and economic costs related to youth substance abuse are high. They result from the financial losses and distress suffered by alcohol and drug related crime victims, increased burdens for the support of adolescents and young adults who are not able to become self-supporting, and greater demands for medical and other treatment services for these youth.
- Youth delinquency: There is an undeniable link between substance abuse and delinquency. Involvement in criminal activities; arrest; adjudication; involvement in violence; development of risk and aggressive behaviours; school and family problems, involvement with negative peer groups, lack of neighbourhood social controls, and physical or sexual abuse are eventual consequences for the many youths engaged in alcohol and other drug abuse.

Most often, the youth who start using drugs have very little information about drugs: indeed, they cannot tell the difference between the physical and the psychological effects of the drugs they might be using. They know nothing about what physical and psychological addiction means. They do not have the knowledge or the skills to take into account the consequences for their social life (friends, family, school). Indeed, many youths start with a positive outlook on drugs, occasional drug use, the problem is then setting the limit since the line between drug use, drug abuse, addiction is very thin and uncertain. And once the realm of drug abuse has been reached, it paves the way for addiction, and the way back is difficult. This is because, drug use among youth often takes the form of an experience: the curiosity, the desire to try something new, to boost intellectual performance in order to satisfy the hunger and urges to discover and know the surrounding reality in all its exciting instances and its deep meanings, regardless of the consequences. In most cases, young people start using drugs with this false hope that the substances will be able to fill the void left by their own unfulfilled social life. And most youth who reach the realm of drug abuse often have a lower self-esteem; undefined personality; family problems; or negative peer groups, which leave them without any safe support networks to know when to set the limit in from using to abusing alcohol and drugs. What is certain, is that the main category of the population vulnerable to drug use is without doubt young people, adolescence being the age when the need for identification is elevated, since it is the age of personal experiences and discovery of the dimensions of reality.

Motivations for drug use among youth can be:

- Stress: the most common cause of drug use. When youth end up going through situations in which they do not know how to react, when the demands related to school, family, or friends are too difficult to fulfil, they can resort to such repression methods, which will disconnect them for a moment, from the very tense reality. Traumas such as parents' divorce, loss, etc., are examples of stressors, and thus, factors that lead youth to turn to drugs, being under the impression that they can forget all the shortcomings from their life.
- Social isolation: a major risk for adolescents to become addicted to drugs. Isolation changes the neural substrate of reward and motivation, making socially isolated youth more sensitive to receiving a reward in the form of drugs. Indeed, socialisation and drugs have the same trajectory inside the brain. Thus, drug use is an attempt to obtain the neurobiological sensation of social connection.
- Lack of self-confidence: Many shy young people declare that under the influence of drugs they can do various things that they would not normally do such as expressing emotions, feeling free, dancing, etc.
- Boredom: being simply bored and not having deep interests, young people see drugs and alcohol as fun, as something to explore, as a desire for the thrill.
- Desire for integration: some youth feel unable to communicate or are shy and face difficulties in making friends. They feel that drugs and alcohol help them feel more valued, and that this can help them integrate more easily into a social group even if the members are known for using substances.

1.3. Drug characteristics and classification

Drug can be a natural or a synthetic substance which by its chemical nature determines the alteration of the functioning of an organ and changes the mental state of a person. The term drug refers to psychoactive substances, especially illegal ones, but also socially accepted ones *(alcohol, tobacco, caffeine)*. Scientifically, drug is referred to as any substance that has the ability to determine a state of physical or mental dependence *(addiction)* and/or *tolerance*. **Addiction** is the strong compulsion felt by the drug users to continue taking the drugs. There are two types of addiction:

- Physical addiction: it is not found in all drugs but occurs in substances with a depressing effect on the central nervous system. For example: opium derivatives such as heroin or morphine, tranquillisers, alcohol. The state of physical withdrawal that occurs among addicts who stop taking drugs in a smaller quantity manifests itself in the form of pathological conditions: tremors of the limbs or even of the whole body, joints and bone pain, nasal discharge, frequently encountered signs of a flu-like state, but much more accentuated.
- Psychic addiction: it is the most important and it is found in all drugs, consisting of a change in behaviour and in a particular mental state, accompanied by the imperative psychological need for periodic or continuous administration of the drug to obtain a state of well-being or to overcome a psychological discomfort.

Tolerance consists in a gradual disappearance of the effects of a drug that is administered repeatedly, over a certain period of time. Thus, in order to obtain the same effect, then a progressive increase in the dose is required *(the dose that for a normal person could be fatal)*. **Withdrawal** refers to the physical and the mental effects that a person experiences when they reduce or completely quit the use of a substance that has created an addiction. If the use of that substance is suddenly stopped, the body is unbalanced, and hence, withdrawal occurs. Its symptoms can vary in intensity and severity, depending on the substance that caused the addiction. Drugs are classified according to several characteristics *(depending on the effect they have on the consumer, their natural or synthetic origin; from the point of view of the legal regime, etc.)*. The classification of the most common used drugs in the medical and prevention field *(the most appropriate classification according to the WHO)* is made according to their *effects on the central nervous system* (CNS) of the consumer. Drugs can also be grouped by how or where they are commonly used.

Table 1. Characteristics and classification of drugs

EFFECTS ON THE CENTRAL NERVOUS SYSTEM	
Drug	**Effects**
Depressants	Slow down the function of the central nervous system: alcohol, benzodiazepines (minor tranquillisers such as Valium), GHB (gamma-hydroxybutyrate), ketamine, opioids (heroin, morphine, codeine) or heroin are among the best known. Slow down the messages between the brain and the body; they do not necessarily make a person feel depressed. The slower messages affect the person's concentration and coordination and their ability to respond to what is happening around them. Small doses of depressants can make a person feel relaxed, calm, and less inhibited. Larger doses can cause sleepiness, vomiting and nausea, unconsciousness and even death.
Hallucinogens	Affect senses and change the way a person sees, hears, tastes, smells, or feels things: cannabis, LDS, hallucinogenic mushrooms, PNC (Phencyclidine), "ethnobotanicals" of the synthetic cannabinoids type. Change sense of reality, a person can have hallucinations. Senses are distorted and the way the person sees, hears, tastes, smells, or feels things is different. For example, a person may see or hear things that are not really there, or a person may have unusual thoughts or feelings. Small doses can cause a feeling of floating, numbness, confusion, disorientation, or dizziness. Larger doses may cause hallucinations, memory loss, distress, anxiety, increased heart rate, paranoia, panic, and aggression.
Stimulants	Speed up the function of the central nervous system: caffeine, nicotine, amphetamines, cocaine, methamphetamines, Ecstasy (MDMA), but also amphetamine-like ethnobotanicals. Speed up the messages between the brain and the body. This can cause a person's heart to beat faster, their blood pressure and body temperature to go up, leading to heat exhaustion or even heat stroke, reduced appetite, agitation, sleeplessness. A person can feel more awake, alert, confident or energetic. Larger doses can cause anxiety, panic, seizures, stomach cramps and paranoia.

HOW OR WHERE THEY ARE COMMONLY USED	
Drug	**Effects**
Analgesics or painkillers	Relieve the symptoms of pain.
Inhalants	Are substances that a person breathes in through the nose (sniffing) or mouth. There are 4 main types of inhalants: volatile solvents, aerosol sprays, gases, nitrites.

Opioid	Are a type of painkiller that can be made from poppy plants (heroin) or produced synthetically (fentanyl).
Party drugs	Are a group of stimulants and hallucinogens used by young people in an attempt to enhance a party, festival, or concert experience.
Performance and image enhancing drugs	Are substances used by people to change their physical appearance or boost their sporting ability. There are 3 main types of performance and image enhancing drugs: anabolic steroids, peptides, hormones.
Medicines prescribed by a doctor	Also known as pharmaceuticals that are not being used appropriately can cause harm, both for the short and the long-term.
Psychoactive drugs	Affect the way you think, feel, and behave.
Synthetic drugs	Are a range of drugs that have been developed to create similar effects to banned drugs.

1.4. Drug addiction and substance abuse disorder

The journey: **drug use -> drug abuse -> addiction -> substance use disorder -> health problems**. Drug abuse occurs when a person takes legal drugs or socially accepted drugs in the ways that are not beneficial. It is the intermediate stage between drug use and drug addiction. A person may abuse drugs to feel good, to relieve stress or to avoid reality. If in the case of substance abuse, the person changes their own healthy habits, and when the person develops a psychological or physical addiction to a substance they cannot stop anymore. Despite unwanted consequences of continued substance abuse, a drug addict feels an uncontrollable urge to obtain and use the drug, and thus, maintaining their destructive behaviour, even if the person wants to quit. Though an initial decision to use drugs is a voluntary decision for the most people, the changes that occur in the brain over time will ultimately determine the addicts' ability to resist the urges to use drugs and to limit their self-control. Quitting is not just a matter of willpower, nor is it simply a choice, as addiction involves physical and mental changes in the brain that make it difficult, if not impossible, to quit without external qualified help. And although the drug addicts are considered delinquents, they are sick people who have reached a state of irresponsibility for their actions. The Diagnostic Statistical Manual for Mental Disorders (DSM) is the publication for the classification of mental disorders that uses a common language and standard criteria and has been published by the American Psychiatric Association. Since its first publication in the 1950s, revisions have gradually added to the total number of mental disorders (psychiatric illness that affect people's thoughts, behaviour, and social ability) and eliminated those that were no longer considered to be mental disorders. It is the manual that is widely used together with the WHO - International Statistical Classification of Diseases and Related Health Problems (ICD).

The first edition of DSM in 1952 created a classification of mental disorders, which established a single category idiocy or insanity that was associated with: *alienation, dementia, derangement, insanity, lunacy, and mental illness*. In its 2013 5th edition (known as the DSM-5), diagnoses of substance abuse and substance dependence were merged into the category of substance use disorders and they are rated by severity as **mild, moderate, or severe**. Drug addiction is itself a disorder/a disease that can lead to other psychiatric disorders:

> **For example,** alcohol addiction produces delirium tremens, while cannabis use accelerates the onset of pre-existing psychiatric diseases to which the person is predisposed, or aggravates existing ones: psychosis, paranoia, schizophrenia, etc.). For the addicted person to be able to return to normal life, a complex combination of medical, psychological, and social measures is needed.
>
> Detoxification process can be the first step in achieving abstinence from depressant drugs, however, detoxification on its own is not sufficient. To have the greatest chance of success, detoxification must be carried out as a result of the drug addict own desire. That is, the motivation should be personal, even if the withdrawal period in which the person will be deprived of the drug they are addicted to, which overlap with this process, being thus a hard, a lasting, and a difficult process.

Classification of types of drug-induced disorders and their characteristics:

- Delirium: can occur due to both intoxication and substance withdrawal. It causes an alteration of consciousness and perception, as well as changes in cognitive functions (memory, orientation, language, etc.). These conditions usually occur over a short period of time (hours or days). Classically, delirium is caused by the consumption of alcohol, hallucinogens, amphetamines, cannabis, cocaine, inhalants, opiates, sedatives, hypnotics, or anxiolytics. Substance-induced dementia is manifested by a clear cognitive impairment, that is, the person's memory, language, their motor activity, the ability to perform various tasks, etc. are affected. They have difficulties in learning new information or in remembering what they have learned, they have failures in recognising objects or in planning or organising daily activities in various areas (social, school, family). The substances that induce it are alcohol, inhalants, sedatives, hypnotics, and anxiolytics.

- Psychotic disorders: may begin during intoxication or during withdrawal. When this disorder occurs, the person suffers from hallucinations or delusions, there will be installed a catatonic behaviour (the lack of response to external stimuli in a person who is awake) and a disorganised use of language. These conditions can lead to social and work impairment. Symptoms appear during or in the month following intoxication or withdrawal. Substances that induce this disorder are alcohol, hallucinogens, amphetamines, cannabis, cocaine, inhalants, opiates, sedatives, hypnotics, and anxiolytics.

- Mood disorders: are highlighted during intoxication or depressive and/or manic symptoms (an elevated, euphoric, or irritable mood) may occur. The symptoms cause significant clinical distress and considerable impairment in important areas of the person's functioning. Substances associated with mood disorders are alcohol, hallucinogens, amphetamines, cocaine, inhalants, opiates, sedatives, hypnotics, and anxiolytics.

- Anxiety disorders: the symptoms are those characteristic of the specific disorder (palpitations, tremors, fear, excessive worry, recurring thoughts, irritability, etc.).

1.5. Drug addiction recovery and rehabilitation

The equal right to health is one of the most essential rights that we enjoy throughout our lives. According to the World Health Organisation, the most fundamental human right is the right to health, more precisely, the access to medical information and healthcare services that have the role of maintaining the health and the well-being of all the people. But in many countries, awareness about mental, emotional, behavioural, and substance use disorders is very limited, especially in the low-middle-income countries (LMICs). And numerous publications and reports highlight that the people living with the mental, emotional, behavioural, and substance use disorders often face extensive human rights violations, stigma, and/or discrimination within the health system and in public discourse. The 2020 European report on drugs shows that the average mortality rate caused by overdoses within Europe is 22.3 deaths per million among people aged 15-64. On the other hand, bringing a person who has fallen into the mirage of drugs back to the normal world requires hard work because addiction is a health problem that is difficult to describe in its true intensity. If physiological addiction can be treated quickly, a mental addiction is difficult to overcome because the person who has consumed drugs for years is vulnerable, and thus, relapses are extremely easy. Hence, when the addicted person admits that they have a drug addiction problem; the first step towards recovery and rehabilitation is made. In general, however, addicted people deny having drug addiction problems and hesitate to seek treatment. In this situation, family, friends, co-workers, or others who care about the person struggling with addiction, by consultation with the health care provider, mental health professional, licensed alcohol and drug counsellor, must then intervene to motivate the addicted person to accept their reality and get help before things get worse or before it is too late to accept and start recovery treatment, which is not a quick fix but a long process that require patience and trust to achieve the desired effect.

Though the definition of recovery remains divided, and thus, subjective in drug rehabilitation, since there are no established standards for measuring recovery. The Betty Ford Institute defined recovery as achieving complete abstinence and personal well-being. Other studies consider drug addiction recovery as near abstinence to be a more suitable definition. So, an effective

treatment means an individualised intervention according to the needs identified in the case of each drug addiction situation in all the spheres of life: physical, psychological, vocational, relational, legal, spiritual. In many cases, several courses of treatment may be required for the patient to fully recover.

The two main categories of treatment are:

- **Behavioural treatment: Cognitive-Behavioural Therapy (CBT).** Which consists of changing unhealthy patterns of thinking and behaviour. The individual learns strategies to manage cravings, avoid cues and situations that lead to relapse. In some cases, it may include individual, family, or group counselling. Psychotherapy has proven its usefulness and effectiveness: Episodes of emotional breakdown, periods of craving; the compelling desire to experience the effects of the drug again, the search for it.

- **Drug treatment: Medication-Assisted Treatment (MAT).** Not valid for all drugs, but only for those that produce physical addiction, with a depressing effect on the central nervous system); for example, opioid addiction to medically prescribed drugs can be treated with buprenorphine, methadone, and naltrexone, which can prevent other opioids from affecting the brain or relieve withdrawal symptoms and help a patient avoid relapse. Naltrexone is also used as a maintenance treatment for alcohol addiction. For an abstinence in the long term, drug substitution should be accompanied by psychological counselling, occupational therapy, support groups, etc.

Therapeutic intervention must thus be global: targeting all components of a person's life, from the family, group of friends, to professional reinsertion. The problems are neither only mental nor physical, but they are also social since the patient's social environment is generally a pathogenic one. A successful model for recovery and rehabilitation of drug addicts is the TC (Teen Challenge) model.

> The Teen Challenge was founded in 1961 by David Wilkerson. The objective of the programme is to give young people the ability to live without resorting to drugs and to authentically grasp the following aspects: assuming responsibility, ability to make good decisions, genuine faith, altruism, seeing work as a value, healthy self-image, and possessing communication and conflict resolution skills. Just removing addiction from a person's life is not enough. Issues left unresolved can later affect the person, triggering relapse. In the programme, the view of an addict is that: *the addict is a normal, valuable person with a lot of potential and one who can get rid of addiction, if they really want to.* The view of addiction is that: *addiction is not a disease, but a learnt behaviour that can be changed.*

A rehabilitation programme is designed so that the young person is helped and empowered, starting with the simplest habits (eating habits, day/night rhythm, and personal hygiene), up to most complex problems (education, emotional stability, social reintegration, the spiritual life, the development of skills and abilities).

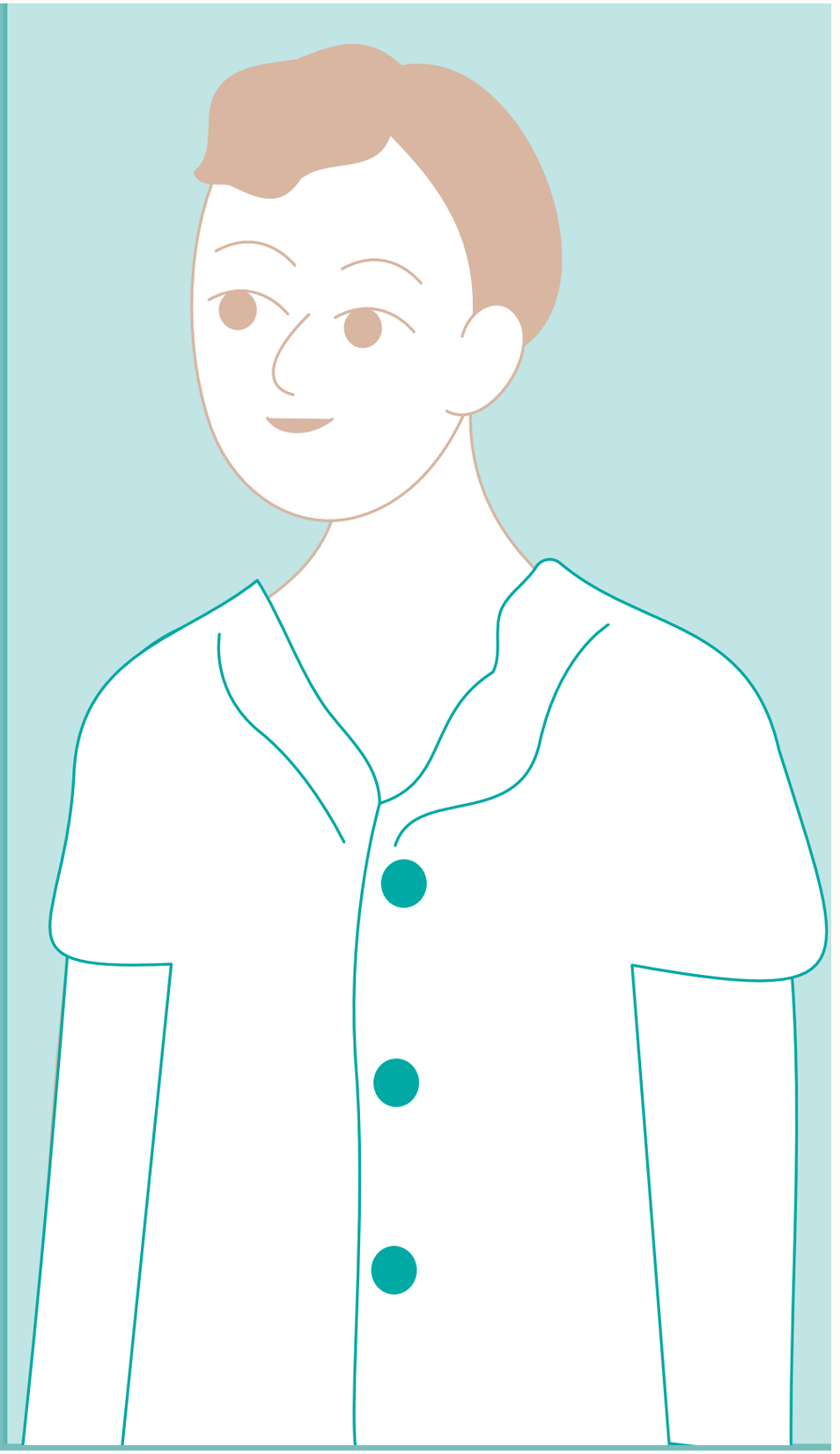
> The rehabilitation centres aim to create a family atmosphere, which conveys respect, acceptance, and love, doubled by a professional approach that facilitates the growth of self-esteem and the feeling of self-sufficiency and helps young people in the process recovery and accountability.

The key to the proven success of the residential rehabilitation programmes is above all the spiritual aspect based on faith. The objective is not for the young person to change their religion, but to acquire a living faith, and the spiritual transformation to determine a process of personal change in values, motivation, and character traits so that the person becomes healthy from a social and emotional point of view, well from a physical point of view and alive spiritually.

> Recovery for the addicted persons means to face themselves, to accept themselves as a worthy human being, without drugs or alcohol. Recovery involves profound changes in how one will look at the world around them and how they will be seen by the world around. They will have to take responsibility for their own feelings and behaviour. Therefore, the recovery process requires great courage on the part of the addicted person and great help from others, but it is not an impossible process.

CHAPTER - 2

Social research on drug abuse among youth



2.1. Context and objective

2.1.1. Research context

In the past few years, European surveys on drug abuse among adolescents and the youth have drawn attention to increased drug use among them, creating speculation about a possible return to the high levels of drug abuse among youth and adolescents that were witnessed in some countries in the 1970s. In its 2015 report, European Monitoring Centre for Drugs and Drug Addiction drew attention to increasing abuse of drugs, drug related risks and increase in number of new psychoactive substances on the drug market. So, with a simple analysis of the studies and research conducted in the last ten years, it is simple to notice that, despite increase and diversification of preventive interventions, and adding new psychoactive substances on the list of prohibited substances, the youth initiate drug use at younger ages as a result of the diversification of psychoactive substances and their combinations and the emergence of some electronic devices for smoking, vaping, etc. Therefore, this research aimed to explore and understand how teenagers perceive the phenomenon of drug abuse, how it affects them and their peers, and what are the risk and protective factors for drug use that youth workers can intervene on: what are the opportunities and challenges perceived by youth in preventing drug and promoting health.

So given the prevailing burden and impact of substance abuse in children and adolescents, it is essential that effective the drug prevention interventions and delivery platforms to enhance social and problem-solving skills, and self-confidence are identified and implemented. Efforts in preventing drug abuse and promoting health and well-being among youth should be concerted on early identification, awareness raising programmes through drug abuse prevention interventions at the family, school, community, and media levels, and routine monitoring and evaluation of these interventions. That is, the focus should be targeting modifiable risk factors and enhancing protective factors for drug abuse through family, school, media, community prevention programmes. Various types of drug prevention interventions can be delivered via school and community, and health care systems with the general goals of risk factor reduction. This research is thus a part of a series of consultation workshops conducted to evaluate the effectiveness of potential interventions to improve youth health and well-being. We developed a conceptual framework based on consultations with youth to identify a set of interventions to be incorporated in youth work.

And therefore, the conceptual framework depicts individual and general risk factors through the life cycle perspective that can have implications at any stage. However, the focus herein was to identifying potential interventions and the delivery platforms targeting youth and their impact on quality of life thereon. We focused on the risk factors including risky sexual behaviours, violence, risky driving (including speeding and drunk driving), and mental health risks. Then we identified a range of potential interventions that could alleviate these risk factors including mental health prevention or promotion interventions, substance abuse, and/or injury prevention interventions. Our conceptual framework shows that implementation of these interventions can yield more immediate and/or direct results, including improving access to mental health and/or substance use services, knowledge about drug use, and the delivery of suicide preventive services among youth. Broadly, the conceptual framework classifies outcomes to individual, community, and societal levels, and it illustrates that the immediate and direct impacts could yield improved health, better youth life, and improved work productivity; which could lead to benefits at the family and community levels.

2.1.2. Research objective

The overall research objective was to assess, identify, and analyse learning needs, and the existing knowledge gaps in terms of preventing drug abuse and promoting health and well-being among teenagers, youth, and youth workers to produce change, positive impact, and added value in drug abuse prevention. Moreover, the research wanted to highlight how the teenagers expect their drug abuse prevention interventions should be integrated in youth work practices, by:

1. Expressing the required knowledge, skills, and attitudes for the youth to be involved in drug abuse prevention.
2. Illustrating the community factors that prevent and/or facilitate youth participation and involved in drug abuse prevention.
3. Presenting youth frustrations in accessing current educational and training offerings on drug abuse prevention.
4. Outlining appropriate educational interventions that would meet their learning needs to effectively involve in drug abuse prevention.
5. Determining the types of education resources that can be developed to help youth workers integrate drug prevention in youth work.

2.2. Methodology and limitations

2.2.1. Research methodology

The participants who took part in open-ended consultation workshops that were organised consisted of 25 high school students having been selected from three years of study, the 9th, 10th and the 11th graders. The selection was based on criteria such as family location (urban area/rural area), family background (students coming from various types of families such as one parent family due to the death of the other or due to divorce), and students whose parent(s) work abroad and had to remained in the care of either the other parent or a distant relative. They were altogether informal leaders in the students' groups and their peer groups, so that they could convey correct information in relation to the addressed topics. Research was conducted using Open-Ended Consultations giving participants the opportunities to identify their real unsatisfied learning needs, the gaps they may have in the area of the prospective knowledge in drug abuse prevention, the teaching, learning resources, and materials, which they considered necessary to meet their learning needs and fill in their identified gaps, as well as the current facilities and obstacles encountered or the ones that they may encounter at the time of their involvement in drug prevention and promoting health and well-being.

An open-ended consultation is:

1. An interactive participation: it facilitates an inclusive discussion among participants to answer questions and solve problems together. It provides competitive workshop activities that allow participants to test their knowledge, skills, and attitudes in the current subject and be able to assess their unmet needs and unfilled gaps.
2. A participant-centred approach: it takes into consideration personal, professional, and lived experiences of the targeted groups to accomplish research goal and objectives, by respecting balance between active and experiential learning.
3. An engaging research process: it requires a clear understanding of key factors limiting a target group's participation and inclusiveness in a certain process aiming to address a particular problem that requires community's contribution to prevent and/or respond to the effects the problem is having on the target group.

2.2.2. Research limitations

This study is subject to several limitations for consideration. Though students who participated in the research easily identified a multitude of risk factors for the initiation and persistence of drug consumption among teenagers, correctly attributing a diagnosis to the present-day Romanian situation, they were unable to identify more than a few means of intervention on the context for their own involvement. Only one participant claimed to be involved in another actions of drug consumption prevention run by the Police. The rest of the participants had hardly any knowledge about other institutions or youth organisations or ones that are involved in the field of drug abuse prevention or that can provide youth with prevention activities and/or possibilities of getting involved in the process of decision making or changing of the problem context. Participants' limited experience in drug abuse prevention as beneficiaries of services of this kind, can be explained by their small number and the compact group they belong.

On the other hand, poor experience in the field of drug abuse prevention may give them a narrow view of the various ways in which drug prevention can be achieved or of the necessary resources and tools. Secondly, although the open-ended consultation workshops provided a safe space for the participants to feel free to express their thoughts, feelings, or practices regarding drug abuse prevention, health promotion and drug use-related experiences, therefore, it is possible that not all of them were able to accurately express such aspects for fear of being labelled or discriminated against. Some of them took the back seat of passive observers of the context and only express their views and discontentment or anxiety in the limited circle of peers, without determining a visible or noticeable impact or an echo in the direction of changing the context. Though participants appreciated their participation in the project as being exquisitely important, as it represented the opportunity for them to make and express their own opinions in safe learning environment to act towards making a change.

2.3. Research insights and results

The research data and inputs collected from participants during workshops are herein used to present the areas that require improvement in the field of drug prevention as a component of youth health promotion,and are presented in these categories:

1. Youth drug abuse prevention learning needs.
2. Youth drug abuse prevention's existing knowledge.
3. Youth drug abuse prevention knowledge gaps.
4. Youth drug abuse prevention and health promotion.

2.3.1. Youth drug abuse prevention learning needs

During open-ended consultations workshop activities, when participants were asked to identify and discuss their needs regarding the necessary knowledge, skills, attitudes, and competences to effectively be involved in youth drug abuse prevention in the context of youth work, they identified and presented various areas of improvement:

1. Providing youth with learning and training opportunities to develop essential skills in drug abuse prevention and health promotion.
2. Improving youth knowledge in the field of drug abuse prevention to change the attitude towards drug users and the at-risk youth.
3. Strengthening the capacity of youth to get involved in youth drug abuse prevention and health promotion interventions.

Table 2. Youth drug abuse prevention learning needs

LEARNING NEEDS	AREAS OF IMPROVEMENT
Providing youth with learning and training opportunities to develop essential skills in drug abuse prevention and health promotion.	• Creating learning opportunities to facilitate teenagers` skills development in selecting and differentiating the correct information from the incorrect or biased and manipulative information that are found in number on the internet through on-line media. • Creating opportunities for the development of advocacy skills among youth to work with the authorities in setting up discussion forums and debating groups to advocate for the development of facilities or services for drug users or for the youth who are at risk of becoming drug users.
Improving youth knowledge in the field of drug abuse prevention to change the attitude towards drug users and the at-risk youth.	• Creating education and training activities and awareness raising campaigns on the process of drug use; drug abuse; addiction; substance use disorders; and health problems, as well as on recovery from drug addiction. And thus, facilitating the development of an open attitudes among youth towards drug users and their family; viewing and accepting them without stigma labelling, criminalising, or discrimination. • Developing open education resources and awareness-raising campaign regarding the importance of adopting a civic, pro-social attitude that engages initiative and the courage of open expression by talking about drug use, drug abuse, addiction, substance use disorders, and health problems among drug addicted people.
Strengthening the capacity of youth to get involved in youth drug abuse prevention and health promotion interventions.	• Designing training courses for teenagers and youth who want to get voluntarily involved in youth well-being and health promotion to acquire and develop the knowledge, skills, attitudes, and communication skills in the field of drug prevention and mental health promotion. • Designing training courses for teenagers and youth on how to create and run the online counter-narrative and alternatives campaigns to raise awareness on the drug abuse related problem among youth by counteracting online misinformation and disinformation around drug use and abuse in youth.

2.3.2. Youth drug abuse prevention knowledge

To highlight existing knowledge among youth in terms of skills, attitudes, and competences towards drug prevention and promotion of health and well-being, the participants were asked to answer questions about how they feel about the current educational and training offers in the fields of drug prevention and health promotion and whether they feel that they have the possibility to access and utilise those offerings so as to reinforce their own knowledge and abilities necessary to be involved in the community-based youth drug abuse prevention. The answers provided by the participants show that they have knowledge about drug prevention, and it about:

1. Risk and proactive factors for drug use, drug abuse, substance use, and drug addiction among youth.
2. High-risk of mental, emotional, behavioural, and substance use disorders among youth how abuse drugs.
3. Effects of drug abuse on the youth who abuse drugs at the family, school, and community levels.

Table 3. Youth drug abuse prevention's existing knowledge

EXISTING KNOWLEDGE	AREAS OF KNOWLEDGE
Knowledge about risk and proactive factors for drug use, drug abuse, substance use, and drug addiction among youth.	• Knowing that being exposed to: family dysfunction, poor parental monitoring; parental substance use; family rejection of sexual orientation or gender identity; association with delinquent or substance using peers; lack of school connectedness; low academic achievement; childhood abuse or trauma; mental health issues, etc. are risk factors for drug abuse and substance use among youth. • Knowing that being exposed to: caring family, parent or family engagement; family support; parental disapproval of and open conversation about drug abuse; positive parental monitoring; school connectedness; positive peers' relationships; good mental health, etc. are protective factors for drug abuse and substance use among youth.
Knowledge about high-risk of mental, emotional, behavioural, and substance use disorders among youth how abuse drugs.	• Knowing that drug use, drug abuse, and drug addiction can lead to long-term mental, emotional, and behavioural disorders or health problems such as anxiety or depression; emotional disturbance, etc. that cause changes in thinking, mood, and/or behaviour among youth, which can affect how they relate to others and make choices. • Knowing that substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including mental and physical health problems, disability, and failure to meet major responsibilities at work, school, or home, which can lead to loss of motivation; problems with relationships, fights, illegal activities, etc.
Knowledge about the effects of drug abuse on the youth who abuse drugs at the family, school, and community levels.	• Knowing that drug use, drug abuse, substance use, and drug addiction have a major impact on individuals, families, and communities as its effects are cumulative, contributing to costly social, physical, and mental health problems. • Knowing that to effectively prevent drug use, drug abuse, substance use, and drug addiction among youth, it requires the combination of family, school, community, and Internet-based interventions based on social competence and social influence approaches.

Table 4. Youth drug abuse prevention knowledge gaps

LEARNING NEEDS	KNOWLEDGE GAPS	EXISTING KNOWLEDGE
Providing youth with learning and training opportunities to develop essential skills in drug abuse prevention and health promotion: • Creating learning opportunities to facilitate teenagers` skills development in selecting and differentiating the correct information from the incorrect or biased and manipulative information that are found in number on the internet through on-line media. • Creating opportunities for the development of advocacy skills among youth to work with the authorities in setting up discussion forums and debating groups to advocate for the development of facilities or services for drug users or for the youth who are at risk of becoming drug users.	**Knowledge gaps that need to be closed for the youth to effectively involve in drug abuse prevention in youth work:** • Before planning any intervention to prevent drug abuse, youth organisations should know and use existing research or have the skills to initiate community-based participatory action research that highlights the learning needs of young people in drug abuse prevention. • Youth organisations should have the capacity to develop campaigns addressing misinformation and disinformation around drug abuse and develop projects that stimulate youth's creativity, skills, abilities, or desire to be involved in drug prevention activities and to work with the authorities in setting up discussion forums and debating groups to advocate for the development of facilities or services for drug users or at-risk youth.	**Knowledge about risk and proactive factors for drug use, drug abuse, substance use, and drug addiction among young people:** • Knowing that being exposed to: family dysfunction, poor parental monitoring; parental substance use; family rejection of sexual orientation or gender identity; association with delinquent or substance using peers; lack of school connectedness; low academic achievement; childhood abuse or trauma; mental health issues, etc. are risk factors for drug abuse and substance use among youth. • Knowing that being exposed to: caring family, parent or family engagement; family support; parental disapproval of and open conversation about drug abuse; positive parental monitoring; school connectedness; positive peers' relationships; good mental health, etc. are protective factors for drug abuse and substance use among youth.
Improving youth knowledge in the field of drug abuse prevention to change the attitude towards drug users and the at-risk youth: • Creating education and training activities and awareness raising campaigns on the process of drug use; drug abuse; addiction; substance use disorders; and health problems, as well as on recovery from drug addiction. And thus, facilitating the development of an open attitudes among youth towards drug users and their family; viewing and accepting them without stigma labelling, criminalising, or discrimination. • Developing open education resources and awareness-raising campaign regarding the importance of adopting a civic, pro-social attitude that engages initiative and the courage of open expression by talking about drug use, drug abuse, addiction, substance use disorders, and health problems among drug addicted people.	**Knowledge gaps that need to be closed for the youth to effectively involve in drug abuse prevention in youth work:** • Youth organisations should have the capacity to develop education and training activities and awareness raising campaigns on the process of drug use; drug abuse; addiction; substance use disorders; and health problems, as well as on the process of recovery from drug addiction targeted at young people, youth institutions, schools, and the community. • Youth organisations should have the capacity to develop education resources and awareness-raising campaign regarding the importance of adopting a civic, pro-social attitude that engages initiative and the courage of open expression by talking about drug use, drug abuse, addiction, substance use disorders, and health problems among drug addicted people.	**Knowledge about high-risk of mental, emotional, behavioural, and substance use disorders among youth how abuse drugs:** • Knowing that drug use, drug abuse, and drug addiction can lead to long-term mental, emotional, and behavioural disorders or health problems such as anxiety or depression; emotional disturbance, etc. that cause changes in thinking, mood, and/or behaviour among youth, which can affect how they relate to others and make choices. • Knowing that substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including mental and physical health problems, disability, and failure to meet major responsibilities at work, school, or home, which can lead to loss of motivation; problems with relationships, fights, illegal activities, etc.

Strengthening the capacity of youth to get involved in youth drug abuse prevention and health promotion interventions:	Knowledge gaps that need to be closed for the youth to effectively involve in drug abuse prevention in youth work:	Knowledge about the effects of drug abuse on the youth who abuse drugs at the family, school, and community levels:
• Designing training courses for teenagers and young people who want to get voluntarily involved in youth well-being and health promotion to acquire and develop the knowledge, skills, attitudes, and communication skills in the field of drug abuse prevention and mental health promotion. • Designing training courses for teenagers and young people on how to create and run the online counter-narrative and alternatives campaigns to raise awareness on the drug abuse related problem among young people by counteracting online misinformation and disinformation around drug use and drug abuse among youth.	• Youth organisations should be equipped with the skills and competences for designing training courses for teenagers and young people who want to get voluntarily involved in youth well-being and health promotion to acquire and develop the knowledge, skills, attitudes, and communication skills in the field of drug abuse prevention and mental health promotion. • Youth organisations should be equipped with the skills and competences for designing training courses for teenagers and young people on how to create and run the Online counter-narrative and alternatives campaigns to raise awareness on the drug abuse related problem among young people by counteracting online misinformation and disinformation around drug abuse among youth.	• Knowing that drug use, drug abuse, substance use, and drug addiction have a major impact on individuals, families, and communities as its effects are cumulative, contributing to costly social, physical, and mental health problems. • Knowing that to effectively prevent drug use, drug abuse, substance use, and drug addiction among youth, it requires the combination of family, school, community, and Internet-based interventions based on social competence and social influence approaches.

2.3.4. Youth drug prevention and health promotion

During workshops with youth, they were asked to discuss and identify not only their own learning needs, but also the frustrations they have related to the current education offers. The aim was to give them the opportunities to highlighting the gaps in their knowledge and education that must be closed to facilitate their effective and long-term involvement in drug prevention programmes and campaigns. In the table above, the middle column shows the gaps in youth knowledge and education that must be closed to facilitate a better involvement of adolescents and youth in prevention of drug abuse, as they were identified through consultations held with participants. Thus, the research results emphasise that youth organisations involved in drug prevention among youth should, first of all, have sufficient competences and resources to carry out studies and research, as the basis for the initiation and the subsequent implementation of counter-narratives campaigns and effective drug abuse prevention projects. Also, for the influence of gaps in education and training in the field of drug prevention to be minimised, youth organisations that are involved in field of drug abuse prevention among youth should take into account youth opinions and their learning needs in terms of knowledge, skills, attitudes and competences as direct beneficiaries.

Table 5. Youth drug abuse prevention and health promotion

MEETING YOUTH LEARNING NEEDS	CLOSING GAPS IN YOUTH WORK
Providing youth with learning and training opportunities to develop essential skills in drug abuse prevention and health promotion.	• Before planning any intervention to prevent drug abuse, youth organisations should use existing research or have the skills to initiate community-based participatory action research that highlights the learning needs of youth in drug prevention. • Youth organisations should have the capacity to develop campaigns addressing misinformation and disinformation around drug abuse and develop projects that stimulate youth's creativity, skills, abilities, and desire to be involved in drug prevention and to work with the authorities to advocate for the development of facilities or services for drug users or for at-risk youth

Improving youth knowledge in the field of drug abuse prevention to change the attitude towards drug users and the at-risk youth.	• Youth organisations should have the capacity to develop education and training activities and awareness raising campaigns on the process of drug use; drug abuse; addiction; substance use disorders; and health problems, as well as on the process of recovery from drug addiction targeted at the youth, institutions, schools, or community. • Youth organisations should have the capacity to develop education resources and awareness-raising campaign regarding the importance of adopting a civic, pro-social attitude that engages initiative of open expression by talking about drug use, drug abuse, addiction, substance use disorders, and health problems among drug addicts.
Strengthening the capacity of youth to get involved in youth drug abuse prevention and health promotion interventions.	• Youth organisations should be equipped with the skills and competences for designing training courses for teenagers and youth who want to get voluntarily involved in youth well-being and health promotion to acquire and develop the knowledge, skills, attitudes, and communication skills in the field of drug prevention and mental health promotion. • Youth organisations should be equipped with skills for designing training courses for teenagers and youth on how to create and run the Online counter-narrative and alternatives campaigns to raise awareness on the drug abuse related problem among youth by counteracting online misinformation and disinformation around drug abuse among youth.

2.4. Participants' perspective analysis

Research outcomes allowed us to determine the most common risk factors involved in the initiation and the continuation of drug use among youth and how youth workers can intervene to minimise those risk factors by focusing on the youth learning needs, knowledge gaps, and existing knowledge. And thus, youth organisations should have in house capacity and human capital necessary to develop the training and educational resources on youth drug abuse prevention and the promotion of youth health and well-being. In the present research, the context of the drug abuse problem as seen by the participants was approached through open ended consultations workshop activities. The workshops focused on reflection on experience activities. The participants who participated in the workshops acknowledged the fact that drugs abuse stand as a major issue that society faces today without making any difference between the urban and the rural area.

Thus, this is an that issue passes on to the teenagers and youth on a regular basis, gaining greater and greater amplitude. Furthermore, the participants expressed their concern for a noticeable and obvious lowering of the initial consumers' age. The participants identified a series of problems, be it at the family, the individual, or society level that generate and maintain drug consumption at high stake. Among the current individual risk factors, those that were brought up in discussions were those that depend on the overall lower informative level related to the information about the effects and the risks directly linked to drug consumption; the specific teenager period feeling of invincibility like *Nothing bad can happen to me*, and drugs aura as an immediate and a handy solution to the problems, depression, anxiety, and/or sufferings. That is, drug consumption is perceived as a method of entertaining among youth, either out of curiosity or out of the necessity of being accepted within a specific group, or to get a certain position or place among their peers.

The participants mentioned a few factors of risk of consumption that are directly related to the family environment:

> *It is the poor inefficient communication among the members of the family, in general and on subjects linked to the drug consumption or other topics of interest for the adolescent, in particular. In some families the parents or other caretaker are not available for children for various*

reasons, while in others they are not open or comfortable with the topic of drug consumption, so teenagers turn to the more or less correct information provided by peers.

Furthermore, if this subject happens to be brought up in discussion most often parents cannot provide accurate information, if any, or they simply resort to forbidding and/or threatening with some forms of punishment if their own children insist on the topic, which cannot have another consequence but stirring their children's curiosity even more together with the desire of trying them out.

As to what concerns the risk factors at the social level (their peers included), participants mentioned:

- Peer pressure for the initiation in drug consumption.
- The extended misinformation about drug consumption exerted both by the authorities *(by failing to acknowledge the seriousness of the phenomenon)* and by mass-media *(persistently broadcasting only catastrophic situations that put an end to life without making any hint to hope of leading a normal life in case measures are taken on time).*
- Corruption and a slightly significant involvement of authorities in the phenomenon's scale *(police, school, educational counsellors, etc.)*.
- Consumers' stigmatisation: a great deal of misinformation about the drugs and their effects available in the on line media, from which the youth are unable to select, and
- The availability of drugs and their easy access to young people.

The social challenges observed by the participants were approached in the second workshop of our consultation; *"the experimentation and practice workshop"*. The participants were also encouraged to discuss and to put together their knowledge based on their own attitudes in a more practical manner, offering them opportunities to practice and to get involved in new situations that require new abilities. Although in a safe context in which to try out new approaches before putting them into practice in the real world.

When the participants were asked about what the most suitable learning activities that they would like to be involved in order to develop their own abilities, attitudes, competences and knowledge to efficiently be involved and engaged in drug abuse prevention in their everyday life or in youth work; the participants responded that:

1. They would like be given access to drug abuse prevention education and training to develop their knowledge, attitudes, competences and skills.
2. They desire interactive and dynamic activity through participatory training courses.
3. They would appreciate if youth workers and social workers are able to forward information through interactive activities such as peer-education, seminaries, webinars, and workshops where youth who experienced drug abuse, substance abuse, drug addiction, or went through recovery and rehabilitation would be invited to share their experiences.

Moreover, the participants highlighted the need to offer the opportunities to learn from young people who experienced drug abuse, substance abuse, drug addiction, or went through recovery and rehabilitation. Indeed, this would enhance youth's ability to grasp the topic as it involves an empathic side as well, which can furthermore contribute to:

- Setting up informative support groups at school level not only on the topic of drugs consumption, but also educational exchanges on best practice experiences,
- Setting up social pages on media where topic videos should be uploaded in order to draw attention and sensitise the young audience in what concerns the associated risks to drug consumption or drugs trafficking: *such as watching films, documentaries followed by debates, which can make use of interactive learning aids.*

2.5. Discussion and conclusion

Through this study with the youth, we wanted to find out new possibilities and different ways of integrating young people's needs into the community centred interventions. So, the workshop activities provided the participants with a stimulus for the implementation and putting into practice the latest acquisitions in terms of knowledge, abilities, attitude, and capability in drug abuse prevention beyond workshop context. The participants were invited

to discus and identify what types of training and learning resources, tools and/or materials that should be developed and produced to facilitate youth in a more efficient way to address the problem of drug use, drug abuse, and substance use in their daily life, their work, or their activities. The debriefs carried with participants highlighted five categories of resources necessary to transfer into the outer reality the acquired knowledge, abilities, attitudes, and capabilities, which are:

- Digital resources: pictures about the drug abuse effects, educational videos introducing some real cases through life stories, and dedicated online platforms such as websites with opinion pools, surveys, and data on drug abuse; and interactive learning materials presenting the right information in the field of drug abuse prevention and health promotion.

- Human Resources: Charismatic spokespeople, who are not only energetic but also well trained in the field of drug abuse prevention and health promotion, the selection of a target group out of youth who are willing to interact and contribute to the discussions during training events, and working with volunteers who are trained and ex-consumers who possess ability to communicate, to tell their stories.

- Material Resources: brochures, leaflets accompanied by QR codes that can direct youth to websites where they can find information to meet their learning needs about drug abuse prevention or health promotion in a safe environment. This can include educational and training materials for youth workers, guidebooks and learning manual for youth or volunteers, and interactive presentations or simulation games that put one in the shoes of a person who is addicted to substances (role-play, video games that realistically present the negative effects of drugs consumption), forum theatre scripts, etc.

- Institutional Resources: inter-institutional collaborations and partnerships through projects focusing on drug abuse prevention among youth and the promotion of youth health and well-being. This can contribute to strengthening the capacity of youth workers and youth organisations involved in the field of drug abuse prevention.

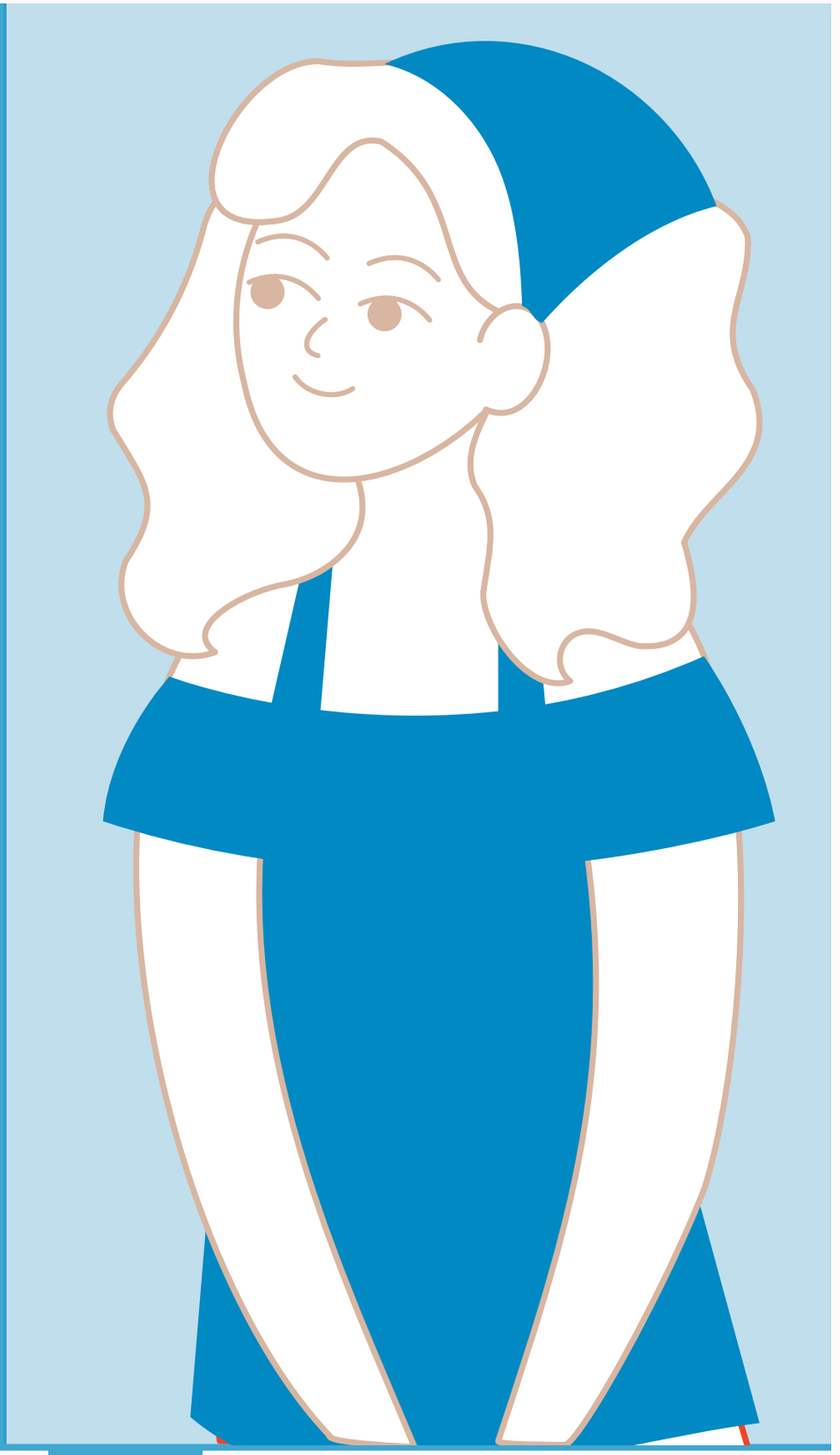
- Personalised Resources: making youth-friendly educational and training tools and materials necessary to strengthen youth's problem-solving skills, communication skills, organisational skills, digital skills, and emotion intelligence skills that can lead to a good mental health and a high level of self-confidence, self-esteem, and self-awareness to minimize the influence of the risk factors for drug abuse among youth.

Therefore, the main conclusion that emerged from this study is that youth, although we are talking about a small group made up of 25 participants, are dissatisfied with the current educational and training offers in the field of drug use prevention. It is not only that they are insufficient family, school, community, and Internet-based interventions or that they do not cover all the vulnerable groups, but they also do not cover the educational needs of adolescents and the youth in the fields of drug prevention and the promotion of youth health and well-being. That is, the current educational and training programmes on drug abuse prevention tarted at the youth are not only insufficient and ineffective, but they do not also offer the youth real opportunities for involvement in changing the context of drug abuse at the family, school, community levels.

Hence, this study highlights the real educational and training needs among youth, but also the ways and resources through which they propose to satisfy the respective educational needs that include them, both as receivers of education and training, as well as the transmitters (volunteers involved in the prevention of drug abuse providing courses, activities, workshops, etc. to their peers). That is precisely why, in order to optimise and make the campaigns or the interventions to prevent drug abuse more efficient, youth organisations (either governmental or non-governmental) involved in the field of drug abuse prevention should carry out studies based on community-based participatory action research and then use obtained results to create resources at the level of the community and the target group to whom it is addressed.

CHAPTER-3

Drug consumption among young people



3.1. Socially accepted drugs, illegal drugs

Drugs have been used legally and illegally for thousands of years, therefore, the considerations should be given to why, how, and when they are used. From one phase of society's evolution to another, what is legal has been credited to either one drug or another. But beyond the social acceptance or rejection of drugs by society, their negative effects on the individual's health and social relationships are undeniable. This is because some drugs have long been accepted by society. Alcohol, the nicotine from tobacco, and the caffeine and the theine from coffee and tea are the drugs that can cause some degree of addiction to those who consume them. Campaigns against smoking have become more vehement since its health risks were realised, and while drink-driving was totally banned because it led to serious road accidents. But smoking and drinking have both been left up to each individual to decide. The most socially accepted drugs in Europe are alcohol, nicotine, and volatile substances, but also certain substances from the class of amphetamines that are found in certain slimming products and drugs with psychoactive effects, but only with a medical prescription and with numerous specifications. The most used illegal drugs are cannabis (in some countries there is a controlled consumption of such a drug, and this makes it socially acceptable), cocaine, ecstasy, heroin, LSD, methamphetamines, poppers, ketamine, GHB, etc.

Alcohol is consumed and spread everywhere. Today, even from a young age, children can begin to consume it. It is a psychoactive drug, with an immediate potential for overdose, poisoning and physiological dependence (or alcoholism). And alcoholism has become one of the most common causes of addiction in the world. The physiological dependence caused by alcoholism means that the addicted person goes through withdrawal (in form of a headache known as a "hangover," increased anxiety known as "chills," and fatigue or trouble sleeping) when its use ceases or decreases. Whereas **Ethanol** has been consumed by humans since prehistoric times, that was done for a variety of reasons: hygienic, food, medicinal, religious, entertainment. **Nicotine** is an alkaloid present in tobacco leaves and which, when consumed in small concentrations (about 1 mg of absorbed nicotine), acts as a stimulant, being the main factor responsible for addiction. The pharmacological and behavioural characteristics that determine tobacco addiction are similar to those of heroin and cocaine addiction. Tobacco was used in past for earaches and toothaches and occasionally as a poultice. Or smoking was a cure for colds, especially if the tobacco was mixed with sage leaves, or the Indian balsam root. Nicotine and its metabolites were studied for treatment of diseases such as: *Parkinson's disease, Alzheimer's disease*. **Amphetamines,** also known as Speed, Uppers, are stimulants of the central nervous system that are used by doctors to treat conditions such as: *attention deficit, narcolepsy, and/or obesity*. Amphetamines are marketed in the form of pills and have the role of stimulating dopamine in the brain. Though doctors prescribe them in a small amount at the beginning, but they might gradually increase it, until they reach the necessary therapeutic effect. Consumed in larger quantities, the level of dopamine will increase uncontrollably in the brain, which will lead to a feeling of euphoria, which increases the risk of addiction.

Currently, many people turn to amphetamines prescribed by doctors to combat anxiety or panic states, because in the shorter term, they produce the feelings of well-being and the absence of anxious states. In the long term, it is addictive and can even cause death. That is, psychotropic drugs are drugs capable of affecting the mind, emotions, and behaviour. Certain psychotropic substances are legal, ***for example,*** *the lithium, prescribed for bipolar disorder or drugs such as: benzodiazepines, barbiturates, opioids, etc*. Some drugs affect the brain every time they are used, while others affect brain functions only if they are consumed in large quantities, continuously. Psychotropic drugs are administered only based on a prescription issued by a psychiatrist. **Opioids** are often prescribed by the doctors because of their important pain-relieving properties. They can be addictive, and thus, it is recommended that they are used under the supervision of a doctor. The most common opioids are *morphine, codeine, fentanyl, and oxycodone*. **Morphine** represents the main active substance in opium. Morphine is a strong analgesic, being used in the treatment of chronic pain, such as pain that occurs in cancer, after a myocardial infarction, etc. Morphine is administered, as a rule, intravenously. When administered as an analgesic, there is no risk of addiction, but in large doses over a long period, the risk of physical addiction increases. **Codeine** is a substance derived from opium that is weaker than morphine. If the person uses the drug for the purposes of respiratory problems for more than a month, an addiction may develop, which the person might not even realise. **Fentanyl** is a painkiller, synthetic opioid, considered to be the most addictive to users, but also the deadliest. It is about 100 times stronger than morphine and is used to treat patients

suffering from severe pain or to treat pain after surgery. Fentanyl can be even more dangerous and powerful than heroin, carrying an increased risk of overdose and death.

Cannabis and cannabinoids can have therapeutic effects in stimulating appetite and relieving symptoms of mental disorders or epilepsy, asthma, cancer, or Alzheimer's disease, regulating inflammatory processes, reducing pain, creating new brain cells, reducing the spread of tumours. It can also ease menstrual pain and reduce the risk of obesity and diabetes. However, further research is needed to better, adequately demonstrate its therapeutic potential or long-term risks. **Cocaine** also known as Coke, Crack, Blanche, Cake, Lady, Charlie, Snow is a fine white powder that acts as a powerful stimulant. The transformation of coca leaves into cocaine hydrochloride is mainly carried out in Colombia, Peru, and Bolivia. It can be diluted or "cut" with other substances to increase the amount. Crack is cocaine that has been further processed with ammonia or sodium bicarbonate and has an appearance of small flakes, stones. Cocaine is usually snorted/inhaled or injected, while crack is smoked. Cocaine remains one of the most used illicit drugs in Europe but with diversity among its users from occasional users to users who regularly use drugs, socially well integrated, in more marginalised and often dependent users who inject cocaine or use crack cocaine. **Heroin,** also known as Gear, Smack, Junk, H, Horse, Harry, White lady is a drug with addictive analgesic properties processed from morphine, a natural substance obtained from the poppy plant. Pure heroin comes in the form of a white powder. Heroin sold on the street is usually brownish white in colour because it is diluted or "cut" with impurities, meaning that each dose is different. It is usually injected, but it can also be snorted, smoked, or inhaled. Heroin consumption continues to cause the highest percentage of morbidity and mortality related to drug consumption in the European Union (through the diseases associated with its consumption by injection, using needles and syringes in common with other users).

3.2. Alcohol, tobacco, drug abuse in youth

Adolescence is the age when the need to identify, to find and to understand oneself and the people around appears. It is the age of personal experiences, the age of searching for the coordinates of the soul and body, the age of discovering the dimensions of reality. And the drugs often take the form of such an experience, which brings together: curiosity, the desire to try something new, to experience everything, the desire to progress and elevate intellectual performance and even the desire to simply be modern. Drug starts to be more and more present in the youth groups in teenagerhood based on the entourage and the school. It is what determines the formation of a biopsychosocial model, which is developed by the interaction between psychological, environmental, and physiological factors. Often, both in the school and the university environments, as well as in ordinary circles, there is a phenomenon of group imitation, in which teenagers, copying their hero, resort to drugs, and in which the psychological factor is decisive. Any user also demonstrates a pathological desire to make followers, the personality being misunderstood by those who have not come into contact with the drug. It is certain, however, that under the influence of the drugs, teenagers seem to overcome difficulties and uncertainties and find an illusory security and an identity. And research into this phenomenon shows that hallucinogens allow users to float; it is a journey that makes user evade from the daily difficulties, contradictions, and feel in control of the situation.

Adolescence is also the age of emotional tensions and anguish, apparently incomprehensible to those around. Many times, for the teenagers troubled by their own questions of identity and belonging; barriers and aggressions, more or less real, from the outside, drugs seem the only and best solution to get by. The psychological profile of the young consumer is dominated by neurotic traits, affective dependence, intolerance to frustration, separation anxiety, isolation, irritability, shyness or hypersensitivity. But then there is an opposition of the ego against the world, which is considered an aggressive, unjust, and oppressive element. So, the solutions that the adolescents find to resolve these conflicts is to withdraw into a world constructed, determined, and maintained by the drugs. This world makes them happy, satisfies their primal instincts, and thus fades their conflict for a while. Some studies have found, in drug users, the presence of an uncontrolled and demonstrative emotional state, in the sense of alienation from those around them and a weak control of impulsivity. Self-knowledge and self-definition, solving one's own problems is also limited by adolescent's cognitive immaturity. Hence, the main risk factors that can determine drug use could be related to the mental, emotional, and behavioural disorders, anxiety, depression, loneliness, frustrations, or interpersonal conflicts. The fact that some young teenagers use drugs further shows that there are insurmountable barriers.

So, the reasons why young people become drug users or even drug addicts are multiple and have to do with factors that may influence them from the outside, but which are usually related to an intrinsic need of the individual who chooses to use drugs such as:

- Curiosity: a person tries the drug out of a desire to satisfy a curiosity about something they have heard about.
- Peer pressure: in the entourage there are other drug users who influence through systematic pressure the decision to consume on those who have not already done so. Peer pressure is very strong during adolescence and, in extreme cases, can lead to antisocial acts. Compared to other factors, peer pressure significantly influences illicit drug behaviour.
- Dysfunctional family environment: It is very likely that young drug users come from families with poor interaction. Young people are exposed to increased risks for drug use if they come from families with members who have experimented with or are addicted to drugs, or in which parents use drinks or hard drugs, either recreationally or to solve problems. The lack of warmth and bonding between parents and children induce situations with increased risk for drug abuse.
- Traumas from the past: the need of a person who ends up consuming to repress certain pains from the past, which most often have to do with abuses that arouse feelings of guilt, shame, helplessness, failure, feelings which they cannot deal with naturally, might be the cause for their turning to a surrogate, namely drugs, to escape from reality and to suppress that pain.
- Influence of mass media: young people learn to consume substances also through advertising. Although a positive correlation between media messages and drug use has not yet been demonstrated, certain advertising campaigns have been observed to increase sales.
- Availability of drugs: closely related to normative and legal aspects, but it can also be considered as an independent factor. The degree of availability (number and accessibility of sales points, efficiency of promotion and distribution mechanisms, etc.) for both legal and illegal drugs is an independent risk factor, once other possible factors are eliminated.

3.3. Effects of alcohol, tobacco, and drug abuse

Alcohol is the most easily accessible drug and the most common substance of abuse that disturbs the activity of the nervous system through chemical reactions it produces in the brain, affecting the way people think, speak, feel, and move. Alcohol has sedative effects, although it is initially characterised as a stimulant, due to the state of euphoria it causes, effects of short-term alcohol consumption, encountered immediately after consumption, consist of slowed responses to the environment, decreased coordination or ability to think clearly, temporary memory impairment, vomiting, impaired vision-balance, loss of consciousness, coma, and suffocation with own vomit etc. Excessive alcohol consumption leads to addiction, causing serious diseases especially of the liver, such as hepatitis and/or cirrhosis. Though the long-term complications of alcohol can consist of: frequent fatigue, short-term memory loss, gastrointestinal disorders, hypertension, heart failure, stroke, diabetes, weakened bones, erectile dysfunction, mental illness, but can also consist problems in the relational or social sphere, such as: physical, verbal violence, rape, domestic, work and road accidents, crimes, divorce, loss of job, poor results at school or school dropout, loss of home, divorce, etc.

Although smoking is a habit accepted by society, it is also the cause of very serious illnesses. It creates pleasant sensations without too much effort since it activates the secretion of dopamine. Smokers quickly feel a state of relaxation, which can sometimes suppress their own desire to quit smoking. That is why people who smoke continue this habit, even when it is obvious that their lives are in danger. This feeling of feel-good does not last long, because the nicotine is detached from the neurons that secrete dopamine, then reaches the liver, where it is eliminated through the kidneys and skin. Therefore, after about 45 minutes, the smoker begins to have unpleasant sensations, of nervousness, impatience, and irritability, due to the lack of dopamine that occurs because of the decrease in nicotine in the blood, a fact that leads to withdrawal. That is why the brain asks for another dose, that is, another cigarette or another tobacco product. Tobacco addiction is due to nicotine, which once in body has the same effects as morphine. Once tobacco consumption is suddenly stopped, the effects such as dizziness, tremors, fits of anger, insomnia, increased appetite, and poor concentration occur. So, the possible complications in the case of tobacco use are lung

cancer, oesophagus, bladder, pancreas, bronchitis, emphysema, asthma, increased risk of myocardial infarction, premature aging, infertility, erectile dysfunction, high risk of abortion, serious problems in the new-born.

Individual health risks of cannabis use for example are generally accepted to be lower than the risks associated with heroin or cocaine. Marijuana rarely contributes to fatal overdose, but its use can increase the risk of premature death and the development of pathologies such as cancer and/or suicide. In the short term, cannabis users can have an increased appetite and heart rate, problems in performing physical and intellectual tasks such as driving a vehicle and thinking logically. At high doses, the consumers' perceptions of sound and colour can be intense, while their thinking becomes slowly confused. If the dose is very high, the effects of cannabis are like those of hallucinogens and can cause anxiety, panic, and even psychotic episodes. Regular users of cannabis risk developing a psychological dependence, to the point where they lose interest in all other activities, such as having a work or/and personal relationships. Cannabis smoke contains 50 percent more tar than high-tar cigarettes, which increases users' risk of lung cancer and other respiratory diseases.

The regular consumption of cocaine can be associated with cardiovascular, neurological, and psychiatric problems and with the risk of accidents or the transmission of infectious diseases through unprotected sexual contact and possibly through the shared use of drinking straws. Cocaine has the property of potentiating release of dopamine associated with feelings of overconfidence, alertness, excitement, and euphoria. The effect of these feelings is short-lived, approximately 15-30 minutes, being followed by serious adverse reactions, such as: convulsions, cardiac arrhythmias, myocardial infarction, stroke, dilated pupils, lack of appetite, increased temperature, genetic changes at the level of protein, death. Cocaine addiction is very difficult to treat because of the genetic changes that can be developed on the brain, because of strong psychological addiction. Injecting cocaine has much more intense euphoric effects, but of a much shorter duration, approximately 5-10 minutes. For this reason, users will inject more doses to maintain the desired feeling, often with the risk of overdose. Mixing cocaine with alcohol creates a dangerous cocktail that greatly increases the risk of sudden death.

Ecstasy is a psychoactive drug that can increase the users' level of empathy and induce feeling of closeness to the people around them, making them feel much more sociable. It can influence the activity of three substances released in the brain, such as: dopamine, serotonin: (affects mood, appetite, sleep, sexual arousal, and self-esteem); norepinephrine: (with strong impact on heart rate and blood pressure, being particularly risky for people with cardiovascular disease). In the short term, ecstasy can cause the body to ignore signs of distress, such as dehydration, dizziness, exhaustion, and can interfere with the body's ability to regulate temperature. The consumption can lead to kidney blockage, seizures, heart failure, and sudden death. Large doses cause restlessness, anxiety, and severe hallucinations. It can in the long-term damage certain parts of the brain, leading to severe depression.

The use of heroin gives a very quick feeling of euphoria and pleasure, but these are accompanied by side effects such as: contracted pupils, nausea, vomiting, dry mouth, drowsiness, inability to concentrate and/or apathy, and feeling of heaviness in the hands and feet. Heroin is highly addictive and its users can quickly develop physical or mental dependence. They risk developing tolerance to the drug, which means they consistently need higher doses to get desired effect. The long-term heroin use can often lead to severe weight loss, malnutrition, constipation, insomnia, damage to the nasal mucosa, liver and/or kidney diseases, irregular menstruation, sexual dysfunction, chronic sedation and apathy or blood-borne diseases through shared use of needles and syringes - hepatitis B and C, AIDS. The abrupt withdrawal from heroin leads to withdrawal symptoms that can be severe, such as cramps, diarrhoea, tremors, panic, profuse nasal discharge, etc.

Methamphetamine's effects include the release of dopamine, associated with euphoria, increased alertness, increased energy levels, and/or feelings of invincibility. The effects of such euphoria are also accompanied by long-term negative reactions: marked weight loss, severe dental problems with crushed teeth due to facial muscle contracture and teeth grinding, anxiety, confusion, memory loss, sleep disorders, paranoia, aggressive behaviour, hallucinations, heart disease, heart attack etc. Long-term use produces brain and nervous system damage, psychosis, and a range of personality or mood disorders. Associated withdrawal symptoms may include depression, with an increased risk of suicide. Following the consumption of psychedelic drugs, intense paranoia, diarrhoea, nausea and blood pressure can increase.

3.4. Alcohol addiction: a substance use disorder

Alcohol is a legal substance, widely available, accepted by most societies, with potential for abuse and acute and chronic toxicity. It has a depressing effect on the central nervous system, causing the decrease in neuronal activity, it has an anxiolytic, antidepressant, relaxing and sedative effect, being used by too many people who face anxiety, depression, or insomnia. Alcohol use disorders include a wide range of problems, from binge drinking to addiction. Psychiatric disorders associated with alcohol consumption:

- Personality disorders: (antisocial, avoidant) appear due to prolonged ethanol consumption.
- Anxiety and depression: are present in 90% of chronic users, both during consumption and during early/late withdrawal.
- Suicide: is much more common in people addicted to alcohol, because of the involvement of serotonin, which mediates the aggressive-impulsive behaviour of alcoholics. One out of three suicide cases is based on alcohol consumption.
- Hallucinosis refers to opinions/impressions, whose authenticity the individual tries to test; as he is preoccupied with a possible partner's infidelity, frequently having delusional ideas of jealousy, him being inundated with ideas of persecution, of harm.
- Ethanol intoxication: (drunkenness); shortly after an abusive consumption of alcohol, an uninhibited behaviour appears, the consumer being communicative, expansive, emotionally unstable, can become easily irritable, aggressive, or violent. If the intoxication worsens, the patient becomes confused, disoriented, or lethargic, with an obvious decrease in the level of consciousness.
- Ethanol withdrawal: the signs of withdrawal appear at the earliest 4-6 hours after the drop in blood alcohol concentration and are manifested by tremors of the extremities, nausea, vomiting, sweating, tachycardia, increased blood pressure, anxiety, nervousness, dysphoric mood (sad, irritable), insomnia, sometimes fever. In the uncomplicated form, these symptoms last for a few days, then decrease in intensity.
- Delirium tremens: the most severe complication of withdrawal and generally manifests 2-4 days after stopping alcohol consumption with psychomotor agitation, confessional state, hallucinations, fever over 40 degrees, sweating, tremors of the extremities, of the chin, of the tongue, speech difficulties, the pulse is over 100 beats/minutes, disorientation in space and time and visual hallucinations. Its complications are pneumonia, liver, kidney, heart failure, electrolyte disorders and acidosis, which can lead to death.
- Late withdrawal: Appears after a period of 3-6 months after the cessation of consumption and is manifested by a dysphoric mood (depression and irritability), discrete tremors, insomnia, hypertension. If the patient consumes a certain amount of alcohol, these symptoms disappear, which reinforces his drinking behaviour ("as long as I didn't drink, I was sick, now I don't have anything, so alcohol helps...").
- Alcoholic dementia: alcoholic dementia represents the progressive deterioration of cognitive functions induced by chronic alcohol consumption. It is differentiated from other dementias by the early impairment of the ethical and moral sense, by sexual dis-inhibition, immoral acts, crimes, and medico-legal acts.

3.5. Youth against drug and substance use

Every young person is different, and the reasons why they may be attracted to drugs are also different. Hence, that is why the ways that help them resist temptations and avoid drug use, abuse, and addiction vary from one context to another. So, the prevention of substance abuse must start at a relatively young age: *even from pre-school education, focusing on the development of a healthy lifestyle, as the basis of later prevention*. Must consist appropriate family education: *courses for the parents to familiarise themselves with how to have family conversation about drugs and drug use, which can also include authentic intra-family relationship, parent-parent, parent-child, child-child, spending quality time with family, or active listening, etc*. The goal should be encouraging healthier habits and promoting good family communication, enhancing strong emotional bonds between parents and young people, and improving family norms: self-respect increase confidence of adolescents and encourage them to set their priorities and make the right decisions in what they do. This increases the individual capacity of the adolescents to solve their problems. It is important that the young people are surrounded by an environment that responds to healthy principles, preferably where

there is no drug use or peer pressure to experiment with drug use. If, there is however peer pressure then youth must be prepared to respond:

- If drugs are offered, the young person can refuse firmly and without justification, because the decision not to use drugs belongs to him; for example, humour can be a solution to cope with the situation as it can be difficult to say "NO", but the convictions must be stronger and thus the young person can gain the respect of others.
- Young people need to feel that they belong to a group, and no one wants to be left out of the group for the wrong reasons, but if you are firm about what the young person wants or does not want to do, then they will be respected by their friends.
- Young people should not worry about what others say about them, but on the contrary, they should focus on their own opinion.
- Young people should be aware that peer power is a way for people to seek approval for their behaviour and should think about whether they really want to encourage others to justify their drug use.
- Information about drugs, effects, risks will also increase the level of confidence in the decisions made.

Youth against drug and substance use could be achieved through initiatives that aim to connect and empower the youth to become active in schools, communities and youth organisations for substance use prevention and health promotion. It an approach that provides a platform for youth to share their experiences, ideas, and creativity, and get support for creating their own substance use prevention and health promotion activities. These can include activities such as sport events, religious gatherings, study circles or artistic circles, etc. That is, there are many benefits of youth participation in drug prevention programmes and the young people gain the most from participation since they are the primary beneficiaries. Their decisions determine how well drug prevention programmes should deliver services, implement, and manage policies. Whichever decisions they make and whichever procedure they apply, they are ones affected the most. Young people share challenges, questions, and problems with their peers. They feel secure in confiding with people from the same age group. For many young persons, peer group is an important source of support. It makes sense to include young people in the organisation and delivery of services because they know what techniques will better help them and their peers:

1. **Delivery of services:** the delivery of services is greatly improved with the involvement of youth. By the youth making key decisions concerning matters that are most significant, offered services are more relevant to their needs. Young people are, undoubtedly, the best experts on young people. They understand each other in a way that is difficult for most adults to comprehend: their behaviours, their style, and even their language differ greatly. Having them involved in the planning and decision-making procedures, creates programmes that are geared more towards what the young people know that they need rather than what adults think that they need. The programmes are, therefore, more responsive to what young people want.
2. **Expression:** participation allows youth to share their experiences and ideas on the dangers of drugs. Their perceptions concerning what makes a drug dangerous or how drugs can be avoided differs from what adults believe to be the reasons or rationale. For some youth, participation in a drug prevention programme allows the young people to share their own experiences with drug abuse in which they were directly or indirectly affected. Their encounters with drugs, when told to their peers or other members of the community, provide a prime example of the effects of drugs. For other youth, this is greatly effective because they begin to understand drugs from a point of view of someone of their own age; rather than listening to an adult speak about why they should not take drugs. Young people are more likely to remember what they have heard if they heard it from the person who actually went through the experience.
3. **Skills development:** at an individual level, young people gain skills and knowledge that ensure a better future. Their self-esteem grows with each opportunity because they gain the confidence and awareness to tackle issues on their own. This is strengthened by their leadership roles and responsibilities that empower them to become responsible citizens. Empowering youth to play a greater role in prevention programmes builds upon their ability to overcome limitations to their participation and provide them with opportunities to make decisions that affect their lives and well-being. With respectable roles in prevention programmes, young people are determined to work diligently to fulfil their own expectations, as well as the expectations for the programme.

CHAPTER-4

Drug prevention through youth work

4.1. Youth-based organisations in drug prevention

Alcohol, tobacco, and drugs harm the people other than the users, whether through violence on the street, sexual and domestic violence in the family or simply using government resources, notably through the costs of providing health care, youth unemployment and incapacity benefits, as well as dealing with crimes and disorder. Furthermore, the disadvantaged young refugees, the at-risk youth and youth living in disadvantaged areas, experience more harm than any other age groups. Therefore, increased youth empowerment and awareness-raising on the effects of alcohol, tobacco, and drug abuse on mental health, well-being, and healthy lifestyle and their consequences: *such as school drop-outs, unsafe sexual practices, sexual or domestic violence, communicable diseases, etc*. can mitigate the impacts of these effects on the economic downturns and mental, emotional, behavioural, and substance use disorders among youth. Thus, youth organisations in drug prevention are key in facilitating youth empowerment in drug prevention; by ensuring that the youth have access to relevant services and resources concerning drug abuse and drug abuse prevention, and the resources for organising drug prevention interventions.

Drug prevention in youth work by youth organisations is a youth work that aims at tackling drug abuse among youth and promoting youth health and well-being through a wide range of School, Community, and Media-based interventions. And therefore, the overall objective of drug prevention in youth work by the youth organisations is to counteract misinformation and disinformation around drugs while communicating an accurate information that seeks to:

1. Prevent or delay the start of drug use;
2. Deter drug misuse or abuse; and
3. Prevent or reduce drugs' effects on youth health and well-being.

Therefore, drug prevention interventions planned, designed and delivered by youth organisations in youth work should target all the young people but most importantly, target specific groups with specific needs, such as youth who have already tried drugs or who are considered at-risk youth. Though there is no protocol for drug prevention interventions in youth work as they operate in the realm of non-formal education, for interventions to be more effective, they should be run by both the youth and the youth workers, and they should consider:

1. Enhancing protective factors and reducing risk factors.
2. Strengthening skills to resist drugs, problem-solving skills, and social competencies.
3. Blending interactive and participatory methods with the traditional educational techniques.
4. Targeting youth and giving special attention towards identifying the youth who are most at risk.
5. Generating norms that are strengthened against drug use and being sensitive with respect to ages, cultures, and developmental stages.

4.1.1. The role of youth in drug prevention

As the young people grow, both their capacities and mentalities change as they mature and learn. Their lives during this period of growth are for exploration, and therefore, shaping and creating their own identity. Hence, this is both a positive and negative aspect. On the one hand, it is the period of development where creativity and imagination thrive. On the other hand, it can seem confusing or overwhelming which may cause the young people to make rash decisions. As a result, at what degree should youth exercise, claim, and enjoy their rights becomes a matter of concern, something that most youth organisations struggle with. Should youth workers determine whether a decision is harmful to a young person or should the young people determine this for themselves, as a learning process and form of evaluation. It is a complex issue because the young people should be entrusted with making wise and informed decisions; otherwise, they will lose respect for the youth workers if they feel pushed or that their lived experiences are not valued. They will feel as if adults hold them as incapable of making choices. On the other hand, adults have more experience in decision processes.

In fact, the youth must play an active role in drug prevention programmes. However, it is important to note that youth are not professionals or experts on drugs. They lack experience and knowledge in the non-formal education sense. Of course, they are experts of their own lived experiences based on what they have perceived and/or even have experienced themselves when

it comes to discussing the effects of drugs, but they most likely do not know complex risk factors behind drugs and/or drug abuse. In essence, and from our study, young people do have a general knowledge about drugs, drug abuse, substance use, drug addiction, but they may not know the specifics. For example, a young person may not know how drugs penetrate the entire human body and which organs are affected first, but they know that the entire process has harmful effects on mental, emotional, and behavioural health. Therefore, the youth workers can or should provide support without being in command of the intervention. More accurately, youth workers can be a resource for the young people when they need substantiation.

4.1.2. The role of youth workers in drug prevention

Occasionally, it is difficult for the youth workers to play a more supportive role when engaging and working with the young people. It is challenging because they often fall into the authoritative or the imposing roles without even noticing what they are actually doing. When working with the young people, though, the youth workers must learn to respect and recognise the value of young peoples' ideas and opinions. The youth workers should take the young people's experience seriously because young people will equally respect and take what youth workers say into consideration. Youth workers should therefore plan, design and deliver the drug prevention interventions that encourage the young people to draw upon their own skills, knowledge, and resources. Encouragement can be in the form of asking young people to plan and lead some sessions but to be careful about making comments that will undermine their original intentions. In other words, youth workers should avoid using expressions that decrease the value of the efforts and the knowledge or skills of the young people, such as Wow, I cannot believe you thought of that. Using expressions such as this will only mock young people's intelligence. To them, it indicates that the youth workers are more surprised and astonished rather than impressed.

More importantly, though, the youth workers should provide their expertise and more information when it is needed. In some cases, they can even serve as mentors to youth. The young people must also realise their own benefits for participating with the youth organisations. The youth workers really do have much to share that is relevant to the young peoples' needs. They are willing and are able to offer suggestions, reassurance, resources, and time. However, youth workers should learn to work with youth rather than telling them what to do. The young people ought to take advantage of the youth workers' knowledge, and thus, the youth workers should be willing to share without being too forceful or too dominant. They should not press youth into doing or believing in something because the youth will realise what the youth workers are trying to do and reject it, regardless of how merited or relevant it might have been. Thus, the appearance of being too controlling only discourage young people from participating.

4.2. Drug prevention interventions in youth work

Drug prevention interventions in youth work have the goal of developing media, school, or community-based drug prevention programmes aimed at strengthening youth-centred activism and improving youth behaviours, attitudes, and narratives toward drug abuse prevention. So, this includes raising awareness on protective factors and how to reverse and reduce risk factors at the community level. In this regard, the overall objective of drug prevention interventions in youth work is to create educational resources necessary to foster youth empowerment through training, education, and campaigning process based on more practical, dynamic and participatory learning approaches as a means or pathways to foster drug abuse protective behaviours, attitudes, and narratives development. Therefore, such efforts should seek to strengthen the competences, the skills, and the capacity of youth workers in training and campaigning processes, supplemented with educational resources to facilitate the youth empowerment in drug abuse prevention. That is, youth workers should have the capacity to conducting the intervention needs assessment on the challenges of drug abuse among young people; as well as to creating and developing a training programme; integrating community-based drug prevention interventions in their youth work; as well as creating and running street and Online counter drug abuse campaigns.

That is, there are various challenges faced by youth workers, which in the end limit their progress in drug prevention in their youth work. The main problem is the level of empowerment of the youth workers. Implementing a drug prevention intervention at the community level requires formulating its objectives, by defining precise, and measurable statements concerning the results to be achieved and identifying means (activities) to be employed

to meet those objectives. These are both relevant when setting some goals, targets, and indicators of the drug prevention intervention. However, since formulating objectives requires skills, these types of assignments challenge the responsibility of the not sufficiently empowered youth workers, which in turn creates a one-size-fit-all situation seen in many contexts, in which the youth workers are motivated, but do not fully understand **Results-Based-Management** to improve performance and ensure that the drug prevention intervention's activities reflect the objectives to achieve the desired results. To overcome this type of situations, research strongly highlights the need of youth workers' empowerment to adopt **Impact Pathways**, monitoring, and evaluation with a Results-Based Management tool in drug prevention intervention. So, empowerment should be done through training processes like workshops learning activities. Empowerment increases youth workers' capacity while simultaneously achieving their progress regarding the impact pathway. So, youth workers empowerment contributes to the integration of the impact pathway in the implementation of drug prevention interventions which is relevant for drug prevention interventions that focus on advocacy, awareness-raising, and campaigning that require employing interactive techniques, such as peer discussion groups, workshop learning activities, or role-playing which bring about active youth participation and involvement in learning about drug abuse by reinforcing the skills such as interpersonal skills development, or fostering positive behaviour and attitudes, academic motivation, and school bonding.

Therefore, drug prevention interventions in youth work can be conducted at various levels, such as: school programmes, community programmes, or Internet programmes. Those that fall into the category of school-based interventions are mostly and often so designed to intervene as early as preschool to address the risk factors for drug abuse, such as aggressive behaviour, poor social or problem-solving skills, and academic difficulties.

School-based interventions focus on children's social and academic skills, including the enhancing peer relationships, self-control, coping, problem-solving and/or drug-refusal skills. Where possible, school-based prevention interventions are integrated into school's academic programme, because school failure is strongly, often associated with drug abuse. The prevention programmes for elementary school for example target improving academic and social-emotional learning among children to address risk factors for drug abuse, such as early aggression, academic failure, or school drop-outs. Hence, overall, the educational aspect of the school-based prevention interventions focuses on skills development such as: *self-control; emotional awareness; communication; and social and problem-solving*. School-based prevention interventions for the middle or junior high and the high school students for example are all centred around a common goal of *increasing the students academic and social competence through study habits as well as the academic support; communication skills; peer relationships support; self-efficacy and assertiveness; drug resistance skills; reinforcement of anti-drug knowledge, skills, attitudes; and strengthening personal commitments against drug abuse*. Integrated programmes strengthen students' bonding to school and reduce their likelihood of dropping out. Most school-based prevention interventions education materials include information about correcting misperception that many students might have about drugs.

Community-based interventions are the prevention programmes aimed at general populations at key transition points, such as the transition to middle school, that can produce beneficial effects even among high-risk families and children. Such interventions do not single out the risk populations and, therefore, reduce labelling and promote bonding to school or community. So, community-based prevention interventions that combine two or more programmes, such as family-based and school-based programmes, proved to be more effective than a single programme alone. Community-based prevention interventions reaching populations in multiple settings, for example, schools, clubs, the refugee centres, the faith-based organisations, youth-based organisations, and the media, are most effective when they present consistent, anti-drug community-wide messages in each setting. Community-based prevention interventions work at the community level with the youth workers, social workers, religious leaders, law enforcement, or other governmental organisations to enhance the anti-drug norms and pro-social behaviours. Many programmes coordinate prevention efforts across settings to communicate more consistent messages through school, work, religious institutions, and the media. In our context, it is important to note that the carefully structured and targeted media interventions, such as visibility, action, or impact campaigns, have been proven to be very effective in reducing drug abuse among youth.

4.3. Impact pathway to drug prevention

Pathway to social change or an Impact Pathway is a logical causal chain from a drug prevention intervention context to a drug prevention intervention's impact. It looks at how changes in risk factors for drug abuse are anticipated to happen based on the drug prevention intervention undertook by young people. So, a community-based prevention intervention is at the core of an Impact Pathway, more explicit, a community-based prevention intervention plays a major role in achieving change in risk factors for drug abuse both at the Output and the Outcome level, which contribute to the achievement of protective factors for drug abuse among young people based on both their own local realities and challenges. However, for a community-based prevention intervention to achieve changes in risk factors for drug abuse which contribute to protective factors for drug abuse within the community and among young people, it is always a challenge, as it requires the youth workers and their youth organisations to create the conditions for realising both the interventions *(Output)* short-term and *(Outcome)* medium-term results within the intervention's lifecycle, which contribute to achievement of protective factors for drug abuse among youth. Such a thinking is built on the impact pathway; emphasising and visualising the contribution of drug prevention interventions toward long-term results, accompanied by monitoring and evaluation. It outlines plausible pathways on how through education and training activities, the drug prevention intervention's inputs contribute to its results at the Output level, and how through post-training activities, the use or satisfaction of Outputs by training beneficiaries at the individual learners, organisational, or community level contribute to results at the Outcome level, and finally, how the use or satisfaction of Outputs by post-training activities beneficiaries contribute to results at the Impact level.

Drug prevention intervention Logical Framework is an analytical tool used for conceptualising the drug prevention intervention's objectives. Thus, the Logframe tool is built on planning concept of a hierarchy of levels linking the drug prevention intervention inputs, activities, outputs, outcomes, and impacts. There is an assumed cause-and-effect relationship among these elements, with those at the lower level of the hierarchy contributing to the attainment of those above. The analytical structure of the logframe outlines the causal means-ends relationships of how a drug prevention intervention is expected to contribute to its objectives. It is thus possible to configure the indicators for monitoring implementation and results around such a structure by displaying intervention's design logic (inputs, activities, outputs, outcomes, and impacts):

- **Outcomes:** A drug prevention intervention's outcomes are used to undertake community-based actions by youth organisations, youth workers, and young people, which lead to impact that contributes to promoting protective factors for drug abuse among young people.
- **Outputs:** A drug prevention intervention's outputs are used to undertake post-training activities events by both youth workers and young people for young people, which that lead to the attainment of outcomes.
- **Inputs:** A drug prevention intervention's inputs are used to undertake the educational and training activities by youth workers with youth people, which lead to the delivery of outputs.

So, for a drug abuse prevention intervention to be successful it is mandatory to have the community-based drug prevention's training programmes that involve a training course's description, objectives, and outputs that can be turned into real life outcomes.

In the first case, the training course goal should be training youth workers, providing them with training and educational tools which could help them in creating learning opportunities and conditions for youth empowerment in drug abuse prevention through community-based interventions. That is, the youth workers should not only have a knowledge base in the field of drug abuse prevention, but also the capacity to integrate elements of the impact pathway, focusing on intermediate development of the outcomes to facilitate behavioural changes among young people during a community-based prevention intervention. The objectives of such courses include some abilities that youth workers will display after taking it, such as:

- The ability to illustrating a comprehensive model for understanding drug abuse protective and risk factors;
- The ability to create and implement drug abuse prevention measures through community-based interventions;
- The ability to creating learning opportunities through interactive, dynamic, and participatory learning activities to facilitate youth empowerment in drug abuse prevention; and

- The ability to use the training course outputs to achieve outcomes, and thereby, guarantee the achievement of the impacts.

In terms of the media-based prevention interventions, the training course's goal is to train youth workers and provide them with a step-by-step guide to counter drug abuse narratives and messages: learn how to plan, create, or promote drug abuse prevention through counter narratives campaigns, That is, building, presenting, and spreading positive information designed to prevent young people from engaging in conversations and interactions that encourage them to abuse drugs in schools, in community, and in social gathering. The objectives of such a course include some abilities that youth workers will display after taking it, such as:

- The ability to framing the problem: alcohol, drugs, and youth in local contexts;
- The ability to designing and creating innovative counter narratives campaigns to engage with the youth and call them to actions;
- The ability to develop targeted messaging; setting up a targeted audience and interacting with targeted audience: organising the content that is interesting enough to spark dialogue; and
- The ability to monitoring and evaluating the campaign through social media metrics: Awareness and Engagement Metrics.

4.4. Community and media-based interventions

The first step in planning a drug abuse prevention programme is assessing the types of drug problems within the communities and determining the level of the risk factors affecting the local youth community. Therefore, the results of such assessments can be used to raise an awareness of the nature and the seriousness of the community problems and guide selection of the best prevention programmes to address the problems. Next, assessing community's readiness for prevention efforts can help determine whether additional steps are needed to educate the community before launching prevention efforts, such as training the youth workers and/or creating the educational resources for youth organisations. Thereafter, review of current drug prevention programmes is needed to determine the existing resources and gaps in addressing young people's needs, but also to identify additional resources, and/or possible collaborations at the community level. And then finally, planning can benefit from the expertise of community organisations that provide youth services: organising a consultation meeting with leaders of existing youth services providers and youth organisations can set the stage for capturing ideas and resources to better help implement and/or sustain the efforts of drug abuse prevention in youth work. One cannot start such an endeavour without prior asking about why the young people abuse drugs and their concerns and aspirations for the future, because the answers to these questions yield information that guides policies to address the root causes that lead to young people's vulnerability and put them at risk of abusing drugs. It is equally crucial for young people who belong to refugees, migrants, and minority groups who feel excluded, to be included to better understand how they want their needs to fit into an inclusive drug prevention programme.

Such needs assessments include both qualitative and quantitative methods needed to determine the proper intervention to implement. So, qualitative methods are used to explore the youth's behaviours, attitudes, norms or perceptions, as well as the specific aspects and gaps of existing programmes to capture the young people's direct experiences with drug abuse. These methods provide in-depth information and are crucial when designing a community intervention. The quantitative methods that require surveys on knowledge, attitudes, or practices, etc. can be useful for assessing youth stratification on existing programmes and identifying gaps in drug abuse prevention knowledge and their access to care and services. It can include physical visit of existing programmes (communal, family, schools) and can utilise qualitative methods as well. Then quantitative methods are used to measure the extent of coverage, changes in behaviours or attitudes, and to obtain statistical data on knowledge and perceptions of young people on drug abuse prevention, such as of usefulness or satisfaction on existing programmes or the programme being implemented.

4.4.1. Effective community and media-based interventions

Media and community-based drug prevention interventions have proven effective in our youth work context. They were both tested in other project Stand Against Drugs, to determine how they best fit. Herein, we consider the following elements to be at core of an effective community-based drug abuse prevention interventions:

1. **STRUCTURE:** should be one that addresses the programme type, audience, and setting by demonstrating its effectiveness in reaching youth both at the community and the individual level.
    - Programme type: Community-based and Media-based programmes, have demonstrated effectiveness in reaching youth at both the community and the individual level.
    - Audience: The audience must be defined and the reason why it is targeted must be outlined to meet its needs more effectively.
    - Setting: The programmes should be implemented after the training of youth workers has taken place. Thus, they have the skills, educational or campaigning materials for conducting the programmes. This means, using Outputs to create Outcomes through a variety of settings.
2. **CONTENT:** Information, skills development, strategies, and services:
    - Information: the information can include facts about drug laws and policies, and drugs and their effects. Although drug information is important, it has not been found to be an effective intervention by itself; that is, without additional prevention components. Skills development: Training helps to build and improve behaviours (e.g., social, and emotional development, social competence, etc.).
    - Strategies: programmes should be targeted at structural change (e.g., promoting norms, behavioural, attitudes or narratives changes).
    - Services: might include community forums, focus groups, peer learning, counselling, drug-free zones, and youth-cantered information.
3. **DELIVERY:** includes programme adaptation and implementation:
    - Programme adaptation: the programme must match community needs to ensure the right fit. Adaptation involves changing a programme to fit the needs of a specific audience in various settings and conducting a structured review of existing programmes to determine remaining gaps and needs.
    - Implementation: Implementing a community-based programme refers to how it is delivered, including the number of sessions, methods and learning activities used, and programme follow-up. Proper implementation is key to drug abuse prevention programme effectiveness.

On the other hand, the drug prevention interventions within the family are more effective in strengthening protective factors among young children. They aim at teaching the parents about better family communication skills, appropriate discipline styles, firm and/or consistent rule enforcement, and other family management approaches. Research has confirmed the benefits of parents providing consistent rules and discipline, and talking to children about drugs, monitoring their activities, getting to know their friends, and understanding their problems and concerns, and being involved in their learning. This is because the importance of the parent-child relationship continues through adolescence and beyond. Thus, both risk and protective factors are the primary targets of effective drug prevention interventions either used in the family, school, or community settings. The goal of these interventions is to build new and/or strengthen existing protective factors and then reverse, reduce risk factors for drug abuse among youth.

> Effective interventions are usually designed to reach the target population in their primary setting. Though in recent years it has become more common to find interventions for any given target group in a variety of settings, such as holding a family-based programme in a school or a community-based intervention.

So, in addition to setting, interventions can also be described by the specific audience for which they are designed:

1. Universal interventions are designed for the general population, such as all students in a school;

2. Selective interventions target groups at risk or subsets of the general population, such as poor school achievers or children of drug abusers; and
3. Indicated programmes are designed for people already experimenting with drugs.

4.5. Youth engagement and participation

The youth are not problems to be solved, but problem solvers themselves. Today's young people are undeniably an integral part of society. At times, they seem to possess boundless energy and enthusiasm, and often so they offer fresh perspectives on relevant issues. With their unique experiences, viewpoints and vitality, the young people are capable of making extremely important contributions to society. The young people also face a variety of challenges; they are growing up in a rapidly changing environment that continually offers them new knowledge and discoveries. And thus, they must continuously make sense of this dynamic environment while at the same time establishing their own unique identities and expressions. In youthhood, young people confront difficult choices with respect to drugs, alcohol, tobacco, and sex and sometimes respond by experimenting or by rebelling against the traditional sources of authority as well as cultural and social norms and values. Today, drug abuse is becoming an increasing trend and playing a larger role in youth culture and entertainment. Associated with social and economic factors, drug abuse has become more prominent among youth, as drugs have become increasingly varied and accessible.

Traditionally, the youth have been exposed to drug prevention programmes during school years. Schools spaces have been considered ideal places to communicate drug prevention information because they are natural places for the youth to learn. However, this method of prevention on its own has proven to be ineffective. The first problem is that limiting drug prevention programmes to the schools excludes a significant number of young people, among them those with irregular lifestyles who perhaps have dropped out of school and began working. Moreover, the schools setting too often lends itself to the outdated pedagogical approaches, in which the young people are expected to passively absorb the lessons of life transmitted by the teachers. This approach, in which the listener is unable to voice a response to the teachers, means that no true exchange of understanding occurs, and the lesson is not internalised by the listener. Hence, it is ineffective for young people, who search for recognition as individuals who are capable of making the choices that affect their own lives. But such a disconnection is furthermore emphasised by the fact that during school years, the young people begin to look for role models among their peers, rather than among their teachers and/or their parents. Thus, lack of youth participation in drug prevention interventions has other negative implications: in survey carried out by UNICEF in 2011, 60% of young people claimed that they had little or no information on drug abuse prevention within their communities. Youth, regardless of where they lived, they declared that they were being denied access to vital information that was important for both their health and well-being, including mental health.

Therefore, this indicates a general problem in society: young people are often marginalised by society. Furthermore, it also shows the consequences of youth marginalisation: youth feel that they cannot access information central to their own needs. Lack of information is very damaging because it denies youth the ability to make informed decisions about their lives and to become empowered by their decisions and choices. This can spell disaster later down the road. Therefore, drug prevention today calls for new tactics. The existing approaches targeting youth in schools are ineffective, and they sometimes even backfire when the youth rebel against the school authority. Hence, what is needed are the more creative methods that do not include hierarchical structures.

Therefore, consultative processes are appealing because they include both the voices and the lived experience of the young people. They ensure youth participation, a fundamental quality of any drug prevention intervention.

They bring about:

- Competence: Participation is a learning process for youth. They acquire skills such as communication, problem-solving, and social skills, which prepare them for the future.
- Determination and know-how: Participation draws upon the youth's expertise on their own social and cultural conditions, which further helps them to discover the benefits of persisting in a drug prevention intervention and having the courage to reach its goal.

- Self-worth and well-being: Youth begin to realise that they have an actual role and that they are capable of being active contributors. This decreases risk factor in youth as they have more incentive to continue their expression rather than drifting towards negative ventures.
- Conscientiousness: Participation helps youth to take responsibility for themselves, for their peers, for their families and for others. It ultimately supports the development of personality characteristics that are important in a society that demands flexibility, creativity, and tolerance.
- Challenge common thinking: Youth bring new perspectives that influence outcomes in new and unexpected ways. Their participation in drug prevention interventions contests negative stereotypes that categorise youth as indifferent to issues of drugs that concern them.

Youth participation in drug prevention is, itself, a source of information in drug prevention interventions. The relevant information can be gained from young people as citizens and beneficiaries about their changing attitudes and needs, or their views as to what constitutes quality in service provision and barriers to accessing these services.

1. Young people are able to recognise which methods are useful for other young people to access information and which methods still need improvements.
2. Young people know when services are working well for them and they know when services are not and what can be done to create youth-centred and youth-friendly services.
3. Young people enjoy working for what they believe in and they thrive on trying to achieve this.

Hence, such flexibility can help drug prevention interventions to adapt and react to the inevitable changes that youth only know. That is, youth listen to youth and they are effective teachers, reliable messengers and successful recruiters who can convince their peers to join any cause. Young people are knowledgeable on youth attitudes and behaviours because they are the ones living the lives of youth.

Given that young people are always trying to keep up with the latest trends, they are a primary source for tapping into today's rapidly changing youth culture:

1. Young people can provide the community with information concerning anything about the new drugs.
2. Young people are the link between those who deal with drugs and those who wish to know more, but their impact and perspectives on drug prevention are frequently overlooked.
3. Young people can offer drug prevention interventions and greater community unique expertise in the area of anti-drug activities.
4. Young people can provide alternatives that will appeal to the interests of other young people rather than letting bewildered youth believe that drugs are their only choice.

Therefore, young people are equally able to communicate drug prevention interventions or drug response measures based on alternatives to standard practices. Thus, the significance and the importance of youth participation in drug prevention programmes are numerous and diverse. For one:

- Morals and character are developed:
  - Youth participation builds upon moral values, which builds respect, unity and cooperation.
  - Young people appreciate the significance of working together, not just with each other but with the community as well.
  - Young people feel empowered to question what is happening around them, and they gain confidence in themselves when they have support and encouragement from each other.
  - Most of all, Young people learn to become responsible and committed individuals who realise the importance of collaboration in order to achieve a common goal.

CHAPTER-5

Design and delivering of youth drug prevention training

D1 S1 YOUTH HEALTH LITERACY DRUG ABUSE AND WELLBEING

A01. Empowerment in drug prevention and youth wellbeing

Learning activity	Reflecting on experience workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop is used to capture the motivation, imagination, and energy of the workshop audience. Reflecting activities encourage workshop participants to look back on their own personal and/or professional behaviour in a way that prepares them for new learning and change. Reflection is often used at the beginning of a workshop or at a transition from one topic to another. To design a reflecting activity, it is important to identify the past experience that you want to invoke and to do so in an engaging way that can be linked to the workshop topic.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on drug abuse and youth wellbeing during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate drug abuse prevention and youth wellbeing literacy in youth work.
Instructions	1. Divide the participants in small groups. Ask each member of the group to think of and share with the group at least five (5) words that each set describe "Drug Abuse Prevention" and "Youth Wellbeing" based on their experiences and knowledge. 2. Upon completion of this spontaneous interaction, ask each group to analyse and interpret different words from all participants to generate one Word Cloud for each term composed only of ten (10) words that reflect everyone in the group. 3. Ask them to analyse and interpret the terms "Drug Abuse Prevention" and "Youth Wellbeing" and create a list of at least five (5) types of Youth Health and a list of at least five (5) types of Youth Rights. Then provide a flip-chart to each group: a. Which type of three (3) interventions in the context of non-formal education that youth work can use in order to effectively meet youth's learning needs and knowledge gaps in in Drug Abuse Prevention and Youth Wellbeing? b. What do you think are the most appropriate training activities that youth can participate to strengthen their knowledge, skills of of Drug Abuse Prevention and Youth Wellbeing? c. Create one complete training activity that can strengthen youth knowledge, skills, and attitudes of of Drug Abuse Prevention and Youth Wellbeing.

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "drug abuse prevention" and "youth wellbeing literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of drug abuse and youth wellbeing problems in your practice or work? c. How do you see a lack of drug abuse prevention and youth wellbeing literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on drug abuse and youth wellbeing in their youth work. • Participants are able to use interactive training learning activities to integrate drug abuse prevention and youth wellbeing literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

D1 S2 YOUTH HEALTH LITERACY DRUG ABUSE AND WELLBEING

A02. Challenges to drug abuse prevention among youth

Learning activity	Experimenting and practicing workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop encourages participants to use knowledge in a practical way. These activities provide an opportunity for participants to practice and involve themselves in new behaviours and skills. The workshop provides participants a safe environment in which to try out new things before putting them into practice in the "real world." To design experimenting activities, it is important to identify the specific skills you want participants to acquire and to provide ways for these skills to be practiced in a useful way. Role plays are commonly used as experimenting activities in workshops.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on drug abuse and youth wellbeing during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate drug abuse prevention and youth wellbeing literacy in youth work.
Instructions	1. Ask each participant to imagine one situation that can occur or has occurred in his or her personal or professional life that represents a case of drug abuse that escalated into addiction? 2. Divide participants in small groups and ask each participant to present their situation. Ask them to analyse each situation and come up with the types of risk factors each of the situations of drug abuse could be associated with. What type of harm, problems, or effects such a situation of drug abuse could cause? 3. Ask them to analyse and interpret various situations from all participants in the group to identify the protective factors that should have been in place to prevent each of the situation of drug abuse. Create a list of protective factors that reflects each situation. a. Did the interpretations of various situations provide you the opportunity to learn how to overcome differences and become allies to address a common problem from different perspectives? If yes, how? If no, why not? b. How can youth education and training offerings in the field of youth health literacy address the risk factors expressed in your situations to prevent each situation from escalating into addiction?

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "drug abuse prevention" and "youth wellbeing literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of drug abuse and youth wellbeing problems in your practice or work? c. How do you see a lack of drug abuse prevention and youth wellbeing literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on drug abuse and youth wellbeing in their youth work. • Participants are able to use interactive training learning activities to integrate drug abuse prevention and youth wellbeing literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

D1 S3 YOUTH HEALTH LITERACY DRUG ABUSE AND WELLBEING

A03. Raising awareness on drug abuse and youth wellbeing

Learning activity	Planning for application workshop
Training method	Experiential learning: Workshop-based learning
Goal of the activity	This workshop provides a stimulus for implementing and utilizing new learning outside the workshop context. Planning activities prepare participants for and increase the likelihood of transfer of learning to new context or in their work environment. These activities are often used at the conclusion of a workshop or when the focus of the workshop is about to shift from one topic to another. To design planning activities, it is important to identify ways to have participants look toward the future and identify specific ways to put new learning into practice.
Targeted audience	Young people; youth workers or youth educators; trainers or facilitators; youth-based organisations; and other educators involved in youth education and training.
Learning objectives	• Develop participants' knowledge, skills, and attitudes on how to engage with young people on drug abuse and youth wellbeing during training interactions. • Strengthen participants' training skills and capacity in using interactive learning activities to integrate drug abuse prevention and youth wellbeing literacy in youth work.
Instructions	1. Divide participants into their small groups of 4 or 5 persons per group. Then give each small group a flip chart and Handout-A03.1. and Handout-A03.2. 2. Ask each group to discussion the example of the counter-narrative campaign on Handout-A03.1. The discussions should focus on participants' interpretations, descriptions, and meanings the make out of that campaign. 3. After concluding the discussions in small groups, ask each group to use a flipchart to complete Handout-A03.2. Ask each group: a. To think about the the drug abuse and youth wellbeing context they would like to raise awareness about through counter-narrative/alternative campaign? b. To describe the characteristics of the audience they want to target. What is the behavioural or social change they aim to contribute to? c. To describe how they will achieve that impact. How many people do they aim to reach? How much campaign content do they aim to produce? How many times per week do they plan to post a new content? d. To create campaign's content: message(s); medium for each message; and call to action for each message. Which social media channels will they use to run the campaign? Which methods will they use to measure the impact?

Debriefing	1. Check the results in the bigger group with all participants. Discuss the experience with the participants. Ask questions such as: a. How did you manage to do the activity? b. Are you satisfied with the results of your group? c. What was difficult and how could it be done better? 2. Then use the follow-up questions for interactive discussions: a. How can you define or characterise the terms "drug abuse prevention" and "youth wellbeing literacy"? What do they have to do with each other? b. What challenges and opportunities are you facing in dealing with or addressing different forms of drug abuse and youth wellbeing problems in your practice or work? c. How do you see a lack of drug abuse prevention and youth wellbeing literacy impacting you personally or the communities or the groups that you work with?
Learning outcomes	• Participants are able to apply gained knowledge and skills to engage with young people on drug abuse and youth wellbeing in their youth work. • Participants are able to use interactive training learning activities to integrate drug abuse prevention and youth wellbeing literacy in their youth work.
Training logistics	• Flipchart paper, large sticky notes, markers, and a tape. • A wall with enough space to attach several sheets of flipchart.
Required time	90 Minutes: As a facilitator you should expect to spend: • 15 Minutes for presenting giving instructions. • 50 Minutes for participants to complete their tasks in small groups. • 25 Minutes for reflection and discussion during debriefing.
Challenges	• This activity brings together different concepts related to what youth need to make effective health decisions for themselves as a means to develop healthier lifestyles necessary to achieve a greater state of health and well-being. We have created a set of 12 workshop learning activities that reflects essential themes in the field of youth health literacy. • The themes including Youth mental health and well-being, Drug abuse and youth well-being, Gender and sexual health literacy, and Digital youth health literacy are discussed, and each is linked to a workshop learning activity. So, beyond having experience in youth health literacy, the facilitator should have experience in human rights education and cultural literacy to facilitator this workshop.
Adjustments	• You can adapt the questions to the profile of the group and context in which a workshop takes place. • This activity works best with small groups, 20-25 participants.

Manual references

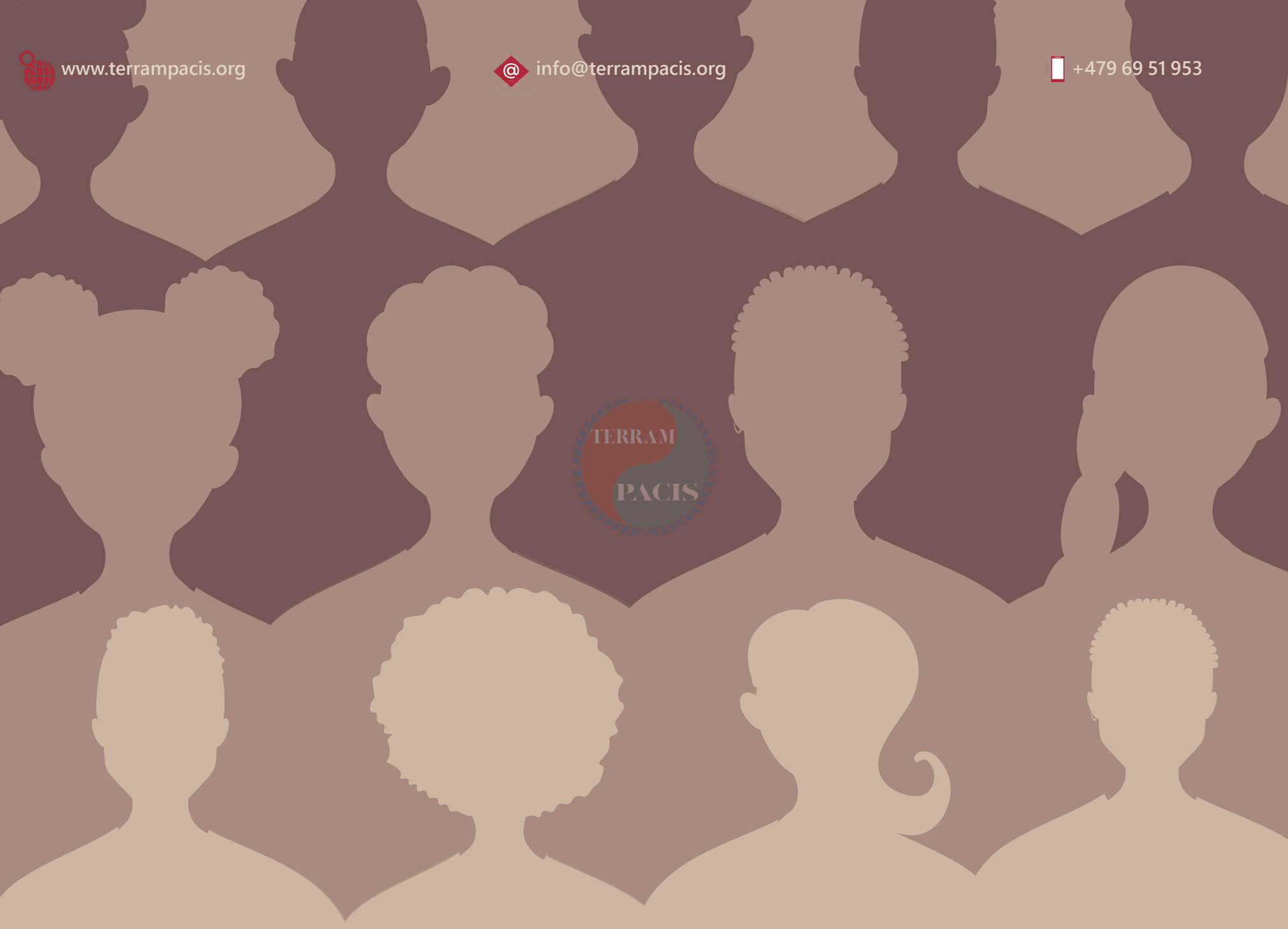
Youth Health Literacy
Project Reference: 2021-2-MT01-KA220-YOU-000049937

Co-funded by the European Union

This manual has been co-funded with support from the European Commission. Its content reflects the views only of the author and the Commission cannot be held responsible for any use which may be made of the information contained herein.

- Ghid de prevenire in domeniul drogurilor adresat specialistilor (www.ana.gov.ro)
- https://www.health.gov.au, https://www.aspenridgerecoverycenters.com,
- https://www.mayoclinic.org, https://www.verywellhealth.com,
- https://en.wikipedia.org, https://www.emergency-live.com, Guide for teaching staff" National Program "Education for health in the Romanian school"-"Evenimentul Românesc" publishing house S.A, 2004
- O. Popescu, A. Achim, A.L. Popescu- "Life in the hexagon of death" -Fiat LUX Publishing House, 2004
- O. Popescu, E. Bucur-"Education for health in school" -Fiat LUX Publishing House, 1999
- GHE. E. Bucur, O. Popescu-"Education for health-in the family and in the school"-Editura Fiat LUX, 2004
- http://www.drugs.ie/resourcesfiles/guides/HPM00053RM.pdf
- https://avocatinpenal.ro/drogurile-legale/
- https://www.dsptimis.ro/promovare/campanie_prevenire_droguri.htm
- https://castlecraig.ro/dependenta/droguri
- https://clinica-aliat-suceava.ro/dependenta-droguri-depresia/
- https://www.sfatulmedicului.ro/Abuz--dependenta--si-intoxicatii/dependenta-de-alcool-si-abuzul-de-droguri-la-adolescenti_23
- https://www.emcdda.europa.eu/system/files/publications/973/TDAC12001ROC_.pdf
- https://ro.warbletoncouncil.org, https://www.verywellmind.com/,
- https://www.romedic.ro/de-ce-consuma-tinerii-droguri, https://drugsinc.eu/,
- https://ro.yestherapyhelps.com, Drog - Wikipedia, Manual de diagnostic și statistică al tulburărilor mintale - Wikipedia, New ESPAD results: teenage drinking and smoking down, but concerns over risky cannabis use and new addictive behaviours | www.espad.org.

www.terrampacis.org
info@terrampacis.org
+479 69 51 953



Co-funded by the European Union

This output has been co-funded with support from the European Commission. Its content reflects the views only of the author and the Commission cannot be held responsible for any use which may be made of the information contained herein.

Edition: ©2024 Youth Drug Prevention
Copyright: All rights reserved.
Publisher: TERRAM PACIS Editorial.
Reference: TPOER-042-YDP/25-03-2024