

# *Best practices in working with adolescents*

Guidelines



Kyiv-2021

International Charitable Foundation “AIDS Foundation East-West” (*AFEW-Ukraine*) is a non-governmental humanitarian public health organisation, which has been working in Ukraine, Moldova, Belarus and Georgia since January 2001.

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Our mission is to improve access to quality health and social services for key populations through introducing evidence-based and innovative approaches, supporting active international and regional knowledge exchange and capacity building of local governmental and non-governmental organisations.

Our key target populations include most-at-risk adolescents, people who use drugs, sex workers, prisoners and people living with HIV.

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These guidelines were developed for people working with most-at-risk adolescents, in particular those who use psychoactive substances. The document describes the specifics of working with adolescents, contains practical recommendations on how to organize preventive interventions as well as description of tools and references to useful resources.

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# Introduction

In 2012, we launched a programme to prevent HIV and sexually transmitted infections (STIs) among adolescents who use drugs. Back then, there were very few organisations working with this group in Ukraine. That is why our task was to come up with the most effective methods of work based on the experience of national and international organisations. We selected four cities to work with adolescents: Kropyvnytskyi, back then called Kirovohrad (Return to Life CBO), Poltava (Public Health CBO), Kharkiv (Blago CBO) and Chernivtsi (New Family CBO). In 2017, in cooperation with Alliance for Public Health we were able to scale up our activities to cover remote towns and villages in the same regions (together with the Light of Hope CBO in Poltava region and with the Parus CBO in Kharkiv region), plus cover three more regions: Kyiv region (Convictus-Ukraine CBO), Odesa region (Way Home CBO) and Donetsk region (Nasha Dopomoga CBO, Sloviansk). Thus, these guidelines are a product of many years of work with adolescents who face a wide range of problems due to the use of psychoactive substances (PAS).

In 2015, we published similar guidelines. They described the models underpinning our work – strengths-based (or assets-based) approaches. This document supplements and updates the previous guidelines and contains new practical tools, examples, quotes, and recommendations.

You can find the guidelines Strengths-Based Social Work with Adolescents at our website: <http://afew.org.ua/sotsialna-robota-z-pidlitkami-z-oporoyu-na-silni-storoni/> (available in Russian).



In the following section we will briefly remind you what strengths-based approaches are, but first we would like to personally thank all our colleagues, who worked together with us for many years to ensure that all adolescents have access to friendly services irrespective of their social status, behaviour, place of residence, gender identity, nationality or other characteristics. They became co-authors of this document. Here are just some of them:

*Alyona Bezhan, Anya Bereza, Daria Brydun, Lyudmila Demyanenko, Anastasia Dubinina, Natalia Zlatopolska, Natalia Kamyshanska, Natalia Lemeshenko, Alyona Lymar, Andriy Makedon, Andriy Matveev, Oleksandr Mohylka, Fedir Moskalenko, Oleksandr Ostapov, Kateryna Perepyolkina, Mykola Pylypko, Dmytro Postevka, Andriy Protopopov, Lilia Slyusar, Olena Tryfonova, Iryna Filenko, Iryna Filippova, Volodymyr Khodunay, and Yuliya Tsymbalistenko.*

When preparing these guidelines, we asked not only professionals, but also adolescents for their advice to make sure that the document reflects not only our vision, but also their vision. Caring about their confidentiality, we are not sharing their names, but we would like to thank them for their support and for being open with us.

Who might be interested in this document? It describes various aspects of working with adolescents, so it can be helpful to a range of professionals: social workers and psychologists who provide support to adolescents (in our guidelines, we often use a general term “counsellor” to refer to such professionals); heads of organisations or project managers as it presents the key components of comprehensive work with adolescents; educators as many tools and instruments can be applied in educational institutions.

We have already mentioned that our projects are aimed at the adolescents who use drugs as drug use is one of the riskiest practices, which can have a significant impact on all aspects of their life. However, we assume that the tools and approaches presented herein are quite universal and can be used in working with any adolescents irrespective of the issues they face. Throughout the years of our work, very few adolescents came to us specifically to seek help in resolving their issues related to the drug use. Most often, they were seeking help in building relations with their parents, improving their academic performance or looking for psychological support due to traumas, violence or other problems they experienced. Those are the factors most often leading to substance abuse and if they are ignored, it would be difficult to expect any changes in the alcohol- or drug-using behaviours. That is why it is so important to work with the whole range of issues faced by adolescents. In the section “Specific Features and Risks of Adolescence” you will learn how the characteristics of this age influence the risky behaviours of adolescents.

In this guide, we often use the word “adolescent” though the national laws in Ukraine use different terminology, referring to people under 18 years of age as “children”, people aged 15 to 17 years old as “adolescent children”, and people under 14 years old as “young children.” However, the term “adolescent” is also used in many laws and regulations. It results in certain ambiguity and confusion in terms of understanding as well as making decisions related to the adolescents aged 10 to 18 years old. In these guidelines, the term “adolescent” is used in line with the World Health Organisation (WHO) definition, according to which adolescence is a transitional phase of an individual's growth and development between childhood and adulthood, i.e. between 10 and 19 years of age. It is one of the key transitional periods of human life, with rapid growth and changes, which are bigger only in infancy. Many aspects of such growth and development are

caused by biological processes, with puberty marking the transition from childhood to adolescence. Adolescence on its own can be considered as a factor of vulnerability as it contributes to high-risk behaviours, in particular to the use of psychoactive substances and unprotected sex.

Despite this fact, adolescents have a very limited access to friendly programmes and services. Many professionals still have very outdated views on morality, which does not allow adolescents to receive accurate information on sexual and reproductive health, condoms and other means of protection or have access to syringe exchange and rehabilitation programmes. Understanding the specific features of adolescence, using evidence-based approaches, and reducing stigma and discrimination among professionals and decision-makers can help develop policies and programmes reflecting the real needs of adolescents.

In 2020, we brought together the best professionals specializing in various aspects of working with adolescents, who share our principles and approaches, at the Conference for and about teens “Through Virtual to Real” with almost 50 speakers. Linked below you can find many interesting presentations and materials shared by the speakers, which are an important addition to these guidelines: <http://afew.org.ua/category/biblioteka/materialy-konferencii-dlya-ta-pro-pidlitkiv-virtualno-pro-realne/>.



Enjoy! We hope that our experience will be helpful to you.

1

*Strengths-based approaches  
in social work*



In our activities, we try to mainly use the strengths-based perspective, focusing on the strengths of our clients. Strengths-based approaches are described in this section.

Since its onset in the beginning of the 20th century, social work took a vital place among the professions aimed at helping people to resolve their problems both at the individual and family level and at the local community level. One of the specific characteristics of this profession is a wide range of theories and practical models applied by social workers. Organisations and practitioners can build their activities based on different models: psychodynamic (with a focus on one's internal mental structures: motives, drive, needs), eco-systemic (with an individual viewed in interaction with the environment), cognitive-behavioural (with a focus on human behaviour and cognitive processes), etc. Each of these models has its own way to explain the roots of social and personal problems and offers different methods to resolve them. In spite of the differences, all models have a lot in common. In particular, most of these models are problem-oriented. The structure of social work based on different models is very similar. First, social workers conduct diagnostics, assessing the life of a person, a family or a community, trying to identify the problems and define their roots. Based on the assessment results, social workers establish the "diagnosis" and develop a "treatment plan." Such approach is often called a medical approach as it follows the same logic: first diagnosis, then treatment. The stages of work often have clear limitations: if clients fail to comply with certain conditions, they may be denied access to the following stage and discharged from the programme. The diagnostic stage in this case is seen as a preliminary stage, which does not influence the client. Problem-oriented models stipulate that the social worker should possess expert knowledge on various problems and ways to resolve them. Clients' responsibility often comes down to following the social worker's instructions and recommendations.

In the second half of the 20th century, there were many questions accumulating to problem-oriented models of social services in sociology, psychology, anthropology, pedagogy and social sciences due to the development of critical approaches, studying the social determinants of human problems and looking at social and economic structures as the source of such problems. Researchers and practitioners more and more often questioned the right of the social worker to play an expert role in relations with the client as such roles may lead to the risk of power imbalance, when the social worker takes the responsibility for making decisions related to the client's life, while the client is only seen as a passive implementer of those decisions. Such relation system may lead to the clients becoming passive, aggravating their feelings of helplessness and hopelessness.

In the 80–90s, alternative models were developed based on the critical approaches in social sciences, social constructionism theory (focusing on building concepts and meanings in social interactions), positive psychology, and research of protective factors. Dennis Saleebey (2002) offered to call such models *strengths-based approaches*. Such approaches are based on the common values:

- Any person, family or community has strengths and resources. Apart from problems, risks, deficits, they all have something that has not been affected by the problems, that helps people live and move forward. Availability of resources, a system of social support increases the chance for positive changes, so it is important to focus on such resources when conducting situation assessment.
- Overcoming challenges brings knowledge and wisdom, not only trauma and pain. Many people who experienced severe crises throughout their lives, later tell that such situations not only ruined some parts of their lives, but also helped them re-define their priorities, realize what they value most, find inner power, believe in themselves, etc. That is why traumatic events may be considered from two perspectives: negative consequences and positive experience.
- People's dreams and hopes should be treated seriously as they give meaning to their lives and give them strength to pursue the change. That is why at the assessment and planning stage the social worker should take into account what the client dreams of and hopes for.
- To recognize strengths, it is important to understand the context of behaviour.

One of the key concepts in strengths-based approaches is resilience, i.e. the ability of an individual to cope with stress and overcome life challenges.

When studying risk factors in the development of behaviour disorders (Garmezy, 1985; Rutter, 1987; Zimmerman and Arunkumar, 1994), researchers pointed out that children and adolescents facing the same environmental risk factors (alcohol abuse in family, poverty, and violence) do not always demonstrate similar behavioural disorders. Certain factors were identified, which helped children and adolescents overcome challenging life circumstances. One of the main objectives of strengths-based approaches is building and supporting human resilience.

Currently, it is considered that resilience is defined by the following factors (Masten and Powell, 2003):

- close supportive relations with other people;
- enabling social environment;
- ability to find sense, meaning and peace in life;
- positive self-esteem;
- skills to cope with stress, resolve problems, communication skills, etc.;
- sense of humour, self-irony;
- life circumstances.

Working with clients, groups or communities, social workers using strengths-based approaches pay a special attention to the factors building resilience and include the promotion of such factors into their problem-solving plans.

Such approaches also stipulate a shift of perspective in the relations between the social worker and the client: accepting the clients' strengths and focusing on their resources, the social worker recognizes their ability to make decisions relating to their own problems as well as act to resolve such problems. In such scenario, the relations between clients and social workers shift to a more horizontal interaction based on cooperation, while clients become experts in their own lives and consequences of the problems faced by them.

The latest prevention and correctional programmes for adolescents and their families are built taking into account their strengths as well as tangible and intangible resources. More information about evidence-based treatment and prevention programmes can be found on the website of the European Monitoring Centre for Drugs and Drug Addiction: <http://www.emcdda.europa.eu/>. Situation assessment should consider not only risk factors in the development of unwanted behaviours, but also the protective factors – both individual and related to the social environment. Programmes for adolescents are usually future-oriented. They help adolescents acquire the essential life skills and support them in making key life decisions. Strengths-based approaches take an important place in the system of support to adolescents facing problems in their lives. The concept of *resilience* is central in most programmes for adolescents. Development of resilience is one of the main tasks of such programmes.



To implement strengths-based approaches, social workers should go through the following steps (Benard, 2002):

- **Listen to the client's story.** Usually clients come to the social worker not to talk about their strengths – most often they come to discuss their problems. That is why the social worker should start with listening to the client's story.
- **Recognize the client's pain.** Recognizing suffering is an essential aspect defining the relations between the social worker and the client. Going straight to discussing the clients' strengths can make them feel that their pain and suffering are depreciated. It is very important to recognize their suffering.
- **Look for strengths.** Listening to the clients' stories, social workers should notice all the things, which help people cope with their problems: positive experience in the past, resources, and strengths.
- **Ask about survival strategies, support, positive things, interests, dreams, goals, and dignity.** To make clients' strengths, coping strategies and possible goals visible, social workers should ask them additional questions.
- **Identify strengths.** As part of the feedback, social workers should tell clients what they noticed in their stories.
- **Link clients' strengths with their goals and dreams.** At this point, clients have already defined their potential goals and strengths. Now social workers should help their clients find a link between them. It supports clients' self-esteem and builds their motivation to achieve the goals.
- **Link clients' goals with their resources.** When working on the future plan, social workers should help clients to use the resources already available to the maximum extent and, if needed, should offer additional resources.
- **Look for opportunities to share the client's experience with people who face similar problems.** An opportunity to share experience is one of the ways to find more meaning in suffering and coping with problems. Experience sharing helps to promote mutual support, build communities and self-help groups among the clients of social services.

Let's look at some examples of using strengths-based approaches. Most tools described in these guidelines are part of such approaches. Here we can separately mention motivational interviewing. Of course, this method can only roughly be called strengths-based (as in this case a major focus is on deficiencies and problems), but this model was truly revolutionary in counselling people who use drugs. Research studies based on

motivational interviewing led to most ideas dominating the sphere of substance abuse treatment being questioned or even challenged. Before this counselling technique appeared, the ideas that people who use drugs have to first recognize that they are sick to start recovery and that low motivation, lies, denial and resistance to change were part of this sickness were taken for granted as well as other similar ideas.

People rarely follow only one approach. Much more often they apply tools and techniques from different approaches based on their own experience, available resources, and the client's preferences and needs. We are no exception and throughout many years of our work we developed a combination of approaches that we use.

Motivational interviewing as a counselling technique appeared as a result of research studies conducted by an American psychologist William R. Miller to assess the efficiency of behavioural interventions in treating alcohol addiction. It was first described in 1983. Miller pointed out that the efficiency of such interventions largely depended on the communication style of the practitioner (doctor or counsellor) providing support. If such practitioner communicates in a client-centred, non-directive way, it increases the efficiency of interventions. Based on their observations, Miller and his colleagues developed a new counselling technique, which they called "motivational interviewing." Thanks to the clinical experience and the research studies demonstrating its effectiveness, the technique was tested in various areas of practice. Today, motivational interviewing is a recognized evidence-based technique in substance abuse treatment.

**Motivational interviewing** focuses people's attention on exploring and resolving the ambivalence in their feelings and emotions about the behaviour change. There is a special focus on working with the client's motivation, which helps further change.

This counselling approach is based on three key elements: counsellor-client cooperation, identification of the client's arguments to support the change and respect of the client's autonomy. As in other counselling techniques, when conducting motivational interviews, the counsellor should demonstrate empathy, attempt to see the world through the client's eyes, support the client's self-efficacy, focusing on previous positive experience and defining the client's skills, knowledge and resources available. It is also important to address resistance: in motivational interviewing resistance appears due to the conflict between the client's and the counsellor's views on the problem and possible ways to resolve it and also when the client feels that his or her autonomy is under threat. Besides, during motivational interviewing the counsellor focuses on identifying discrepancies: change is possible only when people notice the ambivalence between where they want

to be and where they are. In the course of motivational interviewing, the counsellor tries to make such ambivalence visible to the client.

Today, training for the counsellors to apply the approach of motivational interviewing is clearly structured and includes a certified training course, regular supervision with a certified supervisor and working with reference materials. More detailed information about training for counsellors to apply this approach can be found on the website of the Motivational Interviewing Network of Trainers: <http://www.motivationalinterviewing.org>.



Unfortunately, there are no organisations offering certified motivational interviewing training in Ukraine. Almost no modern publications dedicated to this counselling approach have been translated into Ukrainian or Russian.

The basic book on this topic in English is *Motivational Interviewing: Helping People Change*, 3rd ed., Miller & Rollnick (2013). It was published in Russian in 2017 (Уильям Р. Миллер, Стивен Роллник. Мотивационное консультирование: как помочь людям измениться). This book offers a detailed description of the theoretical basis, principles, techniques and areas to apply this approach. Specific features of using motivational interviewing in working with adolescents are presented in *Motivational Interviewing with Adolescents and Young Adults*, 2010. There is also a wide range of books dedicated to the use of this approach in different areas of counselling and social work.

The main web-based source of information is the site: [www.motivationalinterview.net](http://www.motivationalinterview.net). It contains a lot of articles, guides, and videos on the basics of this approach, its efficiency and training opportunities.



**Solution-focused counselling.** This is a good example of a strengths-based counselling approach. The approach was developed starting from 1980s in the Brief Family Therapy Center (BFTC) in Milwaukee (Wisconsin) by social workers and psychotherapists Insoo Kim Berg and Steve de Shazer together with a group of their colleagues. The BFTC team worked a lot with clients who did not benefit from the traditional approaches used at that time. The main task that they had was to find a helpful tool that could be used in face-to-face counselling. As opposed to many other counselling and psychotherapy schools, solution-focused brief therapy (SFBT) was developed not based on the theoretical provisions on how and through which mechanisms change was going to happen in the clients' lives, but based on what actions and questions of counsellors

would be most effective and helpful for clients. Later, those principles were introduced not only in counselling, but also in coaching, management, social work and other areas.

Solution-focused approach is based on finding and formulating solutions, not analysing and searching for the roots of problems. This approach is focused on solutions, hopes, resources, strengths and positive exceptions. Resolving a problem does not require spending much time on studying its causes. This approach is targeted at building and developing well-defined goals.

It is considered that the client's motivation increases when the therapeutic conversation focuses on what the client would like to change. This is an ongoing process in counselling. Talking about their desired future, clients hope that they would be able to achieve it, that change is something they can reach and further maintain.

Though there is no theory in this approach, the professionals following it in their work share certain basic principles and apply them in their counselling styles and techniques:

1. If it is not broken, don't fix it.
2. If it works, do more of it.
3. If it does not work, try doing something else.
4. Solutions do not have to be complicated, they can be very simple.
5. The solution is not always directly related to the problem.
6. The language of problems tends to be different than that of solutions.
7. There are exceptions to all problems.
8. Future is created in the course of conversation with other people.

We try to apply such principles in our work and often use the techniques offered by this approach. Some of them are described below.

The following books on solution-focused counselling are available in Russian:

- Т. Ахола, Б. Фурман. Краткосрочная позитивная психотерапия. – Речь, 2000 [T. Ahola, B. Furman. Short-term positive therapy.]. The title of the book may be misleading, but it is dedicated to solution-focused approach. The publishers probably thought that a book with such title would sell better. It is a translated version of the book by the Finnish solution-based therapists – psychiatrist Ben Furman and psychologist Tapani Ahola. The book is written in a simple language, it is full of examples and can be a good practical guide for counsellors.

- Т. Ахола, Б. Фурман. Терапевтическое консультирование. Беседа, направленная на решение. – Речь, 2001 [T. Ahola, B. Furman. Therapeutic counseling. Conversation aimed at solving.]. Another book by the Finnish authors. It does not contain much theory, but offers a lot of practical examples. This is a great book to first learn about the approach.

There is a website <http://www.sfbt.ru/> available in Russian. Currently, it is the only resource in Russian dedicated to the solution-focused approach. On the website, you can find a wide range of articles on the use of solution-focused approach in counselling, social work, and coaching.



There are many publications in English on solution-focused approach, in particular its use in social work. Probably the basic book for social workers working with adolescents and families in difficult life circumstances is the book by Teri Pichot and Yvonne M. Dolan “Solution-Focused Brief Therapy: Its Effective Use in Agency Settings” (Haworth Marriage and the Family), 2014. The book offers a detailed description of how to adapt solution-focused approach to the realities of organisations providing social services. The book is very practical and contains a lot of tips and tricks for the beginner solution-focused counsellors.

There are a lot of internet resources available in English. Here are some of them:

- <http://www.sfbta.org/> – website of the American Solution-Focused Brief Therapy Association (SFBTA). It contains a lot of information about the approach, its history and current developments in the USA;
- <https://www.brief.org.uk/> – website of London-based BRIEF centre. It offers information about training courses, articles on solution-focused brief therapy, etc.



**Narrative approach.** Guy Shennan, a therapist from the UK, says that this approach is a cousin of the solution-focused approach. The word “narrative” comes from Latin “narrate” meaning “tell, recount.” This approach was developed by Michael White from Australia and David Epston from New Zealand in early 80s of the last century. Within their collaboration, they published a book “Narrative Means to Therapeutic Ends” (1990),

describing the principles and techniques of the new approach in counselling, therapy, and community work. This new approach was called “narrative” because the metaphor of a “narrative” (story) is the main one used in it. Michael White offered the following definition: “A story-line is comprised of events in sequence across time organised according to a plot or theme.”

In each story, there is a character who has hopes, dreams and aspirations.

People describe their lives through narratives. All people have hundreds of stories about themselves. There are some preferred stories: they describe how people would like to see their own lives, the lives of their loved ones and the world around them. Such stories can show us what people appreciate, what they hope for, what their values are. For instance, we as social workers can tell our stories about how we came to this profession, stories about our work, when we are able to perform our professional duties in the best possible way, stories describing our ideal relations with clients, colleagues and managers. All those stories describe us as good social workers.

There are other stories, which can be called problem-saturated. They describe how people would not want to see things contradicting their intentions, dreams and principles in their lives. For instance, we all have stories showing how we could not do our work as we aspired, stories about exhaustion, conflicts, and bureaucracy. All those stories differ from our ideas about what the social work should look like.

There are always a lot of stories co-existing in people’s lives. In addition to the dominant story, there are also alternative or subordinate stories. There is not a single problem, which would take up a person’s life in its entirety: there are always some areas or aspects of life, which contain something else apart from the problem, some experience, which is not part of any story yet.

The stories, which bring people closer to achieving their goals and aspirations, are preferred stories. In this approach, the task of counselling is to help people create conditions for making their preferred stories come true.

So far, two books were published in Russian on various aspects of the narrative practice:

- Уайт М. Карты нарративной практики: введение в нарративную терапию. – М.: Генезис, 2010 [White M. Maps of Narrative Practice]. This is the last book written by Michael White. It describes the theory of the narrative approach and the techniques

used in it. When describing the narrative practice, Michael constantly refers to his own practical experience.

- Уинслейд Д., Монк Д. Нарративная медиация: новый способ в разрешении конфликтов. – М., 2009 [Winslade D., Monk D. Narrative Mediation: A New Approach to Conflict Resolution]. Though this book is dedicated to mediation (a method of conflict resolution through an intermediary), it will also be helpful to people providing professional counselling as it describes the basic techniques of the narrative approach. The book offers a wide range of examples in resolving different conflicts, including family conflicts.

There are rather many materials on the narrative practice available in Russian on the web:

- <https://narribrus.wordpress.com/> – narrative practices in community work. This is the main library of resources on the narrative practices. It contains both materials translated from English and articles written by Russian-speaking narrative practitioners;
- <http://narrativepractice.ru/> – website of the community of Russian-speaking narrative practitioners, offering updates on the new developments in narrative practices as well as a library and information about training opportunities;
- <http://www.narrative.ru/> – website of The Centre for Narrative Psychology and Practice.



The main English-language web-resource is website of the Dulwich Centre founded by Michael White: <http://dulwichcentre.com.au>. It offers a wide range of materials on various aspects of using narrative approach in different areas. The library contains materials in a variety of languages. Besides, the website contains materials of the online courses conducted by the Dulwich Centre and a collection of publications on the narrative practices.

2

*Specific features and risks  
of adolescence*



Adolescence is often called the age of transition, the stage of development when a person transitions from childhood to adulthood. At this stage, every individual has a number of development objectives. Before becoming adolescents, children normally master all the basic cognitive functions: writing, speaking, ability to take care of themselves, follow the rules and understand why it is necessary.

However, with the onset of adolescence something seems to break down: children start to misbehave, break the rules, be rude with adults or become withdrawn. Suddenly, they lose interest in their old hobbies and their new interests come and go.



## **PSYCHOPHYSIOLOGICAL DEVELOPMENT OF ADOLESCENTS**

Behaviour changes are often caused by hormonal changes. Adolescence is characterized by continued growth and puberty. Hormones take an active part in those processes. They influence people's mood and behaviour. Adolescents become more impulsive and hot-tempered or, vice versa, suffer from long periods of sadness. Hormonal imbalance can partially explain the fact that adolescents tend to engage in risky behaviours because at this stage they need more intensive stimuli to maintain their interest and feel joy. That is why they may give their preference to extreme sports, loud music or other stimuli causing strong emotions.

However, not only hormones play their role. The brain continues to grow, and in the period of adolescence prefrontal cortex is going through its most active development phase. This part of brain helps people achieve their long-term goals even if the process of their achievement brings challenges. The ability to put yourself in other person's shoes and empathize with other people is also related to the development of this part of the brain. Prefrontal cortex also controls instant desires and impulses. However, as paradoxical as it may seem, during this stage of active development the prefrontal cortex performs its functions worse than before: old neural connections weaken and new ones have not yet formed, so adolescents have less control over their behaviour than before.

Thus, intensive work of the brain areas responsible for hormonal transformation of the body, emotional regulation and motivation, on the one hand, and ineffective operation of the prefrontal cortex in charge of the behaviour control, social skills, building and

implementing long-term plans, on the other hand, cause the behaviours, which are considered typical for adolescents: impulsiveness, mood swings, changing interests, appetite for risk, rule violations, difficulties with long-term planning, etc. It makes an adolescent who studied music for seven years quit music school when there are just a couple months left till the final exam to get a diploma. That is why a quiet child who used to spend time reading books, reaching the age of adolescence, suddenly starts being rude to teachers, having arguments with parents and spending most time in the street with new friends or, vice versa, a cheerful child suddenly becomes withdrawn and spends all days in the internet. One of the hypotheses explaining why the prefrontal cortex stops performing its functions in adolescents who feel impulsive and emotional due to the hormonal transformation is that such imbalance is required to overcome difficulties, make decisions and follow them. When adolescents overcome difficulties, it allows the parts of their brain responsible for such functions to be formed or re-shaped. Some of the main tasks of this age is to develop empathy, learn how to cooperate, plan, define goals and control one's emotions.

At the same time, desire to experiment, risk, impulsiveness, mood swings, long periods of feeling depressed, and very intense emotions can become the risk factors causing various dysfunctional behaviours: substance abuse, mental health disorders, suicidal behaviours, self-harm, eating disorders, etc. This risk is aggravated with the problems coming from the previous development stages.

One of such problems increasing the risk of various dysfunctional behaviours is attention deficit hyperactivity disorder (ADHD). This disorder develops at early age and manifests itself in hyperactivity, restlessness, impulsiveness, and difficulty concentrating. It is associated with behaviour issues at all stages of human development as well as relationship problems. If the family and the child fail to receive qualified help, at the age of adolescence the child with ADHD often has low self-esteem due to problems with academic performance and dysfunctional relations both with peers and with significant adults. The child may learn to respond to any criticism with aggression or, vice versa, becomes withdrawn and quietly worries about his or her low performance. The child may find alternative ways of socialization, e.g. older friends in the street or in the web, who say that they understand the child's school problems and accept him or her as he or she is. All those consequences of living with ADHD significantly increase the risks of abusing substances, which can make it easier for the child to feel confident, give him or her the experience of positive emotions or mitigate the attention deficit (stimulants). However, in combination with ADHD such self-treatment method may lead to more

severe negative consequences, such as overdoses, traumas due to substance abuse, and higher risk of suicide and violence from the side of both peers and adults.

Another problem contributing to adolescents abusing psychoactive substances is depression. It includes long-term periods of feeling low and is associated with negative thoughts about oneself, other people, the world in general and one's future in this world. Depression leads to losing one's interests and low behavioural and social activity (even up to self-isolation). As strange as it may seem, depression can, on the one hand, serve as a protective factor in terms of substance abuse, because depressed adolescents may avoid contacts with peers, while buying and using drugs requires certain efforts and social activity. On the other hand, if such adolescents have access to drugs, they may use them to cope with their depression symptoms.

Besides, post-traumatic stress disorder symptoms and consequences of previous traumatic events (such as a loss, domestic violence or bullying) may also lead to adolescents starting to abuse substances.

Serious academic problems (dysgraphia, dyslexia, acalculia) can also strongly affect self-esteem, relations with peers, parents, teachers and aggravate the emotional problems typical for this age, with adolescents engaging in various dysfunctional behaviours, including drug abuse, to cope with their issues.

Previous emotional problems (impulsive reactions, emotional sensitivity, etc.) may severely aggravate at the age of adolescence, causing various dysfunctional behaviours.

There are several reasons why it is important to consider specific features of physical and psychological development of this age when working with adolescents.

Firstly, impulsiveness, mood swings, and risky behaviours of adolescents are rather a norm than a problem as they are related to physical and psychological development of human beings. In the period of adolescence, the task is to form one's skills to cope with challenges (for instance, the skills of emotional regulation, behaviour control and planning). Thus, it is essential to focus on building those skills in both individual and group work.

Secondly, physiological changes are also associated with some age-related tasks. In

the period of puberty, adolescents realize their gender and learn relevant social roles and norms. Puberty is also associated with the risks of STIs, pregnancy, sexual violence, etc. That is why it is important to support adolescents as they are growing, offer them emotional assistance and information about responsible behaviours, and help them acquire the required life skills.

Age-specific challenges are also aggravated due to the low level of education in sexual and reproductive health and rights (SRHR). Among adolescents, there are a lot of false beliefs and myths about sexual life. Adolescents (as well as many adults) tend to carelessly trust their partners and avoid thinking about any possible risks. That is why access to condoms and information about sexual and reproductive health are essential components of working with adolescents.



*“Many boys think that only girls need to care about their sexual health, for boys it is not important” (project client).*

*“When you have a regular partner, you don’t have to use condoms. Many people think it is true” (project client).*

Thirdly, when working with adolescents it is important to take into account that at this age dysfunctional behaviours may help to resolve the problems of previous development stages. To help adolescents overcome their problems (e.g. related to substance abuse), it is important to understand what challenges psychoactive substances help them to overcome.



## **AGE-SPECIFIC TASKS RELATED TO THE FAMILY**

Another task of adolescence is gradual separation from the family and gaining autonomy. The paradox is, however, that adolescents at this stage of their life still depend on their families both financially and mentally. Parents’ role in providing emotional support to their children is less significant, but still relevant. Adolescents want to make decisions and buy things on their own, but often they lack the required knowledge, financial

means or skills to do so. Parents and other family members have to support adolescents' pursuance of autonomy, on the one hand, while helping them in making decisions, on the other hand.

If family remains a place where adolescents can experiment, try new social roles, and learn skills, their chances to successfully go through this stage of their development increase. Family can be a reliable source of support for adolescents, if it helps them to follow the existing rules and learn new ones, related to their changing role in society, offers emotional support, respects and promotes their autonomy. At the same time, there can be additional risk factors associated with the family environment, which can make the challenges of adolescence worse and lead to various dysfunctional behaviours.

One of the risk factors, deepening the problems with the behaviour of adolescents, can be the guarding and controlling style of upbringing in the family. This style offers much fewer opportunities for the development of autonomy and decision-making skills. In some cases, it can cause protesting behaviours and ruin emotional connections in the family.

A cold and detached parenting style is also associated with high risks. Adolescents lose their possibility to get emotional support from their families and have no one to turn for advice to. It can lead to adolescents looking for help and support in other places.

Contradictory style of upbringing, when one family member prohibits certain things while others allow them or when the same family member behaves as a strict and caring father one week, but allows everything the next week, is also a risk factor as in such versatile environment it is difficult for adolescents to find support in building their vital social skills. In such conditions, adolescents may learn to manipulate people, waiting for the right moments to get what they want from others and avoid any consequences of their behaviour.

Mental health problems in one of the parents, their abuse of drugs or alcohol, poor economic situation of the family contribute to dysfunctional behaviours among adolescents. However, the most harmful risk factor is domestic violence against either adolescents or other family members. Violence ruins relationships (in particular with peers), self-esteem, makes adolescents feel hopeless and unsafe and affects their academic performance. Violence can be one of the decisive factors, pushing adolescents to suicides, self-harm, substance abuse, etc.

Substance use can become a form of protest against excessive limitations in the family, against treatment not comfortable for adolescents or their way to cope with negative emotions.

That is why to make interaction with adolescents more effective, it is important to engage families in the change process. An additional focus when working with adolescents can be on changing the relations inside their families, developing their parents' competences, etc.



## **TASKS RELATED TO COMMUNICATION WITH PEERS**

In the age of adolescence, relations with peers as well as relations with the family, change. Peers become the main reference group for adolescents. Their opinion on the key life choices becomes more important than the opinion of parents, teachers or other adults. Self-esteem of adolescents strongly depends on the external assessment of their peers. If provocative behaviour at school is criticized by teachers, but welcomed by classmates, most likely the adolescent would choose to continue behaving this way, despite the possible consequences.

Inclusion in a social group, which supports the development of emotional and social skills, hobbies and interest to various aspects of life, can be a powerful factor allowing to overcome the challenges of adolescence. However, a group of peers can also be a risk factor, if it supports various types of antisocial behaviour. Social exclusion, lack of support, violence or bullying from the side of peers can aggravate the problems related to this stage of development, intensify depression symptoms and lead to self-harm, suicidal behaviour or experiments with drugs.

In practice, it is vital to take this context into account. That is why many programmes for adolescents use group activities as their main format of work. With this in mind, it is important to ensure a sufficient level of security for adolescents in a group. Adolescents can be divided into groups based on their gender, when discussing delicate topics, for instance reproductive health.



*“Yes, it would be easier if I as a boy could discuss boys’ stuff with other boys, and girls – they have their own questions” (project client).*

At the same time, it is important to try and engage both boys and girls in joint conversations. Most our clients support such format of discussions.



*“It is important to give girls more information about boys and give boys more information about girls and about relations between them” (project client).*

*“Such division brings stereotypes and bullshit, we should talk about everything all together. For example, periods are considered to be a girls’ topic. But if people have relations, why does he go to buy her pads? Division is not right” (project client).*

*“I am for equality, for me there should be no division, but some teachers suggest to divide us if there is a request, but usually it is all the same. I think that boys should hear about girls’ issues and vice versa. Division is needed only if people ask for it” (project client).*

*“We have to understand not only ourselves, but also each other” (project client).*

It is also important to consider that adolescents may engage each other in dysfunctional behaviours, so group participants should be carefully selected and divided depending on the degree of their problematic behaviours. For instance, if an adolescent who has never tried drugs, but has risks in terms of starting drug use, happens to be in a group of other adolescents who are active drug users, it will increase his or her chances to start using drugs and will affect the outcomes of social work.

Apart from real interactions, virtual interactions also play an important role for adolescents. According to the recent Social Inclusion, Digitalisation and Young People research study run by the Council of Europe in 2020, only 1% of young people all over the world never had access to internet, while 95% of adolescents use internet every day and 89% of them do it from their mobile phones. In the modern world, adolescents meet each other, interact, flirt, build relations, play games, buy products, follow news and updates online, and because of the COVID-19 pandemic they also study online. Social networks and messengers are extremely popular sources of communication and entertainment. In 2020-2021, the most popular ones in Ukraine were Instagram, Telegram, TikTok, Viber, and Youtube.

Civil society and governmental organisations should use the opportunities of social networks and digital spaces to offer online services for adolescents. Working with adolescents in social media opens a lot of opportunities for social workers, such as:

- attracting new audience to visit web-pages of the organisation and its projects;
- informing new clients about the services available;
- maintaining regular contact with adolescents;
- providing online counselling and other online services.

Besides, active use of smartphones by adolescents creates a space for applying creative approaches, using new channels to deliver essential information to adolescents and offering online consultations. One of the examples is an app for adolescents called Free2Ask. It has a range of functions: online chat with various professionals, interesting and useful content, engaging games. This app allows adolescents from any part of Ukraine not only access helpful information about SRHR and PAS, receive online consultations of psychologists and other experts, but also find the addresses of youth-friendly services nearby.

Though internet offers vast opportunities for self-development, seeking support and

communication with people who are far away, it is important to familiarize adolescents with the risks of virtual interactions.



*“Friends are extremely important for adolescents, and it is not important where they are – in the real or in the virtual world. The main thing is that the adolescent does not understand if it is a friend or just an acquaintance” (project psychologist).*

You can find more information about how to teach adolescents about internet security in the series of lectures:

- Alyona Kryvuliak. Safe relationship with a person we love: lecture for adolescents (available in Ukrainian and Russian): <http://afew.org.ua/krivulyak-alona-bezpechni-stosunki-z-kohanoyu-lyudinoyu/>;
- Alyona Kryvuliak. Rules of online relationship security. A few words about cyberbullying and sexting (available in Ukrainian and Russian): [http://afew.org.ua/krivulyak-alona-pravila-bezpeki-stosunkiv-v-onlajni-kilka-sliv-pro-kiberbuling-ta-seksting](http://afew.org.ua/krivulyak-alona-pravila-bezpeki-stosunkiv-v-onlajni-kilka-sliv-pro-kiberbuling-ta-seksting/);
- Anastasiya Dyakova. Children’s safety in the internet (available in Ukrainian and Russian): <http://afew.org.ua/dyakova-anastasiya-bezpeka-ditej-v-interneti/>;
- Olena Chernykh. Internet security for adolescents (available in Ukrainian and Russian): <http://afew.org.ua/chernih-olena-bezpeka-pidlitkiv-u-merezhi-internet/>.





## **CHOOSING THE PATH IN LIFE AND THE ROLE IN SOCIETY**

Human values also develop. Adolescents start thinking about who they are, what their mission is, what is important for them in life. Formation of values is one of the tasks at this age: values and self-perceptions help adolescents make conscious choices about their further education and their path in life. Significant adults play an important role in supporting this process. Those can be parents or other family members, teachers, sports trainers or favourite singers. They can facilitate this process directly. Besides, significant adults may help adolescents to define their life goals and values (through reading books, self-exploration, etc.)

Belonging to certain communities also helps adolescents in defining their values. That is why at this age it is so important for adolescents to belong to youth subcultures, which help them define and express what is important for them. The more intensive social life of adolescents is, the more opportunities for self-identification they have. Vice versa, the more excluded from society adolescents feel, the more difficult for them it is to cope with this age-specific task. Anxiety about their own future, difficulties with self-determination, losing the purpose in life can lead to various problematic behaviours: depression, self-harm or using psychoactive substances.

That is why, when working with adolescents, social workers should take into account social and cultural context of their development and, if possible, engage a “support team” – people who can act as role models for adolescents, help them define their values and priorities in life.



## **SPECIFIC FEATURES OF DRUG ABUSE AMONG ADOLESCENTS**

The patterns of drug abuse among adolescents can be very different from those among adults. Adult drug users mostly continue using drugs because of their drug dependence symptoms. They need to use drugs to cope with their abstinence syndrome, satisfy their cravings and be able to function. Among adolescents, the motives of drug use are most often associated with their emotional problems, when drugs become the way to reduce the intensity of such problems. Adolescents can also

start experimenting with drugs under the influence of external social factors. They use substances inconsistently, try substances from different categories, use whatever they can get, and mix different substances. Such patterns of substance use can be associated with the risks of intoxication or overdose. As opposed to adult drug users, adolescents who use drugs do not have the required skills to reduce their risks of overdose. It is difficult for adolescents to access drugs, so they often use low quality substances or fake drugs. When using drugs, adolescents often lose control and become an easy target for robbery, sexual abuse or violence. Though adolescents relatively rarely have addiction symptoms, the use of alcohol and drug has a negative impact on their lives. Drug abuse intensively interferes with their physical and mental development process as it affects the parts of brain, which are responsible for motivation as well as regulation of sleep, mood and eating behaviours. Besides, drug abuse affects their health, increasing the risks of traumas, infectious diseases, and intoxication. Drug abuse has a strong impact on the social life of adolescents: it ruins family relations, provokes domestic violence, decreases academic performance, and changes the social circle of adolescents. Drug abuse engages adolescents in illegal activities – selling and buying drugs, robberies, violent crimes. All those things can greatly affect the life trajectory of adolescents.

Thus, when working with adolescents, social workers should view the problem of drug abuse through the lens of its origin, analysing personal, family-related, social and cultural risk factors. The work should be planned bearing in mind the real risks of drug abuse for the health and development of adolescents as well as its impact on their social well-being. If possible, it is important to engage the family, the school and other parties associated with the problem.



*“It is important not to moralize, but to speak about the facts, offer accurate information and give them tasks so that [adolescents] can feel their significance, talk to them on equal terms, use the language they can understand and consult with them” (project social worker).*

Webinar series on working with adolescents (available in Ukrainian): [www.youtube.com/watch?v=n-B\\_NIYg6mk&list=PLs57iPzjbQtW0fT7mNUh2PxzTM4CdPgeK](https://www.youtube.com/watch?v=n-B_NIYg6mk&list=PLs57iPzjbQtW0fT7mNUh2PxzTM4CdPgeK).



Brochure about adolescence (available in Ukrainian): <http://knowledge.org.ua/uk/buklet-pidlitkovij-vik-zapitannja-i-vidpovidi/>.



Lecture by Natalia Pashko. “Manifestations of aggression in adolescence: factors of origin and organisation of care” (available in Ukrainian and Russian): <http://afew.org.ua/pashko-nataliya-proyavi-agresi-v-pidlitkovomu-viczi-faktori-viniknennya-ta-organizacziya-dopomogi/>.



# 3

## *Goals of working with adolescents*



The practitioners working with adolescents who use drugs define the goals of their interventions in very different ways. However, clear understanding of why we work with an adolescent, his or her family or a group of adolescents will define which methods we are going to use, how intensive our support would be and how we would assess the results of our work. So, before you continue reading, please try to answer this question: what is your goal in working with adolescents? What is a good outcome in working with them and what is not? Honest responses to these questions will allow you to realistically gauge your power, critically manage your expectations and maybe look at the challenges in relations with adolescents from a new perspective.

The goals of working with adolescents who use drugs are different from the goals of working with adult drug users. This is first of all related to the age-specific tasks of adolescents, which cannot be ignored when engaging with them. When working with adults who use drugs, practitioners focus on overcoming their addiction or reducing its negative consequences, while when working with adolescents the main focus should be shifted from coping with specific problems to developing the key life skills – emotional regulation, problem solving, future planning, and communication skills. Alongside with practising risky behaviours, adolescents continue developing, learning and socializing. We cannot put those processes on hold. Their social context is critical. If adolescents have to spend long periods of time in a correctional institution or a treatment facility, they continue their development and acquire the skills needed to live in closed facilities, while their skills and knowledge necessary for independent life are underdeveloped. That is why when working with adolescents it is essential to create supporting social environment for their social adaptation and development. The key element here is people who take care of adolescents and their friends, so programmes aimed at adolescents should be built with the engagement of their families and close social environment.

However, in the short term it is important to help adolescents who practice risky behaviours to maintain their health and reduce the harms associated with such behaviours as much as possible. The risks of overdoses, poisoning with unknown substances, facing violence or getting infected with various diseases when using drugs can be much higher for adolescents than for adults. Thus, the first step when starting to work with adolescents who use drugs can be implementing harm reduction interventions: providing information and means to reduce the risks (in particular in terms of getting infected with human immunodeficiency virus (HIV), hepatitis and other infectious diseases) and manage the consequences of overdoses. Meanwhile, long-term efforts should be focused on supporting adolescents and their families in the process of

their development. As it was mentioned above, such support helps not only overcome the existing issues, but also reduce the risks of problematic behaviours in the future (such as suicidal, criminal behaviours, substance abuse, and chronic unemployment). That is why social work with adolescents almost always includes preventive components.

Among practitioners, the term “prevention” is associated with the interventions aimed at preventing the start of drug use among adolescents. Most often prevention means informing adolescents about the negative consequences of drug use and conducting campaigns promoting healthy lifestyles. However, there is no evidence that such information has any impact on drug-using behaviours or that it is helpful for everybody.

Modern prevention approaches are aimed at helping children and adolescents in developing their knowledge and skills to overcome emotional challenges, resolve problems in their relations with peers and survive in the existing social and economic conditions.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) offers the following definition of prevention: prevention is evidence-based socialization where the primary focus is individual decision making about socially appropriate behaviours.

The purpose of prevention can be not only abstinence, but also delayed start of substance use (especially for alcohol), reduced intensity of substance use or prevention of transition from substance use to substance abuse. That is why preventive measures can also be targeted at adolescents who use drugs.

Classification of the interventions used by the EMCDDA contains a number of mutually supportive types of prevention. Such classification is based on the concept of vulnerability to risk factors. Modern research studies show that it is not possible to specify one leading factor contributing to the development of drug dependence. There is a combination of factors (described in the previous section), which define the probability of drug dependence, contributing to it or acting as protectors.

Depending on the impact of risk factors, prevention interventions can be universal (aimed at all the members of a target population regardless of their risks), selective (aimed at specific risk groups) and indicated (aimed at adolescents with high risks). Most prevention strategies regardless of the type of prevention are aimed not at analysing the roots of problems but rather at finding resources, developing life skills and planning future steps. That is why strengths-based approaches can be effectively used as prevention tools.

**Universal prevention interventions.** Such interventions are aimed at big populations and are targeted at building the skills to solve problems, communicate with peers and adults and at forming pro-social values.

**Selective prevention interventions.** The target audience of such interventions is vulnerable populations: e.g. children who skip school, juvenile offenders, children who experienced abuse, etc. Selective prevention interventions may include a huge number of techniques described in these guidelines.

**Indicated prevention interventions.** Such interventions include, on the one hand, working with children and adolescents with high risks of substance abuse (children with adaptation and behaviour disorders), and, on the other hand, working with adolescents who already use drugs, but who cannot be diagnosed with “drug addiction” yet. Indicated prevention usually stipulates implementation of an individual support programme based on a client-oriented plan. The main task of such programme is for the adolescent to acquire the skills of problem solving, decision making, mobilising social resources, etc. That is why indicated prevention interventions may include strengths-based approaches.

In practice, it is difficult to differentiate indicated prevention interventions for adolescents experimenting with drugs from early interventions and even from treatment of substance use disorders. Early interventions stipulate support at the early stages of substance use disorders, and treatment interventions – helping adolescents with the diagnosis of “drug addiction.” Such programmes usually combine individual interventions with family and group interventions. The differences are about the intensity of support provided, not its essence. Treatment programmes more often include inpatient assistance, while early interventions and indicated prevention programmes can be implemented in outpatient settings. Regardless of their intensity, such programmes may have very similar goals: they help adolescents build pro-social and problem-solving skills.

Summarizing the above, the goals of working with adolescents, regardless of the issues they are facing, can be defined as providing them support in overcoming those issues, maintaining their health and social resources, developing the skills necessary for their future independent living, defining their long-term aims and helping them start acting to achieve them. When planning interventions, it is important to view the issue of substance use and its possible solutions in a wider social context. The tasks of helping adolescents to adapt at school, find hobbies, engage in extracurricular activities are not less important in the process of social work than dealing with substance abuse.

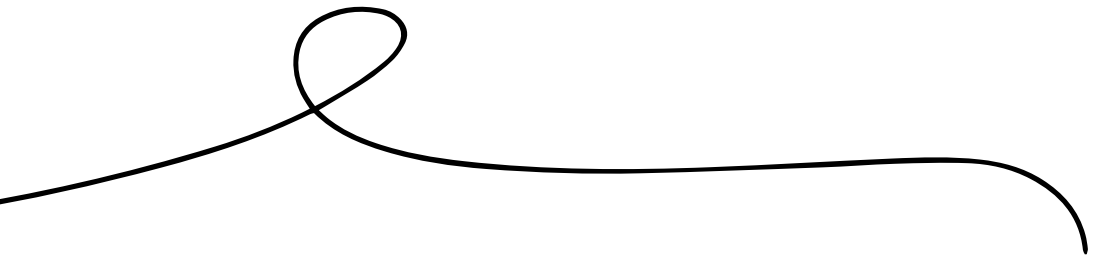
However, defining the goals of our work, we need to coordinate them with the adolescents as social workers can address only the issues the adolescents agree to address, otherwise any interventions will cause resistance from the side of clients. More detailed information about the strategies of addressing motivation and resistance is provided in the section “Motivation to Behaviour Change.”



*“If a client comes to us with a request to reduce the frequency of use, how can we build a request for abstinence? It will never happen, if the client does not want it” (project psychologist).*

4

## *Motivation to behaviour change*



Motivation to behaviour change is one of the central questions for the professionals working with adolescents who use drugs. If you are no exception, before you continue reading ask yourself: “Why is motivating people to change their behaviour so important to me?”

Some of your colleagues would respond that it is not possible to help adolescents change their behaviour if they do not want to. Others would say that many methods and techniques used in social work are based on the consent of adolescents to change and fully contribute to making changes happen. The problem is they don't want to! They don't want to do what we tell them to do, what they promised to do and even what they tried to do. We offer them opportunities to change their behaviour, live interesting lives, learn how to resolve conflicts, improve their relations with their families and so on. Then suddenly they fail to come to classes. Later we find out that instead of coming to the class they were sitting on a bench and drinking alcohol with their friends. Police detained them. It led to some of them having arguments at home. We hope that when they come to class next time, we will together discuss the consequences of alcohol use. But they fail to come again! They continue engaging in risky behaviours, despite all the negative consequences!

Why? This is an essential question not only for people working with adolescents but for any practitioners trying to address chronic behaviour-related disorders. Health psychology offers a number of theories to explain the factors contributing to people's motivation to change health-related behaviours. One of the most influential theories is the health belief model (Rosenstock, 1974). According to this model, the probability of behaviour change depends on a number of factors. The first one is **perceived susceptibility**: the probability of adolescents abstaining from smoking marijuana is affected by the extent to which they believe they risk to face problems because they use marijuana. Usually, it is difficult for adolescents to imagine the consequences. They seem very far and not likely. Information about possible negative consequences currently accessible to adolescents is rather contradictory, it is most often presented in an abstract form and describes the consequences, which may happen in a very long-term perspective. At the same time, the opportunity to have a laugh with friends, enjoy food and music is seen by an adolescent as a direct and significant positive effect. That is why adolescents usually underestimate their susceptibility to drug-related problems.

The next factor is **perceived severity** of risky health-related behaviours. If adolescents do not notice any negative consequences of marijuana use or associate such negative consequences only with other factors (e.g. consider that the problem is punishment

for drug use but not the use itself), the probability of changes will be considerably lower. Another factor influencing health-related behaviours is perceived benefits. If adolescents can see and appreciate the benefits of smoking, while not seeing any benefits of quitting smoking, the probability that they would decide to quit smoking is very low. Trying to motivate adolescents to change their behaviour, practitioners often talk about having a family, getting a good job and respect from other people as possible motives to change risky behaviours. For an adolescent, such arguments are very abstracts. Due to the specifics in the development of nervous system at this age, described in previous sections, delayed abstract benefits do not motivate adolescents. It is hard for them to imagine their future, to set their goals and make consistent steps to achieve them. For them, it is vital to see the direct result of their actions. That is why, considering age-related characteristics of adolescents, to motivate them it is important to focus on the benefits of their new behaviours that they will see right away.

**Perceived barriers** also influence the probability of change according to the health belief model. If adolescents believe that it will be hard for them to change their behaviours, that they will face a lot of obstacles in the process, that if they quit smoking they will lose something important in their lives while getting some unknown benefits, they would most probably not make any steps to change. Besides, health-related behaviours are influenced by motivation to be healthy as well as external and internal cues. External cues may include, for instance, social pressure from the side of law enforcers or support of family members.

A well-known psychologist of the Ukrainian origin Albert Bandura, studying motivation to behaviour changes together with his colleagues, developed a social cognitive theory of health motivation (Bandura, 1986). According to this theory, health motivation is defined by self-efficacy and outcome expectations. Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. Self-efficacy, in its turn, can be defined by previous experience of successes or failures in performing complicated tasks, supportive or degrading, criticising relations with close people, knowing that adolescents have the required skills and can achieve the expected results. Previous experience of adolescents who use drugs often has a negative impact on their self-efficacy. They don't even start acting as they do not believe that they can change or achieve any positive outcomes.

In the theory of planned behaviour (TPB) developed by Icek Ajzen (Ajzen, 1991), the focus is on the power of **intention to change behaviour**, which, in its turn, depends on the individual's perception of the normative pressure from and attitudes of significant

others, subjective norms related to disruptive behaviours as well as beliefs about any factors enabling or disabling the change. Another important notion in this theory, which is conceptually related to the notion of self-efficacy, is **perceived behavioural control**, perceptions on whether it is easy or difficult to exercise the behaviour necessary for change. According to this theory, the probability of behaviour change is the dependence of behavioural intention on subjective behaviour control: an intensive behavioural intention leads to behaviour change only in case of high perceived behavioural control, and vice versa. Coming back to the adolescents who use drugs, we can assume that perceived normative pressure from the social environment and subjective perceptions of the drug using norms can act as significant barriers on the way to forming behavioural intentions. If adolescents see that most of their friends smoke marijuana and their parents drink alcohol when they feel low or face any problems, it is not probable that they will have intentions to quit drugs or alcohol. In contrast, if adolescents believe that all people around are against smoking, that they can talk to their friends and family members when they feel bad, as their parents do, it can help them start their way to change. However, intention is not enough. It is important for adolescents to realize that they have all the necessary skills and resources to change their behaviour.

Generally, we can say that to build and grow confidence, people need to have analysis, reflection and planning skills as well as the ability to implement their plans. Besides, they need stable self-esteem and confidence in their own abilities. All those things fall within the responsibility of prefrontal cortex, which, as we have seen in the previous section, does not work properly in adolescents, especially those who use drugs. Acting inconsistently and impulsively, underestimating risks, overestimating one's own abilities – all those things are normal for adolescents. Drug use, in its turn, aggravate all those qualities. Taking into account all of the above, in practice it does not make sense to expect that adolescents will have a stable motivation to change and make motivation the key and mandatory pre-condition of change. Instead, it is important to help adolescents learn how to analyse the situation, assess the real risks for their health and the possibility of negative social consequences, consciously choose their path in life, build their personal values and rely on them when setting further goals, support their self-esteem based on their strengths and limitations, etc. When we assist adolescents in developing those skills, we help them build their motivation to change. Professionals working with adolescents can say: "We offer them to build their skills and they don't want it!" They are right. Many adolescents, especially if they were brought to get professional help against their own will (e.g. referred by the probation service), refuse to engage in group activities to build the skills which would be helpful for them. Why?

This phenomenon can be explained with the help of another influential theory in the psychology of behaviour change – transtheoretical model (TTM) of behaviour change by James Prochaska and Carlos DiClemente (Prochaska, DiClemente, & Norcross, 1992). In this theory, behaviour change is viewed not as an event, but as a long-term process, with an individual going through certain stages of change and at each of those stages performing specific tasks, which help the individual transition to the next stage.

The process of change starts with the stage of **pre-contemplation** or **pre-intention**. At this stage, people are not thinking that their behaviour has to be changed. They are fine with the situation. They see a lot of positive effects of their current behaviour, ignoring its negative consequences and possible risks. Most adolescents who recently started using drugs are at this stage of change. They are excited about drugs, tell everyone around that all people say about the harm of drugs is not true and respond to any attempts to change their mind aggressively. When social workers meet adolescents at this stage, they often feel powerless and desperate. However, this phase is a natural part of the process of change and the social worker can help the adolescent to move forward in the process of change. For a start, practitioners should stop trying to change the beliefs of adolescents. It does not work. Most often such attempts to argue with an adolescent lead to such adolescent deciding not to talk to the social worker anymore. At this stage, it is vital to focus on building relations with adolescents without focusing on their problematic behaviours. In practice, counsellors can build cooperative relations with their clients using the basic skills of reflective listening. It is critical to demonstrate sincere interest to the adolescent's life. The counsellor can start talking about the areas of life, which are not affected by the problem, trying to find out as much as possible about the client's strengths, about the problems he or she has already been able to resolve, about his or her interests and achievements. When relations are established, the counsellor can share information about the consequences of problematic behaviours in a neutral way. Of course, it should happen only if adolescents give their consent to receive such information. It is important that such information should be evidence-based, emotionally neutral (without any threats or intimidation) and preferably age-specific and time-specific (about the drugs widespread among adolescents today using the language used by adolescents). The main purpose here is to plant a seed of doubt and help the clients critically assess the possible consequences of drug use.

As soon as an individual has any doubts about the unconditional benefits of problematic behaviour, such individual moves to the **contemplation stage**. The main purpose of this stage is to look at the “pros” and “cons” of change and make a decision to change the behaviour. Here the counsellor has more opportunities to act to help the adolescent

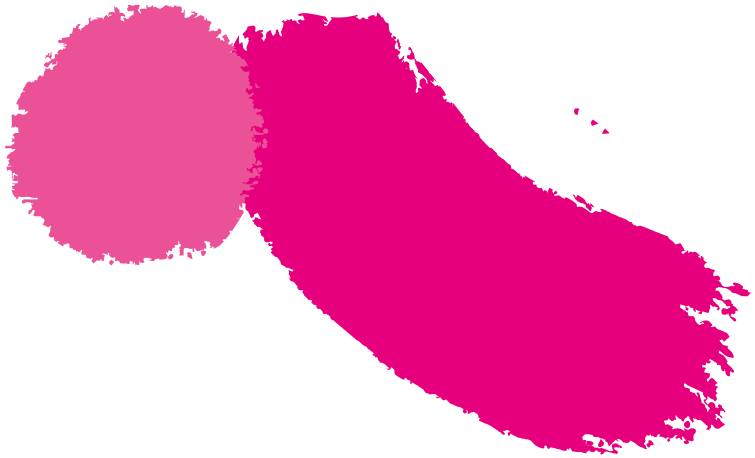
to change his or her behaviour. As before, it is critical to avoid direct pressure, which can lead to resistance and throw the adolescent back to the previous stage. Supporting contemplation, we can give our clients accurate information, help them consider all pros and cons, offer social support and help them re-evaluate their strengths and opportunities for change. This stage can be rather long but it is important not to force changes.

Reconsideration of problematic behaviours and one's own opportunities to change increases motivation to change. At some point, adolescents decide to try and change their behaviour – that is where the preparation stage starts. This stage is called this way because the attempts to change the behaviour may be minor: adolescents try to smoke less, sometimes quit alcohol or try to stay sober for several days. At this stage, support and reinforcement of change are critical. Adolescents assess the effects of change and the steps needed from them to implement the change. If they realize that they can make the change happen and that such change will make their lives better, they start to act. At the **action stage**, adolescents actively learn new skills and cooperate with counsellors. Counsellors usually enjoy working with the adolescents who are at this stage as they not only do what counsellors offer them to do, but actively engage in the process on their own. Those are the motivated adolescents we all dream about. However, we have to remember about the age specifics: though at this point adolescents demonstrate high motivation, when they face challenges they may lose their interest in change or go back to substance use under the pressure of their social environment as they are afraid to lose their friends. Or after looking at the outcomes achieved, adolescents can decide to stop acting and have a relapse. However, if they can go through this stage, they transition to the **maintenance stage**. At this stage, they do not need so much effort to change, but they still have to act to maintain the results. For instance, it is important for them to continue avoiding places, friends and other triggers associated with drug use, taking good care of their physical and mental well-being, and doing the things they like to do. Counsellors have a lot of things to offer adolescents at this stage of change: they can support their new interests, help them build supportive relations with the people who help them change, learn planning their future and so on. Though their problem is now in the past, it is essential to continue working with such adolescents.

Thus, motivating people to change their problematic behaviour is a complex and multidimensional process, which is further complicated with age specifics of adolescence. However, building on the stages of the change process, counsellors can effectively help even those adolescents who actively resist change to move forward.

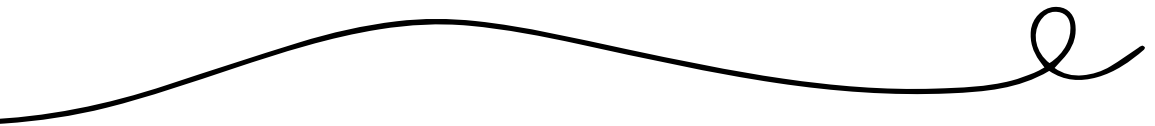
You can learn more about how to work with the adolescents who use drugs and are forced to seek help in the lecture of Arseniy Pavlovsky (available in Russian): <http://afew.org.ua/pavlovskij-arsenij-konsultuvannya-pidlitkiv-yaki-vzhivayut-narkotiki-i-zvernulisya-po-dopomogu-nedobrovilno/>.





# 5

## *Stages and tools in working with adolescents*



In our project, we roughly divide our clients into those who seek one-time (low-threshold) services and those who enrol in high-threshold programmes right away or after a while. “One-time” clients most often seek some information, e.g. they want to know where they can access help or get tested for HIV, get condoms or just hang out and spend time in a safe space. Usually they do not demonstrate a desire to fundamentally change their life and are not ready for to take consistent steps to achieve such change. Counsellors have to resist the temptation to tell such adolescents what they need to change in their lives and what goals they need to set for themselves. It is important for social workers and psychologists to address those questions and tasks, which the client is ready to address at the moment. If the client only wants to learn his or her HIV status, do not insist on doing more but inform him or her about other services offered at your site. When the client is ready, he or she will come to you. At the same time, it should be mentioned that not all people can easily define and openly voice their concerns. Be attentive to what your client is doing and saying. For instance, if the client is telling you a story of his or her friend, asking how their problem can be resolved, it is very probable that the client is actually speaking about himself or herself. The topics that your clients offer for discussion or their arguments with peers at your site can also tell you what their biggest concerns are.

Though even one visit to your organisation can have a positive impact on the lives of adolescents, at certain point many of them express their readiness and desire to get something more than a couple of services. Depending on their goals and our resources, we can offer such clients to enrol in a case management or rehabilitation programme or, if necessary, combine those two programmes.

Most people working in the social sphere are quite well aware of case management programmes. Usually, such programmes are aimed at helping clients who are facing a certain problem or who find themselves in a difficult situation. For instance, case management can be offered to the adolescents who commit offences or start using drugs. Clear definition of the target group of such intervention allows counsellors to plan the necessary social services and build partnerships with the organisations providing such services. Case management programmes can be targeted at resolving clients’ problems or at preventing certain behaviours. Traditionally, case management interventions are mostly aimed at resolving certain problems, i.e. they remain problem-oriented. When building rapport with the client, conducting an assessment and managing the client’s case, social workers mostly focus on the client’s problems and often do not pay attention to the individual. It can negatively affect the client’s motivation, leading to passivity and hopelessness. Such situation can be avoided if case management relies on using the strengths-based techniques and approaches. We will describe them in detail below.

While case management programmes are aimed at reaching different targets, such as seeking medical help, improving academic performance or economic situation, getting assistance in obtaining documents or social benefits, rehabilitation programmes are exclusively targeted at changing behaviours in the context of drug use. People engaging in rehabilitation programmes can set a goal to quit drugs or to reduce the dose or the frequency of drug use. A client can be engaged in case management and rehabilitation programmes at the same time. You can learn about two variants of the rehabilitation programmes here: <http://afew.org.ua/en/standards-of-correction-program-of-adolescents-deviant-behavior-at-the-age-14-18-years-who-have-experience-of-psychoactive-substance-use/> or here: <http://afew.org.ua/prezentovano-programu-reabilitaczi-pidlitkiv-yaki-zlovzhivayut-abo-znahodyatsya-v-zalezhnosti-vid-psihoaktivnih-rechovin>.



Both programmes usually last from 3 to 12 months. The time limits are tentative as individual programmes can be shorter or longer depending on the client's needs and requests. In any case, we always look at the client's needs and do not limit his or her opportunities to seek more help. When clients seek help, even repeatedly, it always demonstrates their positive skills in resolving their problems and may serve as a basis for achieving further goals.

It should be noted that regardless of the fact if a client enrolls in a case management programme or comes to the organisation only once, he or she should always receive a basic package of services: information about the services offered by our organisation, basic risks and needs assessment, an opportunity to get tested for HIV with a rapid test, informational materials and condoms. To assure the quality of services offered within the project, we developed standards of the integrated packages of services. You will get more information about such standards in the section "Monitoring and Evaluation of the Quality of Services."

Regardless of the goals, work with any client can be roughly divided into the following stages: establishing contact, identifying the client's needs, defining the goals of work and developing an action plan, implementing the action plan to change behaviour or resolve challenging situations, evaluating the results and (if needed) correcting the plan. Below we will discuss each of those stages in more detail and will offer some tools, which can be used at each of them. Distribution of tools by stages is offered for convenience only as most of them (with minor modifications) can be applied for different purposes. We will point out it in the description of certain tools.



## STAGE 1. ESTABLISH CONTACT

Tools and approaches to establish contact with a client greatly depend on how the client came to you. Though participation in our programmes is always voluntary, our clients are often referred to us by our partners, such as juvenile prevention departments or psychologists from vocational schools, or are brought by their parents. Such clients are usually cautious about any services we offer them, so the main task for counsellors at this stage is to build trust with them. Our experience shows that the best way to reduce the anxiety of new clients and build trust is to engage “experienced” clients or peer consultants. That is why we often have trained young people who are the first to meet new clients, tell them about our site, about the services we offer and about other important things. You can read more about how you can train and engage community leaders in your projects in the section “Developing the Leadership Potential of Adolescents.” There are also some recommendations on working with “forced” clients in the section “Motivation to Behaviour Change.”

In some cases, before building contact with a client the social worker may learn the client’s story from the documents provided by partners referring the client to seek help. However, such documents usually contain a lot of information about the client’s problems (diagnoses, offences, risk factors, etc.) but do not contain much information about the client’s strengths, resources, interests, hopes or dreams. Knowing such things could help the social worker to build trust with the client, starting their interview with what the client likes, is interested in or is good at. Besides, it is important to understand what changes people who refer the adolescent to the social worker expect to achieve. To find it out, the social worker can hold previous interviews with such people asking them some questions about the client:

- *How could our services help this family?*
- *What did the child and the family do well during any previous interventions?*
- *What are the strengths of this family?*

People referring the adolescent for counselling can also be asked what clients and their families already tried doing, but it failed to help them. Answers to such questions will allow, when developing an action plan, to take into account previous experience of the client and focus on what can work, not trying to repeat what does not work.

## SOME TOOLS THAT CAN BE USED AT THIS STAGE



### “SELF-PORTRAIT”

This exercise can be offered for a group of participants to get acquainted.

All participants sit in a circle. They are all asked to describe themselves speaking on behalf of a third person. For instance: “Nina is a short girl. She is 14. She has dark hair and green eyes. She wears glasses.” After a short description of appearance, the participants should describe their character. Other participants can ask questions to clarify some details or to learn more about the third person presenting the description.

There should be a moderator coordinating self-presentations as well as questions. Questions should be relevant, should demonstrate interest in the person who is to answer the question and should aim at learning more details.



### “MY UNIVERSE”

This exercise can be done both individually and in a group. The main task is for the participants to get to know each other, help them open up and learn the skills of self-presentation.

For this exercise, the participants will need A4 size paper, pencils or felt-tip pens. Each of them should take a piece of paper and draw a sun in the centre, writing a big letter “I” inside the sun. Then they should draw lines from the “I” circle – centre of their universe – to stars and planets (all stars and planets should be drawn and called continuing the sentences below):

- *My favourite thing to do is...*
- *My favourite colour is...*
- *My favourite animal is...*
- *My friend is...*
- *My favourite sound is...*
- *My favourite smell is...*
- *My favourite game is...*

- *My favourite clothes are...*
- *My favourite music is...*
- *Most of all I like to...*
- *My favourite place is...*
- *My favourite heroes are...*
- *I feel that I am capable in...*
- *The person I respect most is...*
- *Best of all I can...*
- *I know that I can...*
- *I feel confident because...*

After the participants finish their drawings, they fix them in their chests and randomly move around the room looking at other people's "universes."

The moderator points out that the participants' "star maps" show that they all have many opportunities, have things in common and things which are unique.



## **STAGE 2. DEFINE THE CLIENT'S NEEDS AND ASSESS HIS OR HER SITUATION**

Strengths-based situation assessment has a difficult task: on the one hand, it is necessary to assess the problem, its extent, duration, impact on the person's life, and on the other hand – help the person to believe in his or her power, stay strong and find more external and internal resources. Strengths-based techniques help to achieve those objectives.

At this stage, in addition to discussing the problems, which brought the client to us, it is also important to conduct basic diagnostics of the client's personal characteristics, values and attitudes as well as anxiety, depression, aggression or suicidal behaviours. If the counsellor suspects that the client may have some mental health disorders, the client should be offered a consultation with a mental health specialist. Of course, people are rarely happy to hear such suggestions and often are not willing to follow it, but we as practitioners have to understand that sometimes the use of psychoactive substances

may be directly linked to mental health disorders, so our preventive interventions with no required treatment can be ineffective.

Diagnostic tools, which can be used in this case, include Hospital Anxiety and Depression Scale (HADS), Brief Psychiatric Rating Scale (BPRS), Buss Durkee Hostility Inventory (BDHI, authors – Arnold Buss and Ann Durkee), Anna Prykhozhan's Personal Anxiety Scale, questionnaires to screen for post-traumatic stress disorder, interpersonal relations, accentuation of character and many others.

## SOME TOOLS THAT CAN BE USED AT THIS STAGE



### “EXTERNALISATION”

Externalisation can be the basis of strengths-based interviewing. On the one hand, it allows the client to step aside from the problem, observe its story from a distance, see the “allies” of the problem as well as related challenges, assess the extent of its impact on the person's life. On the other hand, it allows to recognize the person's efforts to resolve his or her problem, study the resources and opportunities to influence the problem, visualise dreams and hopes about living without the problem.

Externalisation starts with the adolescent naming the problem, relying on his or her life experience. The following questions can be helpful:

- *What brought you to us? How would you define your problem? Why is it a problem for you and people around you? How could you describe it?*
- *When and how did it become a problem for you? What were the circumstances (your story of living with the problem)?*
- *When and where (in which contexts: at home, in summer, in autumn, with people visiting, in the morning, at night, when you are tired, etc.) does the problem become worse and when and where does it become less intense?*
- *Are there any related problems (which aggravate the main problem)?*
- *Who or what makes the problem stronger? What makes it lose its strength?*

For instance, if the assessment is done with an adolescent who committed an offence, the problem can be called “breach of law.” With the questions above we can track when the “breach of law” appeared in the life of the client, who or what influenced it. We can define the factors leading to the “breach of law”, such as feeling low or offended, friends

who support the “breach of law”, etc. It may be that the situation with the “breach of law” gets worse when the adolescent is in conflict with his or her parents and improves when family relations are good.

After the problem is defined, assessment of its impact on the life of the adolescent can be performed. The following questions can be helpful:

- *How does the problem affect you or your family members?*
- *Which areas of your life are more affected by the problem and which are less affected (self-perception, education, work, relations with family members, hobbies)?*
- *How deeply does the problem interfere with your life and the lives of people around you?*
- *How does the problem affect your perceptions of the future? How does it affect your dreams, hopes, values?*

Not only problems affect people, people also affect problems. Assessment of people's impact on their problems allows recognising their previous efforts and support their ability to manage their lives. The following questions will help to assess the impact:

- *Are there any moments when the problem becomes less intense or disappears? What happens in those moments? How does your life look when the problem is not there?*
- *What did your family members try to do about the problem? Which of those things worked?*

You can also ask if the adolescent tried to seek any help before and if such efforts were successful. It will allow you to take into account the client's previous experience when developing an action plan, do more of the things which work and refrain from doing the things which didn't work. The questions below may help to clarify the situation:

- *Have you tried seeking help before? Where? In which organisations? From which specialists?*
- *What helped you and your family when you worked with specialists before and what failed to help?*
- *Which methods were helpful and which were not?*

Then it is important to help the client assess the impact of the problem on his or her life, ask questions to justify such assessment and discuss the client's chances for a better future. It will help to build and maintain motivation to change.

However, before asking questions to assess the consequences, it would be good to repeat the key points from the previous conversation:

- *Are you happy with how the problem is impacting your life? What is your attitude to what is happening? What is good about it and what is bad about it?*
- *What do you like or don't you like about it? (We ask it in any case: if the client is happy and if he or she is not happy.) Why do you have this attitude to what is happening? Why do you take this position?*



### **“LOOKING FOR EXCEPTIONS”**

Using this technique, the counsellor asks questions about exceptions. Those questions are built around the fact that problems do not exist non-stop, they are not present all the time, and exceptions are the moments when the problem could manifest itself but it does not. Focusing on such moments gives the client hope that the problem will not exist forever. Focusing on non-problematic or at least less problematic periods changes the atmosphere of the counselling session and its tone – the conversation becomes more optimistic and hopeful.



### **“JOURNEY IN TIME” (MISSION POSSIBLE PROGRAMME)**

This technique is part of a programme called Mission Possible. It was developed by Ben Furman, a psychiatrist from Finland, as a modification of the Kids' Skills programme for adolescents. This programme takes into account age-specific features of adolescents with a focus on self-study. Within this programme, adolescents in addition to the main skills also build their ability to self-organise and plan, assess their resources, make a number of steps to achieve their main goal and seek help from their friends and family. Such skills serve as protectors from many behavioural disorders typical for adolescents, so building them is an important preventive and corrective task in working with adolescents. This programme can be implemented both individually and in groups. In both cases, family and close people of adolescents are engaged in the training process.

The Mission Possible programme consists of a number of steps/tasks covering all the stages in working with adolescents. Social workers can use the entire programme or its components in their practice. We will specify the techniques of this programme used at different stages. Support of the environment plays a central role in the programme, so all its tools can be effectively implemented in groups. You can learn more about the programme here: <http://www.kidsskills.org/>.



The first task of the programme is called Journey in Time and is described as follows:

***Take a piece of paper and write a date a year or two ahead on it. It can be any date that you can think of: your birthday, holiday or any other day that means something to you. Now imagine that you can travel in time: you are in the future and it is exactly the same day that you wrote down. You are doing great and decide to write a letter to your counsellor to share what is going on in your life. Maybe you will want to tell where you live, what relations you have with your family and friends, how things are going with your studies or work, if you have a girlfriend or a boyfriend, what you do when you have free time, tell about your health – or any other things going on in your life. Maybe you will also want to share some recent positive news or something which you think is about to happen.***

After clients complete this exercise, they should do the following:

***Show your letter from your “bright future” to your counsellor. Maybe the counsellor will ask you some questions to help you even better imagine the life you would like to have in the future. Update your letter adding the responses to your counsellor’s questions to it. When the letter is ready, show it to someone else. You can choose who can see it. If possible, show your letter to other people who take part in the programme and who can, in their turn, show you the letters from their “bright future.”***

If you are not familiar with this programme, first try going through all its elements on your own. What would your letter from the future look like?

A detailed description of the methodology and a wide range of examples of using the Kids’ Skills with children aged 3 to 14 years old is offered in Ben Furman’s books “Kids’ Skills: Playful and practical solution-finding with children” and “Kids’ Skills in Action: A Solution-focused method for coaching children to overcome difficulties.” Those books are good guides in implementing this method when working with children.



## “DESCARTES SQUARE”

This exercise may be used to understand the general situation of the client, define the purpose of working with the client and prepare an action plan. Besides, it helps the client to define his or her priorities.

Before using this technique, the counsellor and the client define the question/task.

For this exercise, the client will need a piece of paper and a pen. The piece of paper is divided into four parts. Every part should contain responses to one of the questions:

- *What will happen if this happens?*
- *What will happen if this doesn't happen?*
- *What won't happen if this happens?*
- *What won't happen if this doesn't happen?*

It is important to write as many answers as possible to each of those four questions as it will allow to consider the biggest number of options.

After all the responses are written, the counsellor analyses the responses together with the client, focusing on the client's strengths. The responses can help the client in making the decisions and in analysing the client's strengths in overcoming challenges to achieve the desired outcomes. Besides, this tool allows to define the most significant criteria when making a choice and assess the consequences of every possible decision.



## STAGE 3. DEFINE THE GOALS AND DEVELOP AN ACTION PLAN

After discussing the problem, the social worker can start talking about the preferred future. Often the goal is defined as finding a way out of certain problems, e.g. quitting alcohol, resolving a family conflict, treating HIV infection, etc. However, to support the adolescent's motivation to change, it is important to discuss what exactly will change in his or her life if the problems are resolved or do not have such a strong impact on it as they do now and focus on the future. Future is the place where people's hopes

come true, where people build their own lives and can be the masters of their own fate. Future is not pre-defined, it can be discussed and created. Every session starts from discussing what the client wants or hopes for, not why he or she is not happy with their life. Such attitude to the future, which is created and reinforced by setting the goals, discussing the client's strengths and resources, complimenting the client, and looking at exceptions from the problem gives the client a hope, which, in its turn, nurtures the client's ability to overcome the existing challenges, while strengthening and reinforcing itself.

Up to this moment, the client has already assessed the consequences of the problem during its analysis and discussion, realized what he or she does not like about those consequences and decided that another solution would be better. The client also told what he or she tried to do about the problem, what worked and what failed. This knowledge will be helpful when talking about the preferred future and planning it. In this conversation, the counsellor can use the techniques of strengths-based approach and ask the following questions about possible improvement of the situation:

- *If the problem starts disappearing from your life, what changes will you notice first?*
- *What could change as a result of our joint efforts?*
- *What will improve/change, if the problem disappears/does not affect your life anymore?*
- *How will people who referred you to us find out about the improvement, what will they notice (if the client was referred by other specialists)?*

## **SOME TOOLS THAT CAN BE USED AT THIS STAGE**



### **"SCALING EXERCISE"**

Scaling questions are used to assess the current situation as compared with the goals. It is a bridge between where the client is now or has been before and where he or she would like to be in the future. Clients can measure and assess their own situation in all its aspects. All scaling questions are built in a way to make sure that they create and reinforce expectations and anticipation of the desired positive changes.

The scaling questions are formed as follows: "Assess the current situation on a scale from 0 to 10, where 10 is the preferred future and 0 is the worst possible situation." After

the client makes an assessment, the counsellor can ask questions for the client to justify his or her response. In this approach, the counsellor is interested not in why it is not 10 but why it is not 0. After the current assessment is justified, the counsellor can ask about what is needed to move forward along the scale, for example to gain 1 more score.

This tool can also be used when assessing the outcomes of the action plan being implemented.



### "MIRACLE QUESTION"

To help clients describe their preferred future in detail, social workers can use miracle questions. This technique was offered by one of the authors of solution-focused counselling Insoo Kim Berg 20 years ago, when one of her clients was quite pessimistic about the possible therapy outcomes. She said that a miracle should happen for the therapy to be of any help. Insoo followed up on this idea and asked the woman to imagine that a miracle happened. Since then, miracle questions are widely used to shift the clients' focus to their goals and help them think about the opportunities they have not seen before. Such questions allow describing the tasks of change in greater detail, support the client's motivation and self-esteem:

***Suppose that after our meeting you go home, spend your evening as usually and go to bed. While you are asleep, a miracle happens overnight and all the problems that brought you here are gone. But you will have no idea that there was a miracle. How will you know that there was a miracle? What will tell you that it happened? How will your family know that there was a miracle?***

Miracle questions and other techniques to define the preferred future allow people to describe their life without current problems and see what for people would like to change. Often problems are so deeply rooted in the clients' lives and seem so endless and comprehensive that people have difficulties even thinking about the existing opportunities – they can't see them. Miracle questions help them do it. The process of imagining a possible solution serves as a catalyst for implementing this solution. One of the most powerful mechanisms of the miracle questions is that diving deep into the desired future, making it feel real, the person acquires a new experience, which can give him or her a feeling that they are able to guide their own life. This question allows to ruin the internal disbelief in the possibility of change, allowing the person to feel and comprehend that preferred behaviour and desired events can happen and will happen in future. It reinforces people's hopes and expectations of change. The description of

“miraculous” changes can be rather distant and may seem not really achievable from the current perspective. To help adolescents create a description of the realistic change, plan possible steps to achieve it and find the resources to perform such steps, social workers can use a scaling question, which was described above:

- *On a scale from 0 to 10 assess your current situation, where 10 is what you told when you described the miracle and 1 is the worst situation.*
- *Why not 1?*
- *Would you like to move forward or are you happy with where you are? What do you need to do to stay at this level?*
- *What will happen if you move 1 step forward?*
- *What will your family notice? What will be different for them?*
- *What new opportunities will appear for you and your family if you move 1 step forward?*

Based on the responses about the changes when moving one step forward, we form the tasks for the future action plan (in case management another term – service plan – is also used). Thus, the client and the social worker can define small, specific and achievable tasks.

When defining the tasks, the counsellor can discuss with the client how they can be performed, who can implement them and how professionals can help in performing those tasks. It will be an action plan created and partly owned by the client. Professionals and social support providers play a supportive role in this case. It is also important to discuss the time frame to implement the plan.

The plan can be written on paper and further used to assess the results achieved or can take the form of a contract to be signed with the client. This document can also be used for reporting purposes.



### **"MY PROJECT" (MISSION POSSIBLE PROGRAMME)**

Another way to prepare an individual action plan is My Project tool. After you discussed the preferred future with your client using such techniques as Letter from the Future and Miracle Question or any others, you can start working on your client's personal project and defining its goals. In this case, a project means a detailed plan of what needs

to change, what has to be done for it and what will support the client on the way to change. This exercise is best done in a group. If at the previous stage clients defined their goal on their own, in the beginning you can invite the group participants to share their goals, e.g. to read their Letters from the Future.

For this exercise, ask your client (group participants) to do the first task:

**1. “Project goal”**

*Define a goal, which will bring you closer to your bright future and start a project to achieve this goal. Your project may be about studying, working, changing your lifestyle, improving your relations with another person, performing your duties or anything else, which in your opinion will help you get closer to your bright future. Your counsellor, your friend or any other person who knows you well can help you set a goal.*

*Note. There is only one rule about your goal: it should be positive, not negative. It can be about getting rid of something bad, but through doing something good. A negative goal is about stopping or reducing something, which in your opinion is harmful for you. Such a goal DOES NOT WORK for the methods used in the Mission Possible Programme. A positive goal, vice versa, is about starting or strengthening a behaviour model that you see as useful. This kind of goal WORKS for this approach. To transform a negative goal into a positive one, just think about the good thing which should take the place of the bad thing you would like to get rid of. Then make this good thing your goal.*

*The examples below will help you transform your negative goal into a positive one.*

<b>Negative Goal</b>	<b>Positive Goal</b>
<i>“I will quit eating chocolate”</i>	<i>“I will eat reasonable amounts of chocolate”</i>
<i>“I will quit smoking”</i>	<i>“I will take care of my lungs”</i>
<i>“I will never skip school anymore”</i>	<i>“I will go to school more”</i>
<i>“I will quit drinking alcohol”</i>	<i>“I will drink moderate amounts of alcohol”</i>
<i>“I will stop arguing with XXX”</i>	<i>“I will improve my relations with XXX”</i>
<i>“I will stop doing XXX”</i>	<i>“I will start doing (opposite of XXX)”</i>
<i>“I will stop biting my fingernails”</i>	<i>“I will start taking care of my fingernails”</i>

## 2. “Project name”

After all the participants share their goals, ask them to come up with a name of their project. It would be great if the name is funny. If the participants have a trouble with naming their projects, invite them to talk to a counsellor, their friends or any other people who may have some good suggestions. Ask them to write their project names on their files. Later the participants will be asked to collect the “evidence” of change and store it in their files. In addition to the project name, the participants can come up with slogans or symbols reminding them of their project.

## 3. “Symbol”

When all the projects have their names, give the participants another task:

*Find a piece of jewellery, a mascot, an amulet or another symbolic item, which you will wear or have with you: it will bring you good luck and will remind you about your project. You can show it to people when telling them about your project.*

## 4. “Allies”

Here is the next task:

*Find people who will support your project. Take a piece of paper and draw a sun. Write down the names of those whose support will be important to you around the sun. Show this drawing to the people whose names you have written and ask them to support you. Do not be ashamed to tell people that you wrote down their names because they matter to you and their support is vital.*

## 5. “Reward”

Ask the adolescents to answer the following questions and write their answers down:

- *How will this project help you in making your bright future a reality?*
- *What positive impact will this project have on you?*
- *What positive impact will this project have on other people?*
- *What other positive results do you expect your project to have?*

*You can also ask other people (your friends, counsellor, allies or maybe someone else who knows you well) what positive impact your project will have on them if it is successful. Ask them to write their answers down or do it yourself.*

## **6. “Optimism”**

*Answer the question: “Why do I think that I have a good chance to succeed in my project?” State at least three reasons. If you have problems finding positive arguments, you can ask your counsellor, your friends or allies or anyone else who knows you well for an advice.*

## **7. “Support”**

*Ask other people why they think that you have a good chance to succeed in your project. Ask your counsellor, your friends or allies or anyone else who knows you well to tell you why they believe in you, why they think that you can successfully implement your project. Ask them to write their answers on the piece of paper you marked as “support” or do it yourself.*

## **8. “Stairs”**

Take a piece of paper and draw four stairs. Make sure you leave enough space for writing next to each of them.

- *On the first stair, write down what you have already done to achieve your goal even before you decided to start your project. There is no doubt you have already done something.*
- *On the second stair, describe how you see the next step in your project, which will happen in the nearest days. Imagine that your project will start on its own, with no effort, and describe how you see its start in your imagination.*
- *On the third stair, write down what will be the next step in your project you will make in the nearest weeks. Imagine that the project is going forward on its own, with no effort, and tell what you imagine will happen next.*
- *On the fourth stair, describe what will be the signal for you that the project has been completed. You can choose a date or describe the achievement, which will tell you that you have reached your goal.*

## **9. “Action”**

*Now you need to decide what you want to do to get your project going. Write your plan down on a piece of paper. You don't have to do something big or great. Vice versa, you need to make little steps. Plan something small so that you can be sure you can manage it. Tell your friends, you counsellor and maybe even your support group about the step you plan to make. Then follow your plan and make the step.*

*When you follow your plan, you will be able to feel proud of yourself for making it happen! (Even if you think that you have done nothing special or that your achievement is not big). Write a short report about your step and describe how it happened.*

## **10. Planning a Celebration**

It is essential not only to come up with an action plan but also to decide how your client is going to celebrate success. In all strengths-based approaches, the idea of celebrating success is of great importance. People can celebrate their small achievements or completion of the programme. When you start working with your client, after you define your goals, ask the client to think about how he or she is going to celebrate the achievements:

*Get ready to celebrate the success you are going to achieve after you finish the project. Write down when you are going to finish the project and how you will celebrate it: where, when, whom you are going to invite, what you are going to do? What will you do to make sure people learn about your progress? How will you thank other people for their help and support? What will your celebration look like?*

## **11. “Relapse”**

However positive we are about succeeding in what we do, sometimes we cannot avoid failure and disappointment. Offer your client to get ready for it in advance:

*Get ready to possible relapses or barriers and find a way to keep yourself motivated when you face with them. Take a piece of paper and write down what you are going to think or do in case you have to make a step back.*

*When something happens, you can never say for sure what the consequences will be. That is why your response to what is happening is based on the consequences that*

*you imagine. If you experience something like a relapse, a good way to keep yourself motivated and get yourself back on track is to think about three possible positive effects on your project and even on your life in general.*

To perform all the tasks within this technique, you may need several sessions with your client. Most likely, you will need a separate session to work on every task. You can give tasks to your clients so that they can think in advance what steps they can take or who can support them. Sessions should not be too far away in time to make sure that your clients do not lose their interest. You may say that this technique is more time-consuming as compared to other methods used to define goals and develop action plans. Of course, you are right. However, our observations show that the more clients work on defining their goals and action plans, the better the chances are that they will achieve them. Emotional reinforcement when looking for an amulet, seeking support, defining strengths and planning a celebration also has a positive impact on the programme's success.



This method was originally developed to help people who experienced traumatic events, such as violence, natural disasters, catastrophes or military conflicts. It is based on the narrative therapy ideas.

At first, the tool was applied in group work, but now it is also widely used when working with individuals. It can be used as a programme component or as a separate technique. It may be adapted to any age, but works especially well with children.

The method consists of several stages. You can start by asking children what trees they know, how they can tell one tree from another, what they know about the tree structures and if they know the functions of different parts of the tree. It will help children to better feel the metaphor.

### **First stage: Tree of Life**

The task of this stage is to build the preferred story of a person, a story about his or her knowledge, skills, dreams and aspirations. For this purpose, the trainer invites children to draw a tree and can show an example by drawing a tree. The tree should have routes, a trunk, branches, leaves and fruits. It is also important for the tree to grow in the ground.

Every part of the tree has a special meaning. After the drawings are ready, the trainer asks the participants to write down the meaning of the tree parts. In the process of drawing and writing, the trainer can ask additional questions.

The roots symbolize the origin: where the child was born, origin and story of the child's family, his or her ancestors, favourite books and films that had a strong impact on the child.

The surface of the ground symbolises everyday life: what a usual day of the child looks like, what things and activities it contains.

The trunk symbolises knowledge and skills, all the things which the child can do well. It can be anything: riding a bike, reading, doing sports, talking to grown-ups, etc.

The branches are the child's dreams, hopes and wishes.

The leaves are significant people in the child's life: parents, relatives, friends or any other people who matter to the child. Even if some people are already gone, their names can still be included. If children feel sad remembering someone who died, the trainer may ask additional questions:

- *Were there any moments when you were happy together?*
- *What was great about this person?*
- *Would this person be happy that you remember him/her this way?*

These questions allow the child to tell why the relations with that person were important and thus to honour the memory of that person.

The fruits symbolise the gifts of life – the things, which were given to us in life. First of all, those are non-material things: care, love, friendship, etc. The trainer can also ask additional questions about who gave the child those gifts and why.

After children are done with their drawings, the trainer asks them to put their “trees” on a wall in a row. They will make a whole “forest” of “trees.” The trainer can also ask some of the children to tell about their “trees.” At this stage, it is important to avoid any pressure. The child may refuse to tell other people about his or her “tree.” While the child is talking, the trainer may ask some additional questions.

## **Second stage: “Forest of Life”**

After those who want to tell about their “trees,” the trainer can draw the children’s attention to the “forest” they have created. The trainer may discuss this “forest” with them: why they like it, what its strengths and opportunities are, how many people take care of it? The trainer can also discuss with the children the differences and similarities of their “trees,” talk about how the “trees” survive together in the “forest” and support each other.

## **Third stage: “When the storms come”**

The first two stages reinforced the children’s contact with their preferred life stories, resources, dreams, and significant people. They formed a firm basis for transitioning to the next stage. At the third stage, the task of the trainer is to create conditions to discuss traumatic events in the children’s lives, while preventing the risk of re-traumatization. To avoid additional traumas, it is vital to focus on children’s ability to cope with difficulties. It is also important to underline that children are not guilty that they experienced any traumatic events.

The trainer uses the metaphor of trees in the forest asking children if the trees always feel safe in the forest and what dangers they can face there. After children tell about the dangers (storms, droughts, animals, etc.), the trainer asks: “Are the trees the ones to blame that they are facing dangers?” Of course, children say: “No!”

Then, using the forest metaphor, the trainer can initiate a discussion of the dangers they may face. He can ask what dangers children may face, how all those dangers affect them and how they cope with them. The questions should be asked carefully, without pushing children to speak about their own experiences. However, if some children want to share their survival stories, the trainer should support them in such conversation. After the discussion, it is important to ask children if they are the ones to blame that they are facing certain dangers. Most of them will answer: “No!”

After that the trainer goes back to the forest metaphor. He asks if there are always storms in the forest or if there are some calm sunny days. What can happen in the forest when the sun is shining?

Then the trainer shifts from the forest metaphor to the children’s lives, asking what they like to do when they have good days. They can tell about their favourite games and things they enjoy doing.

Name of the team

Goals of the team

Team emblem

Trainer:

Goalkeeper:

Players:

1.

2.

Team colours and uniform

3.

4.

5.

6.

7.

8.

9.

10.

Doctor:

Fans:

1.

2.

Song

3.

4.

5.

Home stadium:

## Fourth stage: Recognition and confirmation

The programme ends with presenting certificates to each of the participants. The certificates usually indicate children's knowledge, skills, goals, hopes and dreams, recognising other people's contribution in their lives.

This programme can be used not only to help people who experienced traumatic events, but with all those who want to change their lives. In such cases, the stage "When the storms come" can be omitted.

Another interpretation of this exercise can be the Team of Life exercise based on football and sports metaphor. This version will best work for children for whom it is easier to associate with a sports team than with a tree (see the table above on page 64).

David Denborough's article about this method has been translated into Russian and is available at the website dedicated to the narrative practices: <https://narribrus.wordpress.com/2009/01/18/tree-of-life/>.



### "JOURNEY OF LIFE"

Just like the previous tool, this method is based on the narrative model. It can be used as a separate technique or in combination with other tools and approaches.

In this exercise, the trainer invites clients to graphically depict their journey. Before they start drawing, the trainer can talk to them about travelling. Below you may find some questions for discussion at this stage:

- *Do you like travelling?*
- *Why do you like travelling?*
- *What places do you like to go to, how do you get there?*
- *What journeys do you remember most often?*
- *Where else would you like to go?*
- *How do you usually get ready for a journey? What do you take with you?*
- *Do you travel alone or with other people?*
- *What challenges can you face during your journey? How can you overcome those challenges? What can you do to avoid them? And so on.*

Then the trainer can invite the client to draw his or her life or part of it as a journey. When you work with changes, the starting point of the journey can be the moment when the person decided to change his or her life and the ending point can be the moment when the person's new life becomes a routine.

The trainer gives some instruction on how to create the drawing. We start with drawing a circle in the middle of a piece of paper: it symbolises the place where we are now. Then we draw a road from the lower left to the upper right corner. The road crosses the circle that we have drawn. On the left of the circle, we will see the road that the person has already covered, on the right – the path that the person has to cover.

### **Part 1: Looking back**

**Where we come from.** In the beginning, the trainer asks the client to describe where his or her journey to change started: from what place, culture, language, faith. Every traveller has some people who supported the idea of the journey or inspired it. Who are those people? What was their contribution for the journey to start?

**Who is with you in your journey.** Those can be your family members and friends or people who inspire you (it does not matter if you know them in real life or if they are still alive). Those can be some specific people or communities, groups, organisations, including people from different generations. The client can name his or her friends, pets, celebrities, favourite writers, etc. The trainer invites the client to write all those people down in the circle in the middle of the drawing.

**Beliefs, values, principles.** Now we need to write down values, principles, and beliefs which guide us on our way. They can be symbolised with a compass. Where did you get those values, principles or beliefs? Who brought them into your life?

**Favourite places.** Going through changes, people visit new exciting places. The client should mark his or her favourite places, which he or she has already visited along the way.

**Milestones.** What has the client already achieved during this journey? The counsellor asks to draw some milestones symbolising two or three key achievements. How did the client manage to do it? Who supported the client in achieving those milestones?

**Barriers.** Then the client is invited to draw several stones and a river crossing his or her way before the circle. They symbolise the barriers which the client has faced. How did

the client manage to overcome, avoid them or get around them? How did the client do it? Who helped the client?

**Survival kit.** In the upper left corner, the client draws a survival/first aid kit/go-bag. It should contain the client's skills, resources, experience, favourite quotes, songs, films, books and so on, which the client can rely on in an emergency situation. Next to this kit, the client can also write down what helps him or her to go through tough times, recover and find the strength.

## **Part 2: Looking forward**

Now it is time to look forward – where the client needs to go.

**Final point of the journey.** At the end of the way, the client is invited to write down his or her hopes, dreams and aspirations. They may be about the client's own life or the client's friends, family, community or future generations. For how long has the client had those hopes, dreams and aspirations? How did the client manage not to let them go? Who supported the client?

**Places to visit.** On the remaining part of the way, the client is invited to write down the places he or she would like to visit. Those can also be the places the client would like to show people from his or her circle of support.

**Things to achieve.** The trainer invites the client to draw three new milestones to symbolise future achievements. Those should be some achievable things – something the client wants to happen. The client can write an achievement related to his or her personal life, another one related to the community, and yet another one related to the future generation of travellers.

**Contribution to other people's lives.** In the past, there were people who made their contribution to the client's journey, helped the client to start moving and supported him or her along the way. Now the client can think about his or her contribution to other people's lives. Maybe there is something the client has got from other people and now would like to share.

**Barriers to overcome.** On the way forward, the client is invited to draw some stones or rocks symbolising future challenges and a river to cross. How could the client overcome, avoid or get around those barriers? How could the circle of support help him or her in it?

**Music for the road.** During the journey, songs help people to stay brave, find strength and remember about their hopes and dreams. The client can choose a song to help him or her in the future journey.

### **Part 3: Looking at your path from a bird's eye view**

**Good memories.** You have already covered some of your path. Probably there are some good things you like to remember. What good memories can you take with you? Stars in the sky will symbolise them. You can describe those memories in detail, including sounds, tastes, and smells you associate them with. Who else is present in those memories? Why is every one of those memories important?

**Name of the journey.** The client can give a symbolic name to his or her journey.

**Message for others.** Along their path of life, people learn and gain wisdom. They can share their wisdom with others. Maybe the client can already come up with a message, a proverb or a piece of advice for those who only start their journey. What message, proverb or piece of advice would it be?

This exercise can be done both individually and in a group. It can also be used with groups/clients who currently do not go through any changes, then this journey will serve as a metaphor for all their life.

There are no resources in Ukrainian/Russian describing this technique. Detailed instructions in English can be found in David Denborough's book "Retelling the Stories of Our Lives: Everyday Narrative Therapy to Draw Inspiration and Transform Experience." In addition to this technique, the book offers many other structured narrative exercises, which can be used both separately and in everyday practice.



### **INTERVIEW TO ASSESS THE LIFE SKILLS OF ADOLESCENTS "24 HOURS OF MY LIFE"**

(adapted to the work with adolescents by specialists of the Dialogue Centre,  
New Family CBO)

When defining the goals of work with a counsellor, adolescents often have difficulties answering the question: "What are your best expectations of working with the counsellor?" or "What would your day look like without the problems that you have today?" Sometimes, it is difficult for adolescents to describe the chain of their actions,

which finally led them to the counsellor. It is also hard for them to define the “new” goals on the way to change. Interview to assess the life skills of adolescents “*24 Hours of My Life*” is a tool, which can help adolescents define their key *motives* (hopes, goals) and respective *behaviours* (rational use of their resources) at the initial stage of working with a counsellor, and using the assessment of their day, efforts and time analyse the required changes, if necessary.

In this case, interview means a conversation of a counsellor and an adolescent using open-ended questions aimed at finding solutions to reach short-term goals.

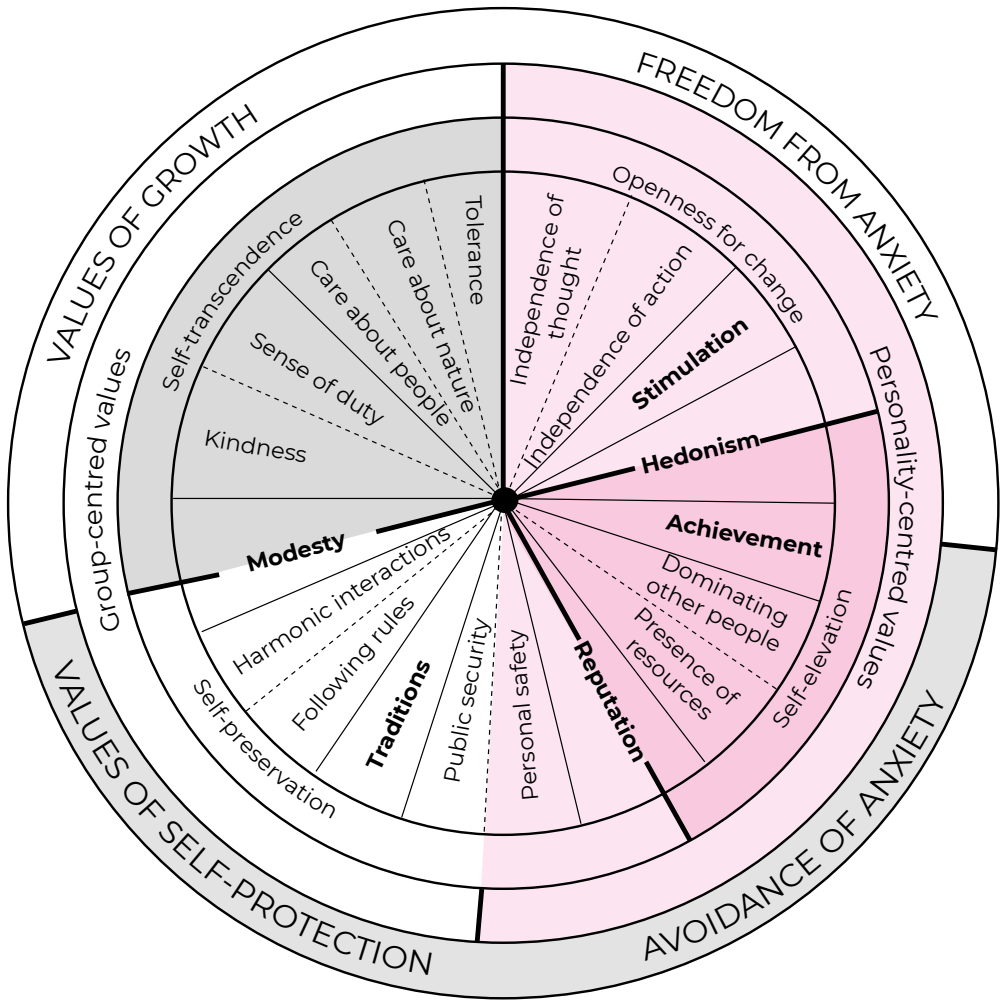
In the beginning of the interview, ask the adolescent to answer a question: “*What day would you like to assess in terms of the results you achieved?*” It can be a successful day or a desired day from the adolescent’s life. Both examples can be used for adolescents to assess their resources, time, efforts and relevance of their chosen behaviour to the goal they would like to achieve.

Thus, the tool can be used to learn about the adolescents’ values at a certain point of their lives (to see if the goal is important for them, how they talk about it). It can also be used to set the goals.

For instance, an adolescent has difficulties with academic performance and defines the goal as self-fulfilment through education, but during the interview he or she most of the time talks about the need to improve relations with peers. Then the counsellor should ask the following questions: *What hopes do you have about your relations with peers? Where do they come from? Do your concerns about such relations affect your motivation (desire) to study? What is most important for you now?* Such assessment will allow the counsellor and the adolescent to set the priorities and distribute the adolescent’s efforts and resources in a rational way so that his or her improved relations with peers would result in a desire to study and be active at school.

Besides, this tool can be used to assess the adolescent’s priorities when he or she comes to the counsellor to define the areas (skills) for development. It can also be helpful to define a new goal for further work with the adolescent. The tool can be used to reinforce the client’s skills of self-analysis and planning further actions.

It is recommended to be used with adolescents above ten years of age, who need a counsellor’s support to define their goals and resolve their communication problems.



The materials required to work with the tool: a form to fill in, a table of the adolescent's values. An example of the values, which can define the behaviour of adolescents and their motivation to change is presented in the figure.

Why do we need a list of values? Based on this list, you can do long-term and short-term planning. Values define people's behaviour in critical situations, their positions in arguments (readiness to resolve problems), and their ways to settle important questions.

Every person has six to ten personal values, defining his or her behaviour, helping the person to set goals and achieve them. Among the priorities specified in the questions below define those which are important for you at the moment.

# INTERVIEW TO ASSESS THE LIFE SKILLS OF ADOLESCENTS “24 HOURS OF MY LIFE”

1. Where do you see yourself in a month? Describe yourself, your achievements and people around you..

.....  
.....  
.....

2. Fill in the table thinking about your day (24 hours) yesterday:

Nº	I spend my time and efforts on...	Number of hours spent
1.	Sleep	
2.	Eating	
3.	Studies	
4.	Skills	
5.	Social media	
6.	Communication	
7.	Family	
8.	Games	
9.	Love relations	
10.	Rest	
11.	Taking care of myself and my appearance	
12.	Hobbies	

3. A successful day for you is a day... (finish the sentence):

.....  
.....  
.....

4. You won a 25th hour in your day. What will you do in this hour to feel happy?

.....  
.....  
.....

**5. What is most important in a person's life?** (Choose three options and underline them)

- Health
- Financial well-being
- Ability to be creative
- Well-being of family and friends
- Career/social status
- Ability to help people
- Fame
- Leisure and entertainment

**6. Which of those values do you consider hard to reach?** (Select three options)

.....

.....

.....

**7. Are you happy with your life?** (Underline)

- Yes, completely
- Not exactly
- I am not happy with my life
- Other (specify):.....

**8. What do you think is the reason of your failures?** (Underline)

- It's just a coincidence.
- It's a result of other people's actions, which do not depend on me.
- The reason is my own actions and character.

**9. What helps you achieve success (reach your goals, feel happy, etc.)?** (Underline)

- It's just a coincidence.
- It's a result of other people's actions, which do not depend on me.
- The reason is my own actions and character.

*Analyse your responses:*

- *Do your efforts correspond to your goals? Why?*
- *What helps you plan your time (define how much time you will spend on what)?*
- *What do you need to achieve the results you want?*
- *Who or what can help you?*
- *What steps are you ready to take to get the results you want?*



## "MY WORLD" COLLAGE EXERCISE

This exercise helps find ways to improve the quality of life. For this exercise, you will need the following materials: A3 size white paper, scissors, paints, pencils, glue, old magazines, books, newspapers, and old photos.

The choice of images for the collage will depend on the person's desires, dreams, fears, and needs. For many people, it is much easier to show how they feel through metaphors. Adolescents usually like such exercises. This exercise can be done both individually and in a group.

Ask the adolescents to choose a topic for their collages. It is a very important part of the exercise. The topic should depict their biggest concerns at the moment. The more honestly and clearly they choose the topic, the more useful information we can get.

Instructions:

- *Sit down and make yourself comfortable. Close your eyes. Imagine how you would like to see your future.*
- *How do you imagine your life? Is it bright, dynamic, full of events? Or settled, calm, and stable? What events would you like to see in your future?*
- *Stay with it. Feel it.*
- *Now open your eyes. Take the magazines, the pictures, and the newspapers. Look at them. Choose the illustrations that you like. Any of them. Anything that feels like your cup of tea. Pay attention at titles or captions. Maybe they contain some words which speak to you.*
- *When you feel that you have selected enough images, start cutting them out. Do the same with titles and captions.*
- *Now put all the images and words on a piece of paper. Do not hurry. You can make several attempts, change their places, remove the images, which don't seem to fit and add new ones. Do anything you need to do before you feel: "That is what I need! I like it this way!" Fix everything you have chosen on your piece of paper.*

When you finish the work, have a look at your collage.

- *What do you feel when you look at it? What mood does this collage put you in?*
- *What do you like most in this collage?*
- *Which three small steps you can make right now to come closer to your dream? Make them!*

Save your collage. Look at it in a week, in a month... in six months.

Maybe you will find something you haven't noticed before in the collage or in yourself.

When we ask those questions, we help people to better understand their feelings about the topic they chose for their collage and later interpret the real-life situation, when people have such feelings.

There is a number of other aspects, which we need to pay attention to.

For instance, how parts of the collage are located on the piece of paper. If the collage is created by a right-hander, the right part of the poster usually means the future, the desire to grow and progress, and the left one symbolises the past, the regress, being "stuck" in hard moments or sad feelings. For a left-hander it is vice versa.

Maybe there are some gaps in the collage. Then you can ask the client what such gaps mean for him or her. Or, vice versa, it may be that there is no free space left at all. You can also discuss why it is so. Besides, you can talk about the colours the client chose for the collage. What associations do they trigger? What emotions?

When analysing the collage, it is easier to understand how different parts of our personality help us or vice versa. We can see how we can reach our goals and make our dreams come true. For some people, it will be important to make sure that they choose the right goal and that they are moving in the right direction.



## **STAGE 4. IMPLEMENT THE ACTION PLAN**

While the client implements the action plan, the counsellor may perform a supporting function (through monitoring of the implementation process) and a protective function (by representing the client's interests in the organisations providing various services). To

support the client, the counsellor can organise a counselling session one week after the client starts implementing the action plan. Key questions for discussion:

- *What is better now? How were you able to make the change?*
- *What works? What helped you make it work?*
- *What corrections can be made in the plan for it to help you better achieve your goals?*

To teach your clients to listen to themselves and notice positive changes in their lives, you can invite them to answer the following three questions every day:

- *What did I do yesterday that made me feel better and brought me closer to my goal?*
- *What did other people do that made me feel better?*
- *What did I see, eat or smell that made me feel better?*

In the course of your counselling sessions, you can discuss if those questions help your clients better notice the change and understand their feelings.

Such conversations help the clients to focus on the progress and on their actions and make corrections in the plan if necessary. If some services of other providers do not meet the interests of your clients or their rights are violated, at this stage the social worker can intervene as a person representing the client's interest. With such support of the social worker, clients can receive the services which meet their needs and interests in the best possible way.

At this stage (as well as at the stage of needs assessment) you can also use the questions about exceptions. Discussing the situations when their problems did not manifest in their usual negative way can greatly support clients on their way to change. But what can you do when your clients tell you that there were no exceptions or that things recently got worse or that they are facing some difficult circumstances they cannot change? In such cases, the counsellor can use coping questions and look at what the client is doing to prevent things from getting worse. Those questions can help clients keep believing in their own strength.

If clients feel comfortable working with metaphors, in addition to the coping questions you can offer them an exercise called My Dragon.

## SOME TOOLS THAT CAN BE USED AT THIS STAGE



### "MY DRAGON" EXERCISE

This exercise helps analyse fears or other barriers preventing the client from implementing the action plan.

The client is invited to draw his or her dragon and make a story about how the client is going to fight the dragon. The dragon symbolises the client's fears or concerns about making the next step or about the problem in general. The purpose of this exercise is to show the client the need to use the acquired knowledge and skills to overcome his or her fears and concerns.

Ask the client to draw a dragon symbolising the client's fears or any other issues on the way to the goal. You can ask additional questions:

- *Why is the dragon dangerous?*
- *What is its power?*
- *What is the dragon afraid of?*
- *What is needed to beat the dragon?*
- *How will you beat it? (Here it is important to talk about "how," not "if" to build the client's confidence in success).*

During the conversation, adolescents can tell about the reasons of their fears, which may be related to their previous negative experience in solving problems or lack of support. This information will help you better understand where you can focus your efforts.

So, depending on the client's responses, you can either point out that the client has all the chances to beat the dragon and think about how you are going to support the client's self-esteem or talk about the additional knowledge and skills that will help the client to defeat the dragon and reach the goal.



## "PROJECT IMPLEMENTATION" (MISSION POSSIBLE PROGRAMME)

If you used the Mission Possible techniques when assessing the needs and goals and preparing an action plan, use the following approach to help your client implement the project.

At the group or individual counselling sessions, ask your clients what parts of their plans they were able to implement. Pay attention even at the smallest changes. Ask if your clients were able to receive any support. If you work with a group and support was provided by other group participants, invite the client to thank those people who helped him or her. After the client's presentation, invite other participants to write words of support on pieces of paper and put them in the client's file. If you work with your client individually, write the words of support yourself.

Ask the adolescent to maintain a Change Log to keep record of all the progress. It will help the adolescent to track the changes to discuss them at the following sessions.



## "WRITING LETTERS"

Narrative approach is one of the few therapeutic models using writing as a method of working with clients. Following counselling sessions, narrative counsellors often write letters to their clients, where they can describe their observations of the positive changes in the client's behaviour and the client's progress in reaching the goals. Such letters help building links with the client's preferred story. Narrative practitioners can also issue various diplomas and certificates to confirm certain skills and knowledge acquired by their clients.



## "EMOTIONS JOURNAL"

To work with your clients' emotions, you can try using the Emotions Journal exercise with an "wheel of emotions." The exercise will help define the emotions of your client at every stage of the action plan implementation, building the client's motivation to change. It is important for clients to learn how to be aware of their emotions in the situations of conflict and conflict resolution to assess the pre-conditions of such situations in the future. Thus, clients will learn emotional self-regulation, will get an experience of assessing risk factors and will know how to plan further steps to avoid negative consequences.

Together with the counsellor, clients should discuss the objectives of keeping an Emotions Journal and choose a convenient format of journaling. The counsellor gives instructions on how to keep the journal and familiarises the client with the “wheel of emotions” (see below).

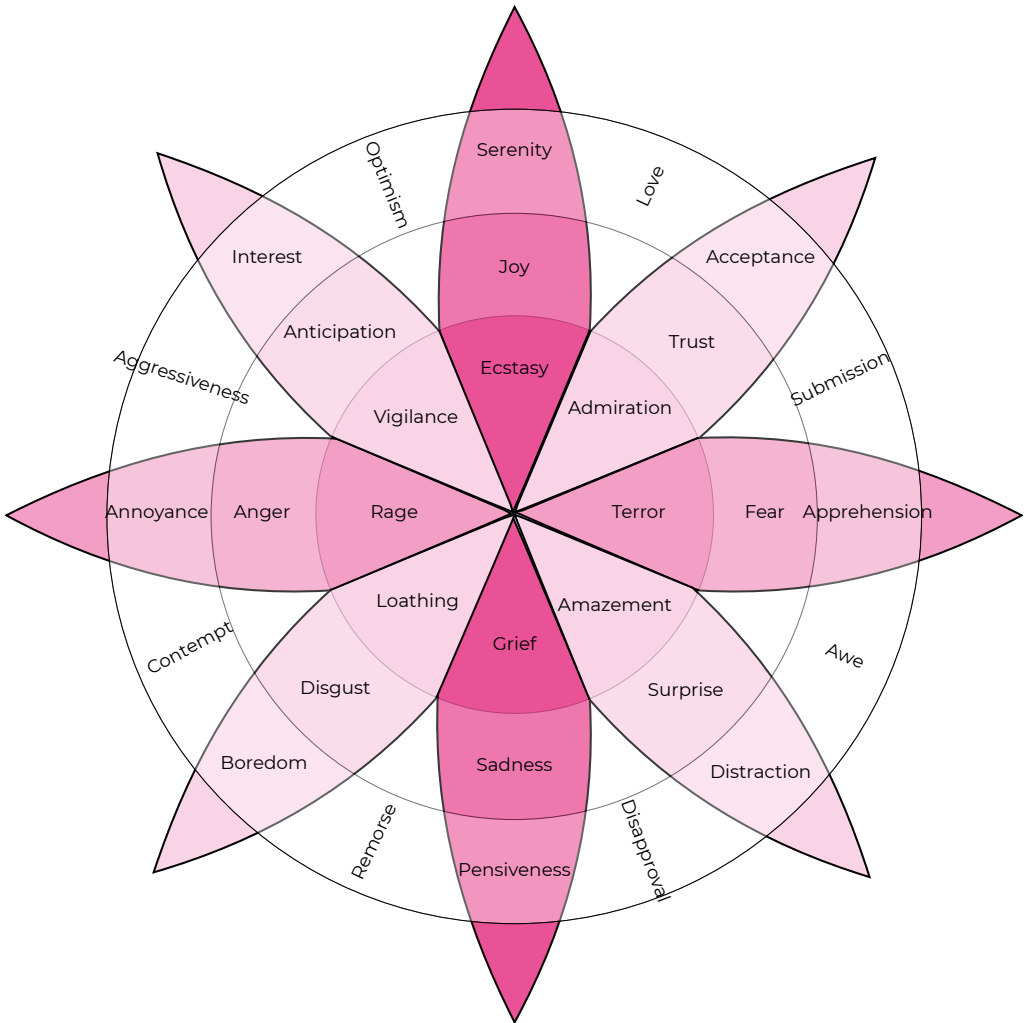
Entries to the Emotions Journal should include:

- *time/date;*
- *description of the situation when the client felt emotional;*
- *emotions experienced by the client;*
- *client's actions;*
- *consequences of the situation for the client;*
- *preferred behaviour or situation.*

Let's take an example. The client's parents are not happy with the amount of time the client spends “in the smartphone.” Parents' dissatisfaction leads to frequent arguments with the client. The client feels angry and irritated due to the excessive control, has very emotional reactions to their complaints, yells and blames the parents for not trusting him/her. Such situations lead to family conflicts. Sometimes the client runs away from home due to constant arguments. Preferred behaviour/situation would be lack of parents' control over the use of the smartphone, dialogue between the client and his/her parents about the client's needs to use the phone with both parties feeling responsible for satisfying the needs and complying with the safety rules. Analysing the preferred situation, the counsellor asks the client to think what emotions he/she has about it and what he/she can do for it to become real. This exercise helps not only define problematic situations and analyse one's emotions, but also describe the preferred future and the skills, which will help to make it real.



## "THE WHEEL OF EMOTIONS"



At the stage of action plan implementation, it is especially important to search for external support for the adolescent to change. It is good if your clients have some close people who can support them. You can engage family members and other close people to support the adolescent using such techniques as "Outsider-Witness Practice" and "Family Sculpting".

In the section "Working with the Family" you can learn more about the role of the family in the life of an adolescent and find out about other formats of work engaging family members and other significant adults.



## "OUTSIDER-WITNESS PRACTICE"

One of the narrative practices, which help develop a preferred story, is the outsider-witness practice. Witnesses can be some people who are invited as “audience” for the therapeutic conversation. They act as a third party whose aim is to listen, witness, recognise preferred stories and statements of the person seeking counselling. Outsider witnesses can be people from the client’s environment (family members, friends, etc.) or people outside the client’s social network. Those can be people of caring professions, representing a “reflective team” or former clients who previously sought help with similar problems and agreed to help in the therapy of other people when necessary. Outsider witnesses can be present at one particular session or (if it is a group of professionals working together) can be regularly present at therapeutic sessions.

When more than one outsider witness is present (especially if it is a team of people working together), team members help each other to give their feedback. For instance, after one of the outsider witnesses speaks, another one may ask him or her a number of questions to make the process more useful. When outsider witnesses talk to each other, the client listens and does not intervene.

Presence of outsider witnesses at therapeutic sessions may be very important, especially if they listen and give feedback in certain ways.



## "FAMILY SCULPTING"

The Family Sculpting exercise unites families, making family members think about themselves as a certain unity in diversity, where both the whole and each of its elements are important. “Sculpting” not only unites the family, but also emphasises each individual’s personality. Besides, it makes individuals summarize their personal experience, make sense of it, and then interpret it. It also gives the counsellor an opportunity to directly intervene into the family system, helping family members change their positions in the family and thus helping build more acceptable boundaries inside the family. In this context, we can say that the exercise can be used to facilitate positive changes in the family and make it more functional.

This exercise requires the presence of at least two people and some easy-to-move pieces of furniture, which can serve as substitutes of the family members not present at the

session. The “sculpture” can depict the family at the present moment or in the past. It may include any members of the extended family required for the therapeutic purposes.

Telling clients about this technique, the counsellor should explain that “sculpting” is useful first of all to show how it feels to be a member of this family. Sometimes it is easier to show it than to tell it. Family members can take turns to share their vision of family relations with a living sculpture so that their poses and positions in space depict their actions and feelings towards each other.

The counsellor offers the “sculptor” to treat all family members as if they are made of clay. The “sculptor” puts every family member in a position showing his or her role in the family in a non-verbal way. The process continues up to the moment when the “sculptor” is happy with the work. It is important for the family members to allow the “sculptor” to treat them as material to create a “sculpture” realizing that later they will switch roles.

When all family member build their “sculptures” depicting emotional situation in the family at a certain moment of time, the counsellor can ask them to build a “sculpture” of a perfect family.

The counsellor can intervene suggesting alternative options or commenting on the creative process. The image of a perfect family can later be used to track the dynamics and define the goals of working with the family. Discrepancies between the family members’ perceptions of the family structure can tell the counsellor and the family members themselves much more than the traditional verbal techniques.

After every “sculpture” is created, ask the “sculptor” to give a name to his or her creation and ask the following questions:

- *To each family member: How do you feel about your place among other family members?*
- *To the whole family: Was this “sculpture” unexpected for you?*
- *To each family member: Did you know that the “sculptor” perceived you this way?*
- *To the whole family: Do you agree that your family functions as this “sculpture” shows?*
- *To the “sculptor” or the family: What changes in the family functioning would you like to see?*

“Sculpting” can be also used in the individual work, then furniture or other big things in the room can play the roles of family members. Though in this case family members are not physically present, it can also be very informative. Interpretation of the “sculpture” should not be too strict: remember that it only reflects a subjective view of one of the family members, the realities of his or her inner world.

Using the above-mentioned techniques, together with the client you can start building the client’s skills necessary to achieve the set goals. Besides, it is essential to organise training events on such topics as sexual and reproductive health, human rights, leadership skills and offer adolescents some alternative ways to spend their time (sports and art classes, hobby groups, etc.)

Below we would like to suggest some formats of group activities. It should be noted that apart from awareness-raising such activities can also serve as a good way to engage new clients in your programmes, e.g. if you organise them in educational institutions.



### **PREVENTIVE QUEST “DRUGS? NOT MY THEME!”**

Target audience: adolescents aged 14 to 19 years old who practice risky behaviours and have an experience of using psychoactive substances.

This game was developed by the Compass Centre run by the Kharkiv-based Blago CBO. It was piloted with adolescents who study at vocational schools, attend social and psychological rehabilitation centres or stay in detention facilities.

The goal of the quest is to raise the awareness of adolescents about socially significant diseases (HIV/AIDS, STIs, tuberculosis, viral hepatitis) and build their skills in using the acquired knowledge when making decisions in their everyday life.

#### **Objectives:**

1. expand and consolidate the participants’ knowledge about HIV/AIDS, STIs, tuberculosis, viral hepatitis, health promotion as well as their rights and responsibilities;
2. help the participants to realize that using PAS is one of the most dangerous factors affecting their health;

3. practice decision-making skills
4. help the participants to build their skills of team work.

Using such format of work as quest allows to draw the attention of participants to a certain topic; intensify their perception of new information through using visuals; develop their logical thinking, intuition, ability to quickly find a way to resolve any situation; identify the hidden strengths of adolescents, find potential leaders; develop their communicative skills and ability to work in a team. The quest is competitive, which helps build the participants' motivation to receive information about the consequences of risky behaviours.

The number of quest participants depends on the number of stations, which can be organised with the help of partners and volunteers. Every team consists of five to seven participants. It is better not to have more participants in a team, otherwise it turns into a crowd with one or two leaders making all the decisions.

We had a successful experience of conducting such quests jointly with police. Annual preventive quests "Drugs? Not My Theme!" have been organised in Kharkiv since 2015. The participants are clients of the Compass Centre, adolescents registered with the juvenile probation service, attending social and psychological rehabilitation centres as well as general and vocational schools. Traditionally, the event is organised on the territory of the training centre of the National Police in Kharkiv, which allows to make it large-scale and attractive for partners, media and sponsors.

Information stations are mixed with sports and team-building stations. Usually there are stations dedicated to the knowledge of the routes of HIV transmission, sexual and reproductive health and sexually transmitted infections, means of contraception, tolerant attitude to people living with HIV, drugs and consequences of their use. Police is responsible for the stations on the rights of adolescents and their responsibility for committing offences. Teams can spend no more than seven minutes at every station. Tasks for the stations may be prepared specially for the game (e.g. crosswords, puzzles, quizzes) or can be based on the existing interactive games (e.g. from the Join-in Circuit).

Traditionally, the quest is closed with awarding prizes and certificates to the teams.

You can find a detailed description of this tool here: [http://afew.org.ua/metodichka-kvest\\_bлаго/](http://afew.org.ua/metodichka-kvest_bлаго/).



Another example of the group activities we often use in our work is the Join-in Circuit interactive exhibition developed by the Federal Centre for Health Education (BZgA) in cooperation with Deutschen Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ). Join-in Circuit is a training tool on reproductive health, HIV/AIDS and STI prevention, which allows the participants to analyse their risky behaviour and its possible consequences and develop their own prevention strategies.

The model combines a portable awareness-raising interactive exhibition and a learning game. The Join-in Circuit consists of five interactive stations, each of which is equipped with a special stand and colourful materials. At every station, there is a trained facilitator, who leads group discussion on the topics relevant to young people. Such topics help the participants to link their own situations and experiences with the risks of getting infected with HIV and STIs. List of topics: Routes of HIV Transmission, HIV/AIDS: Questions & Answers, Protection from HIV, STIs and Contraception, Your Life is Your Choice, Next to You.

This tool can be aimed at different target audiences, but it is mostly used for HIV prevention among adolescents and young people over 14 years of age, who live in rural or urban areas, schoolchildren, students, conscripts, etc.

Features of the tool and its advantages in working with youth:

- reflects the real needs and interests of participants;
- helps to initiate an equal dialogue;
- motivates participants to intensively interact with each other;
- appeals to emotions in addition to brain and thinking;
- appeals to the personal experience of participants, helps to analyse their everyday life situations;
- helps the participants to develop their own prevention strategies to avoid getting infected with HIV and STIs.

You can learn more about the tool at the website:

<https://www.giz.de/en/worldwide/32650.html>. You

can also download a guide on using the tool here:

<https://phc.org.ua/diyalnist/proekti/ne-day-snidu-shans/biblioteka-materialiv/marshrut-bezpeki>.



Of course, it is very important to find resources to engage adolescents in sports activities, art classes and other leisure activities in addition to therapeutic and training interventions.

Whatever technique or exercise you decide to use, do not forget to compliment adolescents! Usually, counsellors using the strengths-based approach pay a lot of compliments to their clients. Their compliments are special – they emphasize what clients are doing to improve their situations. Such compliments are focused on the clients' strengths, often – on their positive past experience. The task of the compliments is to show the clients what they need to keep doing, which behaviours they have to strengthen. It builds hope as people realize they have already done it and they can do it again. Compliments are also contained in the questions asked by the counsellors: instead of “Why...?” questions, which often put people in a defending position, counsellors ask “How...?” questions. Such questions contain compliments as they stipulate that clients do something right, using their resources and initiative.



## **STAGE 5. EVALUATE THE RESULTS**

Though we describe evaluation of results as a separate stage, it makes more sense to say that evaluation should take place not at the end of the cycle, but throughout the whole process of change. It allows us to come up with a timely response if circumstances change, help clients not to lose their motivation and learn to notice any positive change, even if it is small. For instance, if our client wants to improve his/her academic performance, but so far all he/she can do is wake up early, we can help the client see that it is already a success. Interim evaluation of results can also help us make corrections in the action plan if something does not work. Remember: one of the principles of strengths-based counselling is “if it does not work, try doing something else.” In general, the ability to evaluate results is a very important skill, which has to be built, and your advice may help the client in it. Thus, analysing the results and correcting the action plan can become essential components of the change process and facilitate implementation of the action plan.

Both interim and final evaluation of results can start with discussing the outcomes of the initial needs assessment: name of the problem, its story, its impact on the client's life, preferred future, scale-based assessment and plans to move forward. Difficulties in evaluating the results may arise if the goals were not defined clearly. For instance, if in

the beginning the client told that he/she would like to be happy, but failed to describe what exactly should happen, most likely you will not be able to evaluate the results. The more detailed and specific the action plan and the goals are, the easier it is to evaluate the results.

When the strengths-based approach is used, counselling sessions usually start with a question about what has changed (focusing on the positive change). The counsellor is expecting some positive change and this feeling is gradually shared by the client, who also starts noticing and consciously looking for positive change and thus starts to expect that the situation will change in the desired direction. Such question may sound as follows: "What is better now?" In any case, the counsellor tries to "build on success," asking for more detail: when the client first noticed the change, where it happened, how big was the change, who else noticed it? What did other people do to make it possible and what did the client do to make the positive change happen? One of the best questions allowing to bring more detail to the description of change and make it stronger is the question "What else?". As a result, people can look at their lives from a different angle and start noticing their strengths and resources.

At this stage, the Scaling Exercise described in the section "Define the goals and develop an action plan" can be used. Ask your client to do the scaling exercise again and measure the current situation and then ask:

- Why not 1 (2, 3...)?
- Which of your actions helped to achieve this result?
- What professional services helped you to move up the scale and how?
- What changes happened in your life because you implemented the action plan?
- How did the change influence your attitude to yourself and to your environment?  
How did the attitude of other people to you change?

Then you can ask the client if he/she is happy with the current situation or if he/she wants to move forward. If the client is happy, you can discuss how he/she can retain the achievements. If the client would like to move forward, you can ask about moving one more score up the scale: "How will you understand that you moved one score up?"

Depending on the objectives you defined with your client in the beginning, after the evaluation you can suggest to close your case with the client or continue the work to achieve new objectives.



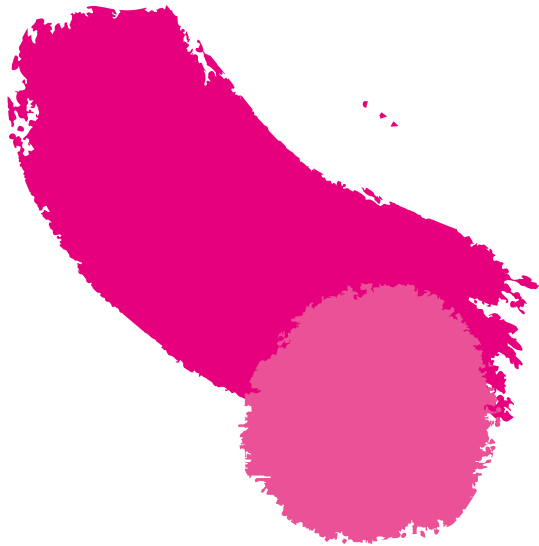
## STAGE 6. WRAP UP THE PROGRAMME

Wrapping up is as important as any other stage of the programme. Completion of the programme can bring a lot of stress to the client's life. Imagine that for the last six months the client was sure that there are people who can always help him/her and now he/she remains alone. Preparation for programme completion should take enough time to gradually make sure that the client is ready to deal with his/her problems of his/her own. At this stage, it is important to discuss: when the client's participation in the programme will be completed, what should change in his/her life or behaviour so that you can conclude that the programme can be completed, what will happen in the client's life after the end of the programme, if the client can keep in touch with you and sometimes come to the site just to talk and share updates. Tell the client that you are not breaking the contact with him/her, but see his/her achievements, which allow the client to resolve any possible issues that may arise in future on his/her own. Of course, in practice it is quite difficult to define the moment when you can let your client go. Some clients from our target group may need support for several years before they feel ready to complete the programme. However, we should try to set this goal when working with our clients.

Celebrating achievements can help our clients complete the programme and make this process more comfortable for them. We have already mentioned it before, so if at the stage of setting goals and developing an action plan you already planned a celebration, now it is the best time to bring this plan to life. It would be great if the celebration would be reinforced with some symbolic actions: you can invite the adolescent to make a speech in front of other clients, sharing his/her "success story" and award him/her a certificate or a memorable gift. It would be helpful if other adolescents who only start their journeys towards change could also take part in the celebration. In any case, the client should be able to choose the desired format of celebration.

# 6

## *Working with the family*



As children grow up, their peers start playing a more important role in their lives than their parents. At the same time, peer influence can be ambivalent: on the one hand, they can support the adolescent's aspiration to develop, learn new skills, overcome challenges and, on the other hand, they can contribute to the formation of problematic behaviours, family conflicts, and aggravate social disadaptation. Although peers play a critical role, family is still important for the adolescent. Adolescents still depend on their families both emotionally and financially. They still need understanding and support of their parents. Many key factors, which contribute to problematic behaviours (drug use, self-harm, aggression, etc.) may be related to the family. First of all, it is domestic violence. It is hard to find another factor, which can have such a strong impact on the development of problems among adolescents. Drug use among family members greatly increases the chances for the problematic behaviour of adolescents. Parents' mental health disorders (depression, bipolar disorder, schizophrenia) also aggravate the risks of the adolescent starting to use drugs or developing a drug dependence. Parenting strategies, family rules and traditions, level of emotional support can be both risks and protectors in the development of problematic behaviour. Inconsistent, versatile upbringing, focus on punishment for breaking the rules instead of support to cultivate the desired behaviours, unclear, changing or unrealistic expectations, and lack of emotional support can facilitate or support problematic behaviours. On the other hand, presence of clear, sound and realistic family rules, consistent and coordinated parenting strategies with a focus on reinforcement of the desired behaviours, not on punishment, warm and supportive relations with parents can serve as protectors to prevent the development of risky behaviours and help changing problematic behaviours that have already been formed.

That is why working with the family is one of the crucial tasks to include while planning services for the adolescents who use drugs. If family members cannot be engaged, it usually slows down the process and often is the key obstacle on the way to changing risky behaviours. It is crucial for social workers to maintain cooperation both with adolescents and with their family members. When meeting with the family, the counsellor should be very careful with the information that the adolescent shared about him/herself. It is quite possible that adolescents can hide information about drug use, HIV status or other sensitive issues from their parents. If the counsellor shares such information with parents without the adolescent's consent, it can have a negative impact on the counsellor's relations with the adolescent. On the other hand, helping the adolescent to conceal his/her problematic behaviours (e.g. suicidal thoughts, health problems, etc.) can support such behaviours. That is why it is important to leave it up to adolescents to share such information about themselves, while motivating and supporting them to open up to their family members, considering the consequences, which make them hide such problems (e.g. risks of domestic violence).

## **Social work with the family**

If parents or other family members experience any problems, which can affect their ability to be adequately engaged in the adolescent's life or contribute to domestic violence, the social worker can include psychosocial support of parents or family as a whole in the case management plan. For instance, if a family member has an addiction problem, referral of such family member to a treatment programme can be an effective intervention, allowing to improve the chances to change the adolescent's behaviour. If a family member suffers from depression or another mental health disorder, finding adequate treatment to decrease the intensity of symptoms may also have a significant impact on the adolescent's behaviour as such family member will be able to play a supportive and guiding role in the adolescent's life.

Social and economic hardships also greatly affect the ability of the family to perform its functions. They may contribute to the development of problematic behaviours or aggravation of the existing problems. Support in accessing welfare, help of a family assistant (a professional or a volunteer who helps the family to cope with routine tasks, such as cooking meals, taking care of children, cleaning, budget planning, etc.), employment assistance, creating opportunities for joint leisure activities and other direct support provided to the family can also be effective. Such interventions may contribute to better emotional climate in the family, help parents feel that they are able to set a good example for their children, provide their children with everything they need and regain their authority in the eyes of adolescents.

## **Family therapy**

Family therapy is one of the popular interventions used in various situations, starting from the issues of adolescents with academic performance and ending with drug abuse problems. Its popularity is based on the idea shared by many professionals that the "Family is the root of any problems." Considering the complex nature of any behaviour problems, including individual, family and social factors, this statement may be rephrased as follows: "Maybe problems are partly rooted in the family." Depending on the model selected, family therapy may help to define the roots of problems and find effective solutions, which stipulate re-building the family hierarchy, changing the way of communication within the family system or altering behaviour patterns in the family. There are quite many types of family therapy, such as classic systematic family therapy, strategic family therapy, behavioural family therapy, dynamic family therapy, and constructivist family therapy. Those approaches are based on different theoretical concepts and use different interventions, but they all agree that the adolescent's

problem has a significant impact on other family members, family relations, family hierarchy and rules and that family hierarchy and rules as well as relations in the family can directly or indirectly cause such problems, support or intensify them. Analysing interactions around the problematic behaviours, family therapists help the family members change their problematic communication patterns and start cooperating to find a solution. Family therapy can be an effective way to achieve change, however it has certain limitations, first of all related to the need for all family members to be involved in the therapy. Therapists resolve this issue in different ways depending on their approach, but most often lack of a parent's consent to engage in the therapy becomes an obstacle.

### **Therapy for parents**

When the initial assessment shows that the problematic behaviours of an adolescent is first of all supported by problems in the relations between his/her parents, counselling for parents without engaging the adolescent can be one of the effective interventions. Depending on the specific situation, such counselling can take different forms, e.g. mediation (in case of conflicts related to parenting approaches, divorce, etc.) or counselling on the parenting strategies. Such interventions can help parents agree on their parenting strategies, increase their level of mutual support and understanding, and develop their skills to become good parents of an adolescent.

### **Group work with parents**

Group work with parents can also be an effective intervention, decreasing the intensity of the adolescent's problematic behaviour or significantly reducing the risks of such behaviour. One of the widely used forms of group work is support groups for parents. Below we will give an example of how such groups can be organized.

Group work should be based on the cognitive behaviour approach. Duration of each meeting should be up to three hours. Group facilitator is usually a psychotherapist specialising in addictive behaviours. According to the group rules, the host of each session is selected from among its participants. The scope of work includes providing psycho-emotional support to parents to change their models of communication with their children (programme clients). Traditionally, a group meets once a week. Every month, group participants attend awareness-raising meetings with professionals, where they receive information about the peculiarities of adolescence, behaviour and emotional changes of adolescents, their needs, rights, as well as the mechanisms and algorithms of effective communication in the family to support the process of change, prevent violence, conflicts, etc., and form the constructive dialogue skills. Group work

supports clients in re-building contacts with their family members, which helps to prevent risky behaviours and reinforces the intention to implement the action plan within the programme and beyond.

However, group work with parents does not only imply emotional support. Building parenting skills necessary to regulate problematic behaviours is also an effective and rather widely used intervention. There are many programmes to build parenting skills. Description of some programmes and approaches in working with families is offered in the Guide to implementing family skills training programmes for drug abuse prevention (UNODC, 2009): <https://www.unodc.org/documents/prevention/family-guidelines-R.pdf> (in Russian). Usually, such approaches focused on the skills, which help to set family rules and requirements to the adolescent and support the adolescent in complying with such requirements, build the skills of emotional support, problem resolution and conflict management as well as mutual support. Sometimes programmes to build parenting skills include joint sessions for children and parents, but most often such sessions are organized only for parents.



### **Family group conferences**

Another way to work with families, which allows to make a strong impact on the family situation is family group conferences. This method is still not widely known, so we would like to tell about it in more detail. Usually, social services use case management model with the families in difficult life situations when providing social support to such families. This process includes building contact, conducting a comprehensive assessment of the problematic situation, developing a plan to overcome the situation, implementing the plan and evaluating the outcomes. However, social workers often complain that even families which are interested and motivated at the start, usually become passive and lose their motivation while they are implementing the plan. Family group conferences are a method allowing to avoid it.

*Family group conferences* are defined as organised meetings of family members and public officials (social workers, police officers, etc.) on the issues of proper child care, child's protection or on any offences committed by the child.

Family group conferences change the relations between professionals and organisations, on the one hand, and family members, on the other hand. They are based on the concept that family members are experts in their problems, so the family should develop a plan to resolve such problems and should be responsible for its implementation. In the course

of the conference, public officials play a supporting role, mostly providing information about the opportunities to receive various services. In other words, professionals do not conduct diagnostics, do not give advice, do not make any predictions, they are only sharing information about the opportunities the family can use or reject. Such format of work helps the family to choose the best course of action to ensure adequate care of the child. Family here is understood in a broad sense: those can be close and extended family, friends of the family, neighbours, child's friends – all those people, who take care or could take care of the child.

A family group conference is organised around a central issue or a central theme, which is determined in advance. It should answer the question: *“What should change as a result of this conference?”* The theme should not contain a direct answer to the question what to do. For instance, *“How to help the child feel happy at school?”* is a good theme for a family group conference, while *“How to find a maths tutor for the child?”* is not a good one as it already contains a piece of advice on what to do.

The process of conducting a family group conference is divided into several stages, including a meeting of the family with professionals, where they voice the concerns of all parties and private time for the family to come up with an action plan. Then the family presents the plan to the professionals, who accept it, if it does not ignore the problem under discussion. Meetings of the family with public officials are coordinated and facilitated by an independent facilitator, who does not work with the family as a social worker. In Europe, volunteers from the local communities often facilitate family group conferences. It is sometimes hard for the organisations providing social services to comply with this requirement, but it is very important.

Thus, engaging family into the social work with adolescents is one of the key tasks in helping adolescents who use drugs. Social workers have a wide range of methods to be used when working with families depending on the challenges the family is experiencing. Effective work with family can help in strengthening family relations, contribute to the development of supporting relations between adolescents and their parents, allow parents to build their parenting skills, thus improving the discipline in the family.

You can find more information about the family group conferences in the manual *Strengths-Based Social Work with Adolescents* (in Russian): <http://afew.org.ua/sotsialna-robota-z-pidlitkami-z-oporoyu-na-silni-storoni/>. There is also an educational cartoon about this method (in Russian with English subtitles): <https://youtu.be/3ligRnVOZNE>.





7

*Developing leadership potential  
of the adolescents*

Fortunately, today everybody is used to the slogan “Nothing for us without us.” Many experts support the idea that community engagement when planning and implementing projects and interventions is a necessary condition to make sure they are effective. Our project is no exception and for many years we have been trying various tools to improve the leadership potential of adolescents and engage them in all the aspects of project implementation. In this section, we will share some of our observations on what works well and what benefits projects and organisations get when they actively engage adolescents in their work.

To start, we should probably define who a leader is. Usually, leaders are seen as people who are able to work in a team, get other people interested and motivate them, bear responsibility and be flexible, appreciate the opinions of others, are ready to make decisions and be a positive example. How can you select young people who will be able to demonstrate all those qualities from among your clients? In most cases, adolescents come to our projects right when they experience difficulties with the above-mentioned qualities, so our primary goal is to help them develop those qualities. That is why, when we were discussing the criteria to select future leaders, we defined just one criterion – the desire of adolescents to take part in the leadership activities that we offer.

When we started planning and implementing the leadership component of our project, we set a number of goals. Firstly, with the help of community leaders we wanted to improve our project and make our services more attractive to other adolescents. We also planned to engage them in advocacy activities to protect their interests and include the required interventions in our programmes. Of course, we also wanted the adolescents to grow and develop.

To achieve those goals, we used the following activities:

- Leadership School;
- training leaders in providing peer-to-peer services;
- engaging leaders into project planning and implementation;
- engaging leaders into advocacy activities;
- implementing leadership projects.

Let's have a closer look at each of the activities.

## Leadership School

As we have mentioned above, we decided not to select “natural” leaders from among our adolescent clients. Our main task was to find people who would like to become leaders and help them build the necessary skills. For this purpose, we organize Leadership Schools in every organisation with varying content and duration. Below we describe a model of such Leadership School and, if you are interested in this format of work, you can adapt it to your goals and opportunities.

The Leadership School lasts from 6 to 12 months and includes the following modules:

1. Effective Communication
2. Life Skills
3. Teamwork
4. Sexual and Reproductive Health and Prevention of Risky Behaviours
5. Human Rights
6. Community Service.

Every module consists of 3-4 two-hour workshops. Theoretical material is combined with practical assignments. For instance, when the participants study sexual and reproductive health, they are offered to try and monitor the quality of HIV pre- and post-test counselling and testing services. Adolescents visit health facilities in their city to check their compliance with the counselling and testing protocol and assess how health workers treat them. With this exercise, we, first of all, teach adolescents to take care of their health and seek health services. Besides, we obtain valuable information about the quality of services provided in the city: we can see if adolescents are denied services when they come without their parents, if confidentiality requirements are met, etc. Such information allows us to more effectively plan our advocacy activities at the local level or training events for our partners.

Another example of practical assignments can be engaging adolescents to organize various events. Adolescents enjoy helping us to carry out preventive quests, campaigns, flash mobs, etc. Every year, we enrol several groups of adolescents to take part in the Leadership Schools.

The most active adolescents are invited to the Leadership Camp. Young leaders take the responsibility for defining the agenda of the camp and for settling some of the administrative issues. Participation in the camp is not only a good opportunity to acquire new knowledge and skills, but also a great motivation for those who only start their training.

### **Providing peer-to-peer services**

Leaders who complete their training are engaged to work with new clients and provide mentorship to those who just started to study at the Leadership School. As we have already mentioned, leaders help us create a friendly atmosphere and serve as primary contacts for the adolescents who come to us for the first time and do not trust us yet. Besides, leaders provide basic consultations on sexual and reproductive health and rights (SRHR) and human rights. It should be noted that when engaging young leaders to project implementation, it is important not to put the obligations of project staff on their shoulders as it can be unsafe both for them and for our clients. So, when we talk about peer-to-peer services, the task of young leaders is just to define the issues and concerns of other adolescents and refer them to the adult professionals. This scheme works very well in the educational institutions, where the leaders study. Other boys and girls know that our leaders are engaged with our project, so they often come to them asking where and how they can access help and accurate information. If you plan to engage adolescents in the provision of peer-to-peer services, you need to ensure supervision for such adolescents from the side of your staff members. Such supervision may include regular exchange of information as well as support in dealing with challenging situations.

Another format of engaging leaders in the project activities can be the so-called Autonomy Day. Once a month, leaders organize meetings with clients and other potential leaders. During such meetings, they can watch films, play team-building games, celebrate birthdays, etc. Leaders are responsible for organizing, preparing, and conducting such activities as well as for discipline and cleaning the premises after the event. They come up with the format of activities, give a list of all the required materials to their mentor and make sure that everything is prepared in time. Usually, all the preparations take about two weeks. Such Autonomy Days allow the leaders to try planning and preparing small events, get some experience in organizing groups of people and retaining their attention. As for the participants of such activities, it is an opportunity for them to take part in some exciting events and, as a result, build their motivation to seek project services.

## **Engaging leaders in project planning and implementation**

In our project, we try to engage leaders not only when we conduct some activities, but also when we plan our projects. Representatives of the leader teams take part in regular working meetings with project staff and in annual meetings to develop our plans and strategies. Engaging adolescents in such meetings helps us to plan the activities and services, which meet the needs of our target audience.

## **Engaging leaders in advocacy activities**

Though we do not focus on this topic in our publication, advocacy is a very important part of any project aimed at scaling up access to quality services. There are a lot of resources on advocacy, so we do not have an ambitious goal to tell in several paragraphs about what advocacy is and what advocacy tools are available. However, when talking about the engagement of adolescent leaders, it should be noted that they should participate not only in the provision of services, but also in advocacy as adolescents are the ones who know best about the challenges they face when seeking help. We have an experience of engaging adolescents in the operation of coordination councils of HIV and drug policy as well as in the development of a number of municipal and regional youth programmes. Certainly, it is not so easy to make an adolescent a member of the coordination committee. In many cities, we faced the resistance of local committees to such format of engagement. However, if you are not able to formally engage adolescents into the work of committees and working groups developing youth programmes and policies, you can at least discuss such documents with adolescents and voice their ideas when you meet with your partners.

## **Implementing leadership projects**

The activities described above really help to develop the leadership skills of adolescents and make a positive impact on the quality of services. To increase the role of adolescents in youth programmes and motivate them to be more proactive in order to achieve changes, we offer leadership grants. This approach is based on the understanding that people can learn only from their own experience. If we want adolescents to become leaders in their own lives and in the lives of their communities, it is essential to come up with such tools, which would make them believe in themselves, teach them responsibility and teamwork, while also having a positive impact on the lives of other people. Implementing leadership projects is a tool, which combines all those opportunities.

During one of our Leadership Camps, we trained young leaders in writing project proposals, telling them about the expected outcomes and indicators, budgets and reports. Later, leader teams were also trained separately in each city within our Leadership School.

Then we announced our leadership grants, which were provided once a year in the amount of EUR 500–700 per project. Adolescents were responsible for everything: selecting an idea, writing a project proposal, preparing a budget, implementing the project and drafting a report. Mentors of the leader teams helped with advice and provided consultations on some issues, but all the responsibility for project implementation lied with the adolescent leaders. The average duration of projects was about six months.

Below we give some examples of the projects implemented by our leaders. In one of the cities, adolescent leaders created an online magazine for adolescents, with the articles for the magazine written by adolescent authors. In another city, adolescents developed a prevention board game, which is now actively used not only by the young leaders but also by our project staff. Within another project, adolescents opened a movie club, where adolescents watched themed films and later discussed the films and the issues presented in them. The discussion was facilitated by the young leaders. There were also many other initiatives implemented within the grants.

When implementing the activities within this component, the most challenging task was to build cooperation in the team. In some cases, by the end of the project only one active leader was left, who did all the work. That is why, when we allocated further grants, we paid more attention to the issues of team interaction and responsibility. It is important for the mentors not to impose the roles (deciding who is doing what in the team), but to give the leaders an opportunity to make their own decisions. A good format of work was when one of the mentors was an experienced young leader.

When we share our experience in implementing leadership projects, we often hear from our colleagues that other projects do not have enough money to offer leadership grants.

Indeed, not all projects have flexible budgets, which allow allocating money for such activities. However, if your donor is ready for a dialogue, you can offer to change the format of activities already planned in your project. For instance, if you plan to organize a public campaign, you can engage a team of young leaders to implement it, offer them to come up with an idea of the campaign, prepare a budget and organize the activities. This way, you will comply with your project obligations, will conduct a campaign, which will be attractive for your target audience and will contribute to building the potential of your young leaders.

If you work in a government institution, but you are interested in such format of work, there are quite many opportunities to receive small grants to develop the communities of key populations, and leadership projects can be implemented using such grants.

Another challenge can be related to the formalities: who gets the money and uses it. In our case, the money for the leadership project was received by a civil society organisation, which was mentoring the leadership team. Of course, all financial operations were run by professional accountants, but all other duties, including contacts with suppliers, were performed by the young leaders.

Leadership activities gave a lot to our project. We see that our services become more interesting and attractive to adolescents. Now we have more new clients thanks to the activities organized by our young leaders. Project staff members point out that the support of young leaders helps them to work with other clients more effectively as well as prevents their emotional burnout. Besides, with the experience acquired within our project, the leader teams were able to prepare project proposals and receive grants from other donors.

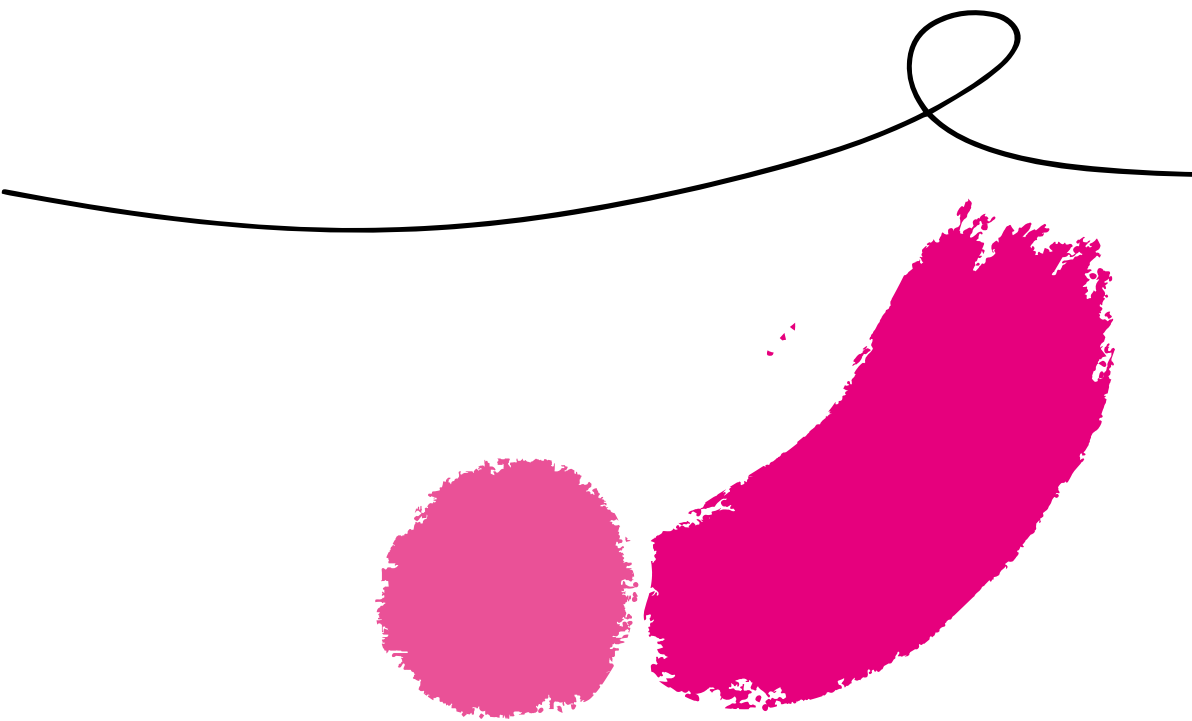
However, what is more important is the impact of leadership activities on the lives of adolescents. Those of them, who were engaged in leadership projects, pointed out that this experience helped them learn to take the responsibility not only for the project, but also for other spheres of their lives. Young leaders said that after the project it is much easier for them to speak in public. Some of them felt more confident at school and overcame their fear of speaking before the whole class/group of students. The ability to set goals in leadership projects also helps them to set their personal goals related to their studies or work. Besides, the skills of teamwork and dealing with various conflict situations made a positive impact on their relations with other people. For instance, one of the project participants said that now when she has conflicts with her mother she is ready to listen to her mother's position and voice her own.

If you are interested in this topic, you can find more information in the brochure for adolescents "How to Become a Public Health Leader" (in Ukrainian) (<http://afew.org.ua/yak-stati-liderom-u-sferi-gromadskogo-zdorov-ya-sered-molodi/>) and listen to the speech of Olga Rudneva (director of Olena Pinchuk Foundation) about who a real leader is (in Russian): <http://afew.org.ua/rudneva-olga-hto-takij-lider-i-yak-nim-stati/>.



8

*Protection of the rights  
of adolescents*



Our experience shows that adolescent drug users face various rights violations, while other people in their immediate circle, including their parents, do not know about it. Lack of rapid response leads to repeated violations of their rights, creates obstacles in seeking timely professional help and thus increases the probability of negative consequences of substance use as well as other risky behaviours. Thus, violation of adolescents' rights, which goes unnoticed, is one of the serious factors increasing their risks in the context of HIV.

Service providers often record cases when the rights of adolescents are violated. However, such cases are rarely reported formally or become public. First of all, it is because of the lack of relevant mechanisms to identify and record the cases of human rights violations within the system of service delivery to adolescents. Minors often do not know about their rights or do not believe that they can change their situation, so they rarely tell someone about such violations or seek any protection. Besides, social workers and psychologists, who most often deal with the most-at-risk adolescents, do not have either proper knowledge or tools to respond to such violations or think that only lawyers can help in such situations.

That is why in 2016 we had an idea to develop a tool to monitor violations of the rights of most-at-risk adolescents (MARA), which could be used by almost any professionals providing support to such adolescents who have basic knowledge of human rights. It was also important to develop a tool, which would allow professionals to identify the cases of rights violations, even when adolescents come to them with other requests. Since 2017, this idea has been brought into life within a pilot project to implement a tool to monitor and record the cases of MARA's rights violations in Ukraine. This tool was meant to ensure rapid response and support MARA in cases when their rights are violated and also provide for the systematic collection of statistic data to assess the scale of the MARA's rights violations for further advocacy to protect MARA's rights at the national and local levels.

In this section, we will provide a step-by-step guide on how to use the tool to monitor MARA's rights violations.

*The Monitoring Tool consists of the following components:*

- **Guide** on using the tool to monitor MARA's rights violations.
- **Screening questionnaire** for social workers and other professionals to identify

violations of the MARA's rights. The questionnaire should be completed in paper form and includes 11 questions concerning the main areas of the adolescent's life. Every question is aimed to learn more about the adolescent's life and identify any violations of his/her fundamental rights.

- **Legal assistance form.** If it is determined that any of the adolescent's rights have been violated, the counsellor conducting the screening interview can offer the adolescent to seek legal assistance. If the adolescent agrees, the counsellor fills in a special form and hands it over to a lawyer to seek redress of the violated right. The form can be submitted either to a legal officer of the organisation where the adolescent is seeking help or to a lawyer of a partner human rights organisation.
- **Standards of work to protect MARA's rights.** Such standards contain a list of regulations, which define and regulate the delivery of services within the projects working with adolescents; a list and a description of the services aimed at protecting MARA's rights; a description of the knowledge and skills related to human rights that every adolescent should have; contacts of the partner organisations, to which adolescents can be referred if needed; a description of the tool to monitor MARA's rights violations. The document is aimed at helping structure the work to protect the rights of adolescents and improve the quality of relevant services offered to them.

The above-mentioned documents can be downloaded at our website  
(in Ukrainian): <http://afew.org.ua/monitoring-prav/>.



# THE GUIDE TO MONITOR MARA'S RIGHTS VIOLATIONS

**Step 1** Together with the client, fill in a screening form on the MARA's rights violations (or invite the client to fill in the form). Discuss the results.

**Step 2** Conduct a consultation and tell the client about his/her rights, motivate the client to seek help in your organisation or in a partner organisation in case of any questions and/or human rights violations.

## If the client's rights are violated:

**Step 3** Discuss and agree with the client an action plan to restore any violated rights. Such actions may include completing a form to seek legal assistance with a lawyer and/or case management by a social worker. If the client does not want to take any steps to restore the violated rights, the counsellor working with the client should discuss with him/her how to prevent such violations in future.

**Step 4** Hand over the form and any other documents to a lawyer of your organisation or a partner organisation (with the client's consent).

**Step 5** Document the case in your database.

**Step 6** Monitor how the problem is resolved for every case of human rights violations recorded in line with the Guide.

# SCREENING FORM

## for social workers

This form will help a social worker, a psychologist or another counsellor to get to know you and understand how to help you if necessary. Please read this form carefully and fill it in together with your counsellor. You can mark all the responses, which are true for you, yourself or you can answer the questions of your counsellor who will mark relevant responses in the form. When filling in the form, your counsellor may ask you some additional questions to clarify certain details. You do not have to answer any questions, if you don't want to, and you can stop your conversation at any time. You can also ask questions to your counsellor. Any information that you discuss will remain confidential and will not be disclosed to anybody without your permission. If you or your friends experienced any situations, when your rights were violated, you can discuss them with the counsellors working at our organisation and get help!

Gender:  male       female       other: \_\_\_\_\_

Year of birth: \_\_\_\_\_ and/or client code: \_\_\_\_\_

I live in (name of the city): \_\_\_\_\_

I fill in this form with the help of (full name of the social worker/psychologist): \_\_\_\_\_

### 1. Normally I live:

- |  |  |
|--|--|
| <input type="checkbox"/> In a residential facility | <input type="checkbox"/> With my parents   |
| <input type="checkbox"/> In the street             | <input type="checkbox"/> With my guardians |
| <input type="checkbox"/> Alone                     | <input type="checkbox"/> Other: _____      |

Additional comments  
(Why? For how long?):

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### 2. Mostly I have meals:

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Once a day | <input type="checkbox"/> Two/three times a day |
| <input type="checkbox"/> It depends | <input type="checkbox"/> Other: _____          |

Additional comments  
(Why? How?):

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**3. As for my education, I:**

Additional comments  
(Why? What exactly?):

- Attended middle school and then did not continue my studies
- Do not go to school as I do not have money for it (transport, copybooks, etc.) and/or due to other circumstances (I am not permitted, etc.)
- Do not want to go to school as it makes no sense
- Go to school
- Go to a vocational school or a community college
- Other: \_\_\_\_\_

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**4. When I feel sick, I turn to:**

Additional comments (When and how medical assistance was not provided? Who refused to provide you with health services?):

- A teacher at school/college/residential facility
- A social worker
- Do not turn to anyone as no one will help me without money and I do not have money and/or due to any other reasons
- Doctor (health worker) in a clinic/hospital
- Parents, family members
- Other: \_\_\_\_\_

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**5. If someone hurts me physically or insults me, I:**

Additional comments (Did anyone hurt you? How? How often?):

- Will tell about it to a social worker or a school teacher
- Will not tell anyone as it will not change anything
- Have nobody to tell about it
- Will tell my parents about it
- Will tell my family members (but not parents) about it
- Will tell my friend about it
- Other: \_\_\_\_\_

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**6. If I have sex:**

- It is because it gives me an opportunity to get drugs, food, shelter, money, gifts, etc.
- I do it with casual partners
- I do it NOT by choice
- I do it by choice
- I do not do it
- Other: \_\_\_\_\_

Additional comments (Do you always choose to have sex? If not, why/under which circumstances does it happen?):

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**7. I have my own (pocket) money because:**

- My friends/acquaintances support me
- I have a regular job
- My sexual partner gives me money
- My parents/guardians give me money
- I do not have it
- Other: \_\_\_\_\_

Additional comments (How does the lack of pocket money affect your life/behaviour?):

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**8. When I see the police:**

- I am afraid I will be arrested for no reason
- I know they will try to find something to blame on me
- I am afraid they will tell I am selling drugs
- I want to run away
- I feel calm as I know I have done nothing wrong
- Other: \_\_\_\_\_

Additional comments (Why? At which circumstances?):

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**9. Most of all I experience ill treatment from the side of:**

- Police officers
- Social worker
- Psychologist
- Teachers at school/vocational school
- Parents/guardians
- Peers
- Health workers
- I do not feel it, everyone treats me well
- Other: \_\_\_\_\_

Additional comments (Why? At which circumstances?):

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**10. If someone treats me badly, that's because:**

- I am from a poor family
- They know I had sex for money
- They know I used drugs
- I broke the law/have criminal record
- They know I used alcohol
- They know I was in jail
- They know I am sick
- Other: \_\_\_\_\_

Additional comments (Would you like to change the way people treat you? What people? How to change?):

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**11. I have the following identification documents:**

- Birth certificate
- Passport
- Taxpayer ID number
- I have a birth certificate and/or an ID number and/or a passport, but I don't know where they are
- I don't have any documents
- Other: \_\_\_\_\_

Additional comments (Do you know where your documents are/who has them? Can you access them any time you want?):

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By filling in this form, I give my consent to process and analyse the information presented in this form, only to identify any unlawful actions against me and to help me, complying with all the confidentiality requirements. I realize and agree that any information provided by me may be used to summarize the problems experienced by adolescents, not giving out any of my personal details (without mentioning my first name, family name, age or any other personal information that can be used to identify me).

*Please sign and/or write "I agree":*

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I refuse to fill in the form because (please specify the reason of your refusal):

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Let's look at every step of the Screening Form and peculiarities of its use in more detail:

**Step 1. Together with the client, fill in the Screening Form on the MARA's rights violations.**

The Screening Form should be filled in after building contact with an adolescent, with his/her consent (which is recorded by the adolescent signing the form or writing "I agree" at the bottom of the form). The preamble contains the client's details, gender, age and/or client code. The form should be filled in by the counsellor or by the client him/herself, but in the presence and with the help of a social worker/psychologist (or another counsellor working with the client), who states his/her full name and position on the form. The client should be informed that he/she has a right to skip one or several questions or refuse to fill in the form at any stage (at the bottom of the Screening Form there is a box to state the reason for such refusal). It is a good idea to analyse the reasons for skipping some questions or refusal to fill in the form with the client. Maybe the adolescent needs more information about the survey objectives, confidentiality guarantees, etc.

## Comments to the Screening Form

Each of the eleven survey questions is aimed to check if one of the key rights of the adolescent was violated. In every question, there is one or several answers, which may be signals for the social worker/psychologist to ask additional questions (“warning” answers). You can see the examples of such questions below. However, they are not exhaustive and may depend on the client’s situation. Next to every survey question you will find a section for additional notes and comments, which can be filled in both by the counsellor and the client.

*Abstracts from the laws and regulations, which can help to understand how this or that right should be secured are marked with \*\**

**QUESTION 1.** Answers to this question allow to understand if the client’s *right to housing and right to family were violated.*

**“Warning” answers** *“In a residential facility,” “In the street,” “Alone” or “Other.”*

If an adolescent chooses one of the first three answers or “Other,” the counsellor should ask about the reasons why the adolescent does not live in the family. If there are any facts proving that the adolescent was forced to leave home, that his/her parents sold their house or the adolescent was not able to inherit the property (deprivation of the right to housing), possibly because the parents died, are in prison or their whereabouts are unknown, such information should be included into the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Where do you sleep at night?*
- *Do you live with any adults?*
- *Do you have parents and/or other relatives? Where do they live?*
- *How/when/under which circumstances did you start living on the street? Why did it happen?*
- *When did you find yourself in such conditions? How long have you been living like that?*
- *Did you choose to leave home or were you forced to leave?*

**\*\***The right to family is stipulated in the third part of article 4 of the Family Code of Ukraine: “Everyone has the right to live in the family. A person may be subject to enforceable separation from the family in cases and according to the procedure prescribed by law.” This provision is in line with article 51 of the Constitution of Ukraine: “Parents shall be obliged to sustain their children until they are of full age. Adult children shall be obliged to care for their parents who are incapable to work. The family, childhood, motherhood, and fatherhood shall be under the protection of the State.” Besides, the right to live in the family is closely related to right to housing, which is envisaged in article 47 of the Constitution of Ukraine: “Everyone shall have the right to housing. The State shall create conditions enabling every citizen to build, purchase, or rent housing. Citizens in need of social protection shall be provided with housing by the bodies of State power and local self-government, free of charge or at a price affordable for them in accordance with law. No one shall be arbitrarily deprived of housing other than on the basis of the law pursuant to a court decision.”

**QUESTION 2.** Answers to this question allow to understand if the client’s *right to a standard of living sufficient for themselves and their families* were violated.

**“Warning” answers** *“Once a day,” “It depends,” “Other”.*

If an adolescent chooses one of the first two options or “Other,” the counsellor should try to clarify the adolescent’s situation. If there are any facts showing that the adolescent is not able to have regular meals due to the negligence of adults or that he/she does not have parents or money, the counsellor should ask if the adolescent is able to access any social benefits or is able to have meals at school. If the answer is negative, such information should be included into the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Where do you usually eat? How do you have your meals? Who cooks your food?*
- *Do you have an opportunity to have meals at home/at school/at your relatives?*
- *Who usually buys food for you? Does your family have money for food?*

**\*\***Article 48 of the Constitution of Ukraine states: “Everyone shall have the right to a standard of living sufficient for themselves and their families including adequate nutrition, clothing, and housing.”

According to the first part of article 184 of the Code of Ukraine on Administrative Offences, if parents or persons replacing them fail to fulfil their obligations stipulated by the law to ensure proper living conditions, education and upbringing of minor children, it entails a warning or imposition of a fine from one to three tax-free minimum incomes of citizens. The same actions committed repeatedly within a year after the imposition of administrative penalties entail imposition of a fine of two to four tax-free minimum incomes.

**QUESTION 3.** Answers to this question allow to understand if the client's *right to education* is violated.

**“Warning” answers** “Attended middle school and then did not continue my studies,” “Do not go to school as I do not have money and/or due to other circumstances,” “Do not want to go to school as it makes no sense,” “Other.”

If an adolescent chooses one of the first three options or “Other,” the counsellor should try to clarify the reasons why the respondent fails to attend school. In case if the adolescent was not allowed to continue education, lost his/her documents, which made it impossible to continue studies or experienced degrading treatment and thus lost motivation to study, such situations should be described in the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Could you please tell me when and why you dropped out of school?*
- *Did people treat you well at school/community college? Did you have any conflicts with your peers and/or teachers?*
- *Do you have all you need for studying – copy-books, pens, books, a backpack?*
- *Do you have enough money to buy all the study materials and to pay for transport?*

**\*\***The right to education is set forth in article 53 of the Constitution of Ukraine: “Complete general secondary education shall be compulsory. The State shall ensure accessible and free pre-school, complete general secondary, vocational and higher education at the state and communal educational establishments; the development of pre-school, complete general secondary, extra-curricular, vocational, higher and post-graduate education, various forms of study; the provision of state scholarships and privileges to pupils and students.”

**QUESTION 4.** Answers to this question allow to understand if the client's *right to health protection, medical care and medical insurance* is violated.

**“Warning” answers** “Teacher,” “Social worker,” “Do not turn to anyone,” “Other.”

If an adolescent chooses one of the first three options or “Other,” the counsellor should ask about the reasons why the respondent is not able to go to a doctor and ask if the client knows where to access support (medical, social, psychological, etc.). If there are any facts of the respondent being denied health care, free of charge or in any other way, such information should be stated in the legal assistance form, indicating the healthcare institution and full name of the doctor who failed to provide health care.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Have you ever attended a doctor? When was the last time you attended a doctor? Why did you stop seeing a doctor/do you not see a doctor now?*
- *Are there any other people, apart from the social worker, from whom you could seek medical aid? If no, why?*
- *Have there been any cases, when you were denied health services because you did not have money?*
- *When were you denied health services? Who refused to provide such health services?*

**\*\***Article 49 of the Constitution of Ukraine stipulates that everyone shall have the right to health protection, medical care and medical insurance: “Health protection shall be ensured through state funding of the relevant socio-economic, medical and sanitary, health improvement and prevention programmes. The State shall create conditions for effective medical service accessible to all citizens. State and communal health protection institutions shall render medical care free of charge; the existing network of such institutions shall not be reduced. The State shall promote the development of medical institutions under all forms of ownership. The State shall provide for the development of physical culture and sports, and ensure sanitary-epidemic welfare.”

Besides, the right to health is enshrined in article 6 of the Law of Ukraine dd. 19.11.1992 No. 2801-XII “Fundamentals of the Ukrainian Legislation on Health Care,” Concept of Public Health Development in Ukraine, approved with the Decree of the President of Ukraine dd. 07.12.2000 No. 1313/2000, Decree of the President of Ukraine dd. 06.12.2005

No. 1694/2005 “On Emergency Measures to Reform the Public Health Care System,” and the Law of Ukraine dd. 19.10.2017 No. 2168-VIII “On State Financial Guarantees of Public Health Care.”

**QUESTION 5.** Answers to this question allow to understand if the client’s *right to protection by court, authorized government agency or public official* is violated. Besides, answers to this question can give additional information about the *right to family*.

**“Warning” answers:** “Will tell about it to a social worker or a school teacher,” “Will not tell anyone as it will not change anything,” “Have nobody to tell about it,” “Will tell my family members (but not parents) about it,” “Will tell my friend about it,” “Other.”

Thus, if the respondent chooses any other answer apart from “Will tell my parents about it,” the counsellor should try to learn more about the circumstances leading to violence in any form and offer the required help (officially seeking protection from such violence). Any relevant facts detected should be described in the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Has anyone ever hurt you? How? Have there been any such cases in your life? If there were any such cases, when did it happen last time? How often did it happen?*
- *Could you please tell in more detail what happened? Who hurt you? How? Whom did you tell about it? Has anybody helped you?*

**\*\*Article 55 of the Constitution of Ukraine envisages that human and citizen rights and freedoms shall be protected by court. Everyone shall be guaranteed the right to challenge in court the decisions, actions, or inactivity of State power, local self-government bodies, officials and officers. Everyone shall have the right to appeal for the protection of his rights to the Authorised Human Rights Representative (Ombudsman) to the Verkhovna Rada of Ukraine. Everyone shall have the right to protect his rights and freedoms from violations and illegal encroachments by any means other than prohibited by law.**

**QUESTION 6.** Answers to this question allow to understand if the client’s *right to voluntary sexual relations* is violated; it is closely linked to question 7 concerning *prohibition on sexual exploitation of children*.

**“Warning” answers:** “It is because it gives me an opportunity to get drugs, food, shelter, money, gifts, etc.,” “I do it with casual partners,” “I do it NOT by choice,” “Other.”

If an adolescent chooses one of the first three options or “Other,” the counsellor should ask more questions. Any facts concerning possible deceit, coercion to sex or any facts proving that the sex partner was much older than the client, should be analysed in more detail and included into the legal assistance form if there are any elements of offence.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *I you already have sex, do you always do it by choice? If not, under which circumstances does it happen?*
- *What have you been offered in exchange for sex? When did it happen? Who was it (someone you know or not, where you met, etc.)? Where did it happen (at home, at school, at a club, at your friends' home, etc.)?*
- *Have you ever been forced to have sex? Who did it? Have you told your parents/family members/teachers/friends about it? If no, why?*
- *How old was your sex partner?*

**\*\*Article 154 of the Criminal Code of Ukraine envisages responsibility for compulsion to sexual intercourse “by a person on whom such female or male is financially or officially dependent.”**

**\*\*Article 155 of the Criminal Code of Ukraine envisages responsibility for sexual intercourse with a person under sixteen years of age.**

**\*\*Article 156 of the Criminal Code of Ukraine envisages responsibility for the “debauchery of minors,” i.e. “debauched actions committed in regard of a person under 16 years of age.”**

**\*\*International law recognises the fact that children due to their physical and mental immaturity require special care and protection, including proper legal protection before and after birth. The need to provide special protection to children was first proclaimed in the Geneva Declaration of the Rights of the Child (1924), then reaffirmed in the Universal Declaration of Human Rights (1948) and in the Declaration of the Rights of the Child (1959) and recognized in the International Covenant on Civil and Political Rights and in the Convention on the Rights of the Child (1989). In Ukraine, the UN Convention on the Rights of the Child was ratified by the Resolution of Verkhovna Rada of Ukraine dated 27.02.1991 No. 789-XII. Later, Ukraine ratified all of the above-mentioned treaties as well.**

**\*\*Article 10 of the Law of Ukraine dd. 26.04.2001 No. 2402-III “On the Protection of Childhood” declares that every child is guaranteed the right to liberty, security of person and protection of dignity.**

**QUESTION 7.** Answers to this question allow to understand if there were any cases sexual or economic exploitation of children.

**“Warning” answers:** “My friends/acquaintances support me,” “I have a regular job,” “My sexual partner gives me money,” “I do not have it,” “Other.”

If the respondent chooses any other answer apart from “My parents/guardians give me money,” the counsellor should ask more questions about the potential right violations. If there are any facts about a minor being offered a job, in particular abroad, or if a minor is working in difficult conditions or providing sex services for money, the counsellor should explain the risks of such work. Any responses, which show the facts of unlawful actions or coercion to work, should be studied and described in detail in the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *If you do not have pocket money, how does it influence your life/behaviour?*
- *How many days a week/hours a day do you work? What are your working conditions? How much money do you make? Does your work interfere with your studies?*
- *Why did you decide to work? Who offered you a job?*

**\*\*The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (ratified with the Law of Ukraine dd. 03.04.2003 No. 716-IV) stipulates that any acts related to the sexual exploitation of children shall be fully covered under the national criminal law.**

The Criminal Code of Ukraine prohibits any sexual exploitation of children (parts 2, 3 of Article 149 “Trafficking in human beings and other illegal transfer deals in respect of a human being,” part 3 of Article 301 “Importation, making, sale or distribution of pornographic items;” parts 3, 4 of Article 303 “Pimping or engaging person in employment prostitution”) and economic exploitation, i.e. using the labour of children under the age of employment (Article 150 of the Criminal Code of Ukraine).

**QUESTION 8.** Answers to this question allow to understand if the client's right to the presumption of innocence was violated and check if the client had any contacts with police, if there were any facts of pressure on the client or maybe any facts of unjustified detention or accusation in committing any offences.

**“Warning” answers:** “I am afraid I will be arrested for no reason,” “I know they will try to find something to blame on me,” “I am afraid they will tell I am selling drugs,” “I want to run away,” “Other.”

If the respondent chooses any other answer apart from “I feel calm as I know I have done nothing wrong,” the counsellor should ask more questions about the potential right violations.

Any responses, which show violation of the right to the presumption of innocence or any unlawful actions of police, should be analysed and included into the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Have you ever been detained by police? Could you tell me more about what happened, how and when? Why do you think it happened?*
- *Why are you afraid that you will be accused in doing something wrong? Have there been any such cases before? Could you tell more about what happened, how and when?*

**\*\*Article 62 of the Constitution of Ukraine envisages that a person shall be presumed innocent of committing a crime and shall not be subjected to any criminal punishment until his guilt is proven through a legal procedure and established by a court verdict of guilty. No one shall be obliged to prove his innocence of committing a crime. An accusation shall not be based on illegally obtained evidence or on assumptions. All doubts in regard to the proof of guilt of a person shall be interpreted in his favour. Similar principles are declared in Article 7 of the Convention for the Protection of Human Rights and Fundamental Freedoms. A child shall not be responsible for the losses inflicted thereby (Article 31 of the Civil Code of Ukraine). Article 1178 of the Civil Code of Ukraine stipulates that damage inflicted by an infant (under fourteen years old) shall be indemnified by his/her parents (adopting parents), tutors or the other physical person legally authorized to educate the infant.**

**\*\*Part 2 of Article 184 of the Code of Ukraine on Administrative Offences states that if minors aged 14 to 16 years old commit an offence punishable according to this Code, it entails imposition of a fine of three to five tax-free minimum incomes on their parents or persons replacing them.**

**QUESTION 9.** Answers to this question allow to understand if the client experiences any prejudice from the side of police, social workers, teachers, parents/guardians, which can be a manifestation of *stigma*.

**“Warning” answers:** “Police officers,” “Social worker,” “Psychologist,” “Teachers,” “Parents/guardians,” “Peers,” “Health workers,” “Other.”

If the respondent chooses any other answer apart from “I do not feel it, everyone treats me well,” the counsellor should ask more questions about the potential right violations. The counsellor should always ask additional questions to find out who treated the client and how, how such treatment manifested itself, when was the last time the client experienced such attitude, etc. Such cases and forms of ill-treatment should be analysed and, if there are any unlawful actions, they should be included into the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Who was treating you badly? How was such bad treatment manifested?*
- *When was the last time when someone treated you badly? How often did it happen?*

**\*\*Article 52 of the Constitution of Ukraine states that children shall be equal in their rights regardless of their origin and whether they are born in or out of wedlock. Any violence against a child or his exploitation shall be prosecuted by law.**

**\*\*Article 14 of the Convention for the Protection of Human Rights and Fundamental Freedoms: “Prohibition of discrimination. The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”**

**\*\*Law of Ukraine “On the principles of prevention and combating discrimination in Ukraine” is a framework document containing a definition of “discrimination,” clearly**

defining its key forms and prohibiting any forms of discrimination based on an open list of individual and group characteristics.

**QUESTION 10.** The answers to this question help to understand if there are any facts of discrimination against the client and how they are manifested in the life of the adolescent.

If the respondent chooses any other answer apart from “Other,” the counsellor should ask more questions about the potential right violations. The counsellor should always ask additional questions: “Who did it, how it happened, when was the last time it happened?”. If any cases of discrimination are identified in the course of conversation, they should be included into the legal assistance form.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Who was treating you badly? How was such bad treatment manifested?*
- *When was the last time when someone treated you badly? How often does it happen?*
- *Would you like to change the way people treat you? If yes, whose attitude you'd like to change? How?*

**\*\*Regulatory norms related to this question are the same as for question 9.**

**QUESTION 11.** Answers to this question help to understand if the client has any documents, if yes, then which documents and if no, which documents are to be re-issued.

Examples of follow-up questions that can be asked by the social worker/psychologist:

- *Have you ever had any identification documents? If yes, what happened to them and when?*
- *Have you made any attempts to re-issue your documents? When did you make the last attempt? Why did it fail?*

Passport of a citizen of Ukraine is issued from the age of 14, identification code is issued at any age – in the absence of a passport or before the age of 16 it is issued to a parent or a legal representative/guardian of a minor.

## **Step 2. Conduct a consultation and tell the client about his/her rights.**

After filling in the screening form, the social worker should offer the client basic information about the client's rights (even if no violations were detected). Clients should know their basic rights and where they can seek help if such rights are violated. If necessary, clients can be provided with individual consultations and training on human rights (if offered by the organisation) and/or information materials on the topic (if available). Clients should be told where they can seek assistance if their rights are violated and what they can do to protect their rights.

If the client's rights are violated, the following steps should be followed:

## **Step 3. Discuss and agree with the client an action plan to restore any violated rights.**

At this stage, it is good to find out if the client would like to take action to protect his/her rights, who can support the client and what outcomes the client expects to achieve. It often happens that clients do not want to do anything as they do not believe in success or are afraid to make the situation even worse. In this case, you can discuss what the client can do to avoid such situations in future. If the client would like to try to resolve the situation, plan further steps and organize a consultation with a lawyer from your organisation or from a partner organisation. Together with the lawyer, you will be able to decide if the client's rights were violated and if the client needs legal support. In some cases, the social worker can help the client to resolve the issue without any external support.

## **Step 4. Hand over the form and any other documents to a lawyer of your organisation or a partner organisation (with the client's consent).**

If the client's rights were violated and cannot be restored without legal support, the case should be submitted to receive further legal assistance. If there is a need to engage an external lawyer from a partner organisation or another agency, the counsellor can fill in a legal assistance form and with consent of the client and/or the client's parents/guardians submit it to such lawyer with all the accompanying documents/evidence. The legal assistance form should contain a detailed description of the situation, witnesses and documents, which can prove that the client's rights were violated. When preparing a legal assistance form, pay attention at any evidence/documents attached – they are to be stored (copied/scanned, etc.).

You can find an example of the legal assistance form (in Ukrainian) here: <http://afew.org.ua/wp-content/uploads/2016/12/Forma-zayavido-yurista.pdf>. Using the template will help you collect and organize all the information that a lawyer may need.



### **Step 5. Document the case in your database.**

The cases of rights violations should be documented to monitor the progress in such cases being settled. Statistics and case analysis can be helpful to identify any systematic instances of rights violations and carry out further advocacy to eliminate the prerequisites of such violations.

### **Step 6. Monitor how the problem is resolved for every case of human rights violations recorded in line with the Guide.**

From time to time, you should check if the situation has changed. Maybe you need to seek some additional information or adjust your action plan to restore the rights of your clients.

It bears reminding that human rights are only applicable to the relations between the state (government) and citizens – only the state (government) can violate human rights. Other citizens cannot violate such rights.

It is important to differentiate between situations with indications of human rights violations and situations of human rights violations.

*Situations with indications of human rights violations* are the situations, when clients tell us that their human rights have been violated by the state, while we do not have evidence and/or enough information about such violations. There can be no evidence because of the client not wanting to take further action to prove that his/her rights were violated or because there is no objective possibility to collect any evidence of such violations (e.g. if a lot of time passed since the rights were violated).

*Situations of human rights violations* are the situations, when the client's human rights have been violated by the state and the client's statement of such violations is confirmed with evidence.

Evidence means any documentary proof of the rights violation: written refusals, photo and video evidence, similar (repeated) situations\* that happened to other members of a certain group (e.g. other students). Most likely, clients will not be able to provide such evidence when they first seek your help. After clients discuss their cases with the counsellor and give their consent to collect evidence, they can start collecting such evidence on their own or with the help of your organisation. Evidence can also be received in response to official requests, complaints, letters, etc.

\*Situations, when we have no evidence, but have people who can witness on similar (repeated) cases, can also be interpreted as the situations of human rights violations. For instance, a group of students comes to your organisation and complains that their supervisor collects money for food products, but does not offer them any meals (or offers low-quality meals).

There is a rather simple scheme, which will help you see how a situation with indications of human rights violations can be turned into a situation of human rights violations. After a client faces any situation when his/her rights could have been violated, he/she needs to understand who was the perpetrator violating his/her rights or interests. If it was another person, even authorised by the state, the client has to address the state (represented by authorised government agencies), inform them about such violation and request relevant actions to protect/restore his/her rights. If the client sought help from the state, but the state with its actions or omissions failed to perform its functions, the client gets the required evidence of his/her right being violated and is able to document such violation and apply to a lawyer or another specialist to restore the violated right showing clear facts and relevant proof. In practice, situations often get resolved at the stage when people seek redress from authorised government authorities. To do so, most often people have to file relevant applications or complaints. Government authorities have to respond to any written requests of citizens in writing.

As an example, let us have a look at a typical situation. A 15-year-old girl calls an ambulance after she is beaten by her stepfather. The ambulance operator hears a childish voice and refuses to send an ambulance: "Stop messing around, girl, it is not funny."

This situation has indications of the girl's rights being violated. Recognition of human rights means recognizing that every person has a right to demand the following: I have my rights whatever you say or do as I am a human being just like you are. Every individual has human rights. The state represented by government authorities should guarantee and protect such rights. What can we do to establish that human rights have been

violated? We can seek redress from the head of the government body, which violated the rights and/or the authorised government agency responsible for protecting such rights (Police, Prosecutor's Office, in the case described above – Health Department). The inappropriate response of the ambulance operator may not reflect the position of the Ambulance Service and most likely, when learning about this case, they will take proper action to resolve the situation. The Ambulance Service is authorised by the state to provide emergency medical care, which according to the Constitution should be provided to all people free of charge. The state must guarantee this right and create a special emergency care service, which must perform this duty. Thus, in this case the operator's actions are unlawful as he cannot deny service to anyone without referring to specific instructions and the girl's right to emergency medical care should not be violated.

If the girl is denied medical care, she has to make sure it is officially recorded. She should ask the first name and the family name of the person denying such care, file a complaint for unlawful actions of this person and, if her complaint is ignored, we can say that the state has violated the girl's rights. If there is no possibility to find out the name of the person denying care, the girl still has a right to seek redress, filing a complaint and stating the time of her call to the ambulance and/or calling police. Article 16 of the Law of Ukraine on Citizens' Appeals stipulates that "the complaint on behalf of a citizen under his authority executed in the manner prescribed by law, may be filed by another person, labour collective or a human rights organisation." Referring to this provision and the fact of the adolescent's appeal (date, venue, time, telephone number of the adolescent), your organisation can seek protection of the adolescent's rights.

Taking legal action is a crucial step in protecting one's rights!

The scheme we described above is very simplified. However, it allows to understand that the response to any situation with indications of human rights violations should be about the individual's actions requesting the state to comply with its obligations. The role of social workers is extremely important here, as they have to instil in adolescents the skills to protect their rights and seek help. Even if due to some reasons social workers are not able to resolve a situation and/or refer their clients to a lawyer, it is still important to document the situations with indications of human rights violations as otherwise you will not be able to get any statistics on the violations of adolescents' rights in your city/town and local authorities can use it as a proof that the adolescents' rights are not violated. If it is true and the adolescents' rights are not violated, it should also be documented to analyse how your city was able to achieve such a great result! However,

if it is not true and the adolescents' rights are violated, who, if not you, can help restore justice or at least bring the problem up at the local and national levels?

### **Some lessons learnt based on piloting the tool to monitor MARA's rights violations**

- Most cases of adolescents' rights violations were related to stigma/bullying and discrimination. That is why it is important to offer training programmes for professionals, especially working in healthcare and education, which would be focused on non-stigmatising and non-discriminatory attitude to adolescents. Adoption of the Law of Ukraine dated 18.12.2018 No. 2657-VIII "On introducing amendments to some legislative acts of Ukraine on fighting bullying" can motivate educators to engage in such training programmes.
- Counselling sessions for adolescents on their rights should also cover their obligations. The experience shows that when adolescents get information only about their rights, it can lead to their false perception that adolescents are not responsible for their unlawful actions.
- Using the monitoring tool allows not only to identify the cases of human rights violations, but also to pay more attention to other important aspects of the adolescents' life. Adolescents often seek help because their parents humiliate them. Thought it is not violation of their human rights as stigma here comes from their parents, not from the state, in the context of social work building relations with parents is just as important.
- In most cases, adolescents are not willing to actively protect their rights as they are afraid to have open conflicts and make their situation worse. It is even more difficult to motivate adolescents to protect their rights in small towns, where social connections are tight and it is hard to keep information confidential. That is why examples of successful rights protection can be a good motivation for adolescents. Besides, counsellors should make a focus on building trust with adolescents and supporting them.
- The experience of using the tool shows that even if adolescents refuse to take action to protect their rights, the information shared by social workers and other professionals when analysing their situation helps adolescents to feel more confident in similar situations and protect their rights on their own as well as seek help in future.
- The real number of rights violations that adolescents face may be much higher as professionals often fail to document the cases, when problems are quickly resolved

or when, on the contrary, they consider some cases as very complicated or typical.

- To protect the rights of adolescents, it is crucial to engage lawyers and legal counsellors, in particular from partner organisations. However, in the cities where lawyers were the first people to establish contact with adolescents or offer screening to identify any possible rights violations, the number of cases reported was lower than in the places where adolescents first talked to social workers. We can assume that the trust that adolescents usually build with social workers helps them open up and thus contributes to better identifying any possible violations. If social workers complete basic training on human rights, they are often able to settle certain problems even not engaging lawyers. That is why the role of social workers in detecting human rights violations and protecting the rights of adolescents is essential.

Despite the fact that the tool can be used by counsellors with no legal background, if you plan to implement similar interventions in your organisations, it would be helpful to start with a basic training for your staff and members of your partner network on human rights and rights of the child as well as peculiarities and practices of using the monitoring tool.

Protection of rights is an integral part of any social work, in particular aimed at preventing HIV and promoting safe behaviours. If we analyse the cases identified, we can see the links between the facts of adolescents' rights violations and their risky behaviours. For instance, if an adolescent's right to housing is violated and he or she spends most of the time in the street and has an experience of using psychoactive substances, it can become a risk factor and lead to more frequent drug use and risky sexual behaviours. Vulnerable position of such an adolescent also restricts his or her access to various services. The data obtained through monitoring can also be used for advocacy at the local and national levels.

If you or your organisation would like to get more information or engage in monitoring and documenting the cases of MARA's rights violations, you can find the monitoring tool (in Ukrainian) here: <http://afew.org.ua/monitoring-prav>.



You can also listen to a webinar on this topic (in Russian) in online library of the Knowledge Centre: <http://knowledge.org.ua/webinar-jurista-vity-musatenko-o-narushenii-prav-pgr/>.



Besides, you can watch the presentation of people who were directly involved in launching the tool (in English, Ukrainian and Russian): <http://afew.org.ua/nerubaieva-iryna-ta-musatenko-vita-monitoring-porushennya-prav-pidlitkiv/>.



Some other aspects of the rights protection are covered here (in Russian): <http://afew.org.ua/delemenchuk-oleksandra-vsesvit-garri-pottera-ta-prava-lyudini-charivniki-pravozahisniki/> and here (in Ukrainian with Russian subtitles): <http://afew.org.ua/zubatenko-valeriya-parayuridichna-dopomoga-pravozahist-dlya-pidlitkiv/>.



You can also use the brochure “My rights are always with me” (in Ukrainian) to raise the awareness of adolescents on their rights: <http://afew.org.ua/moyi-prava-zavzhdzi-zi-mnoyu/>. Every section of the brochure contains information on the basic rights and duties of adolescents, references to current laws, contact details of the organisations where adolescents can seek help as well as other important information on human rights that the adolescents should know.

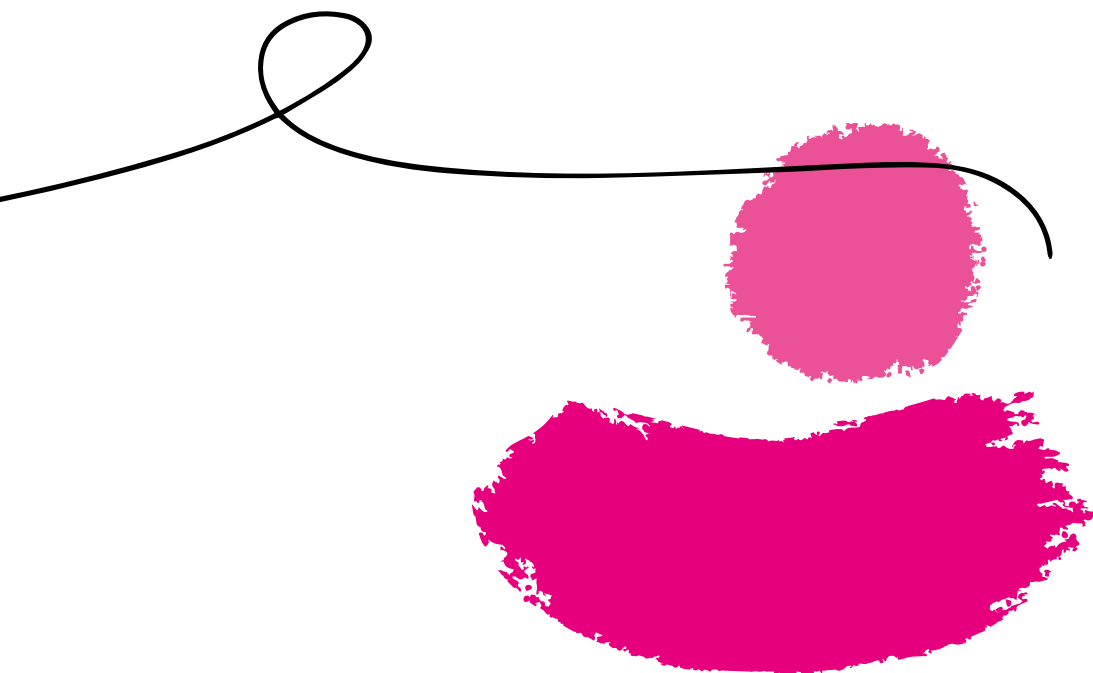


Besides, you can take a free course “Everything you need to know to protect the rights of adolescents in Ukraine” (in Ukrainian), where you will learn what human rights mean and what they are about; what is special about the rights of children and adolescents; what Ukrainian legislation states about the rights to education, labour, family, housing, health care and documents; how to monitor violations of the adolescents’ rights; what to do to protect and restore one’s rights. After you complete the course, you can get a certificate. Link to the course: <https://courses.ed-era.com/courses/course-v1:AFEW+1+2020/about>.



9

*Access to services in rural  
and remote areas*



Before 2017, almost all HIV/STI/TB and drug use prevention services for adolescents were concentrated in large cities, while no activities were carried out in smaller towns or villages. Besides, there were no research studies to analyse the needs and the available resources to support adolescents in such settings. For many years, civil society organisations located in larger cities received numerous requests from their partners working in smaller towns and villages to share their knowledge and provide them with information and awareness-raising materials. In particular, such requests to share experience of organising prevention activities for vulnerable adolescents in rural areas were received from remote training centres, juvenile prevention institutions and other state-run agencies at the local level as well as vocational schools in larger cities, where the majority of students come from remote rural areas. However, for a long time limited resources did not allow to support such initiatives.

In late 2017, financial support of Expertise France 5% Initiative opened opportunities allowing to address such requests and start a three-year project "Underage, overlooked: Improving access to integrated HIV services for adolescents most at risk in Ukraine." The overall project goal was to contribute to lowering HIV rates among adolescents who use drugs and their sexual partners by improving the access to quality HIV prevention, treatment and support services in urban and rural areas of Ukraine. Nine experienced civil society organisations (CSOs) from the regions, in which larger cities were successfully implementing prevention projects for youth, such as Poltava, Kharkiv, Donetsk, Odesa, Kyiv, Kirovohrad and Chernivtsi regions, joined the project. In this section, we will show how it is possible to ensure the access of adolescents to friendly services in rural and remote areas, using our project examples.

When we are talking about the format of prevention services for adolescents, most often we imagine a youth centre in a large city, with convenient public transport, with various professionals offering their consultations and with a range of classes organised for adolescents and their parents. In this model, we invite adolescents to our centre, where we offer them a variety of services as well as safe and exciting space for leisure activities. The work of such youth centre can be supported by outreach work – "street social work" or "mobile service delivery sites" – when the professionals working with such centre come to the venues convenient for adolescents to offer their services. Outreach work is performed by social workers and other professionals moving along their route with a mobile van or on foot. Thus, adolescents can receive consultations, information materials, personal protection equipment and hygiene items as well as test for HIV/STIs with rapid tests. Before going on outreach routes, it is always necessary to map the venues where adolescents spend most of their time – parks, abandoned buildings,

deserted construction sites, bridges, wastelands, bars, shopping and entertainment centres, streets, alleys, squares, train stations, music festivals, etc. Besides, social workers organise meeting with local young leaders at the venue in advance and give them all the necessary information, including the schedule of outreach services. Thus, their visits are not perceived by adolescents as an unexpected or undesired intrusion, but, vice versa, most often adolescents wait for the outreach workers to come. The first contact with adolescents takes place at their own territory and on their own terms, which allows them to feel that they control the situation. Later, outreach workers can invite adolescents to the youth centre, which is a new territory, but they already know some people there from the street interventions.

In larger cities with population over 100–200 thousand people such format of work allows to ensure anonymity and confidentiality, not restricting the freedom of adolescents and gradually building trust with them to provide the required support as soon as needed. First of all, it is possible because people working at the youth centre are not acquainted with adolescents, their parents or other people from their immediate circle, which helps them look at the situation from the outside and avoid any labels or stereotypes from the very beginning. But is the same format of work feasible in a smaller town or village, where all people know each other and every adolescent already has a “reputation” in the community? How can work be organised to ensure clients’ confidentiality, which is so important? Where and how can services for the most vulnerable adolescents be organised? How to define if there are such adolescents in the local community and if there is a need in any specific services for youth? Answers to those questions are crucial to plan any effective interventions. That is why we started our project with an exploratory research. Apart from looking for answers to the questions above, it was also aimed at analysing the behaviours of adolescents who use drugs and live in remote and rural areas in seven regions of Ukraine, defining their needs and available services, selecting towns and villages to be covered by each of the nine implementing organisations and defining the specifics and prospects of further interventions in the selected towns and villages. Besides, with this project we wanted to draw the attention of central and local authorities to the problem of drug use and relevant issues of adolescents in remote and rural areas and justify the need to change the system of service delivery in communities to protect the health of adolescents. The study report offers practical recommendations on how to achieve reduction of HIV transmission among adolescents who use drugs and their sexual partners at the national and local levels.

Such exploratory research studies have already been carried out among adolescents and services providers in large cities. At the same time, residents of smaller towns and

rural areas have been overlooked. Those settlements have a much weaker infrastructure for youth development and entertainment. HIV prevention and harm reduction services are usually insufficient or even missing. There are also fewer possibilities for HIV testing, which brings down the chances of early diagnostics and affects the expected outcomes in terms of the adolescents' health and life.

The methods used for the exploratory research included secondary data analysis (overview of all the existing programmes and services for adolescents), mapping services for adolescents and youth in the selected regions, mapping the venues where adolescents spend their time, structured and in-depth interviews with adolescents and focus group discussions with service providers.

The challenges of analysing the situation with adolescents who use drugs in new places were first of all related to the closed nature of this group and lack of trust to government representatives, which is how the interviewers could be perceived. Besides, it should be noted that most adolescents do not associate themselves with drug users, even if they have an experience of using PAS. Some of them used drugs just once, most of them did it from time to time, and only part of them were drug dependent. At the same time, such attempts and episodes of drug use are often hidden, while certain psychoactive substances are not perceived by adolescents as "drugs." Adolescents are not always able to see the real impact of psychoactive substances on their health and life or their level of engagement in drug use.

The data obtained show that most adolescents who use drugs study and/or work; live at home with their parents or in dormitories; regularly attend educational institutions. Thus, they are ordinary adolescents, who have no peculiar characteristics, which would allow easily identifying them among their peers. 24.6% of the respondents had friends/acquaintances who inject drugs and according to expert opinion there were adolescents who inject drugs in the study venues.

Three quarters of the adolescents who used drugs were boys. The average age when the respondents first tried drugs was 14.6 years old. The average age when the respondents first injected drugs was 15.8 years old. More than a half of 14-year-olds (56%) told that they first used drugs when they were 13 years old or younger. These data demonstrate the importance of primary prevention of drug use among the adolescents under 14 years of age, in particular to prevent first attempts of drug use among those who have close friends who use drugs but have not used drugs themselves yet. Most respondents

used non-injecting drugs. However, many adolescents who inject drugs probably have not been interviewed. In-depth interviews confirm that adolescents use a wide range of psychoactive substances and know other adolescents who use drugs. Non-injecting drugs, which respondents reported using: cannabis, amphetamine, spices, methamphetamine, salts, LSD, MDMA (ecstasy), hallucinogenic mushrooms, “pills” (over-the-counter drugs), nasvay; injecting drugs – “shirka” (self-made opioid solution), methadone. Another popular trend is mixing drugs, which means combining 2 or 3 types of substances or combining narcotic drugs with pharmacy medicines or energy drinks. 8.8% of the respondents (60 adolescents) reported an experience of overdose in the recent year. Among them 29 respondents used one drug, 4 – mixed several drugs, 27 – mixed alcohol with drugs.

In-depth interviews show that adolescents use drugs to relax, reduce stress after school (cannabis); for less inhibitions, high spirits and pleasure, to increase performance and get some adrenaline (stimulants). Another important motive is using drugs “socially,” to improve one’s communication and entertainment experience. Cannabis is seen as totally safe and, in some cases, even useful (“it clears the lungs”). Usually adolescents use psychoactive substances together with their friends because, as they say, it is more fun; only in some cases they use drugs alone. Using drugs with a group of friends to relax or relieve stress illustrates one of the biggest needs of adolescents – the need in other people’s support and exciting leisure activities.

76.1% of the respondents have sexual experience (gender variations are not substantial). The average age of sexual debut was 14.9 years old (14.8 for boys and 15.2 for girls). As of the time of survey, two out of 19 girls who had an experience of pregnancy were 16 years old, four were 17 years old, five were 18 years old, and eight were 19 years old. Only half of the respondents (49.6%) stated that they always used condoms when having sex. Using alcohol and/or drugs before sex is very wide-spread among adolescents. Six boys and six girls stated that in the recent year they had sex in exchange for money, clothes or drugs.

Most adolescents in rural and remote areas access internet with their own smartphones (85.4% have their own smartphones and 84.9% use internet every day). There is a high level of engagement in online games, including gambling, among the adolescents. Boys are engaged in such games twice as often as girls. The most popular social media, websites and apps among adolescents are YouTube, VK, Instagram, Viber and Telegram. Most hobbies mentioned by the respondents were not linked to the local entertainment infrastructure.

The survey results confirmed that the access of adolescents in rural and remote areas to drug treatment and harm reduction services is much lower than in larger cities. The most challenging situation is in villages and small towns, which have only primary health care available in local ambulatories, while health services related to drug treatment and reproductive health (key risks for adolescents) are not available. The key barriers hindering the access of adolescents in small settlements to services are institutional and financial barriers as well as the lack of human resources. Some health organisations only work with people over 16 years of age (e.g. confidential counselling rooms in Kyiv and Kharkiv regions). In most analysed cities and towns, youth centres (hubs) aimed to promote social engagement and development of young people were missing or, if they were available, they were not functioning to their full capacity. Adolescents who use drugs are not among the target populations of the Centres of Social Services for Family, Children and Youth. Such centres can only refer young people to re-socialisation facilities for drug dependent young people. Adolescents under 18 years of age do not have a right to seek any services of such re-socialisation facilities on their own. Not all education facilities have staff to provide psychosocial services to adolescents. Not all of them have space to organise any active leisure activities for adolescents (sports, physical development or other extracurricular activities). Qualifications of school psychologists (or psychologists at vocational or technical schools and night schools) not always allow them to provide support to adolescents who use drugs. Probation officers also pointed out that it was necessary to engage a psychologist to work at the probation department. Health facilities do not have any drug abuse specialists working with adolescents or, if there are relevant specialists, they only provide services to people over 18 years of age.

Usually, in smaller towns and villages most people know each other, which leads to confidentiality issues. Adolescents point out that they often cannot even buy condoms in pharmacies, because the person selling condoms knows their parents or other relatives, so they think that in some way their family members or other adolescents will hear the rumours about their visit to the pharmacy. The same goes for confidentiality when receiving certain services. Girls said that there were cases when they went to a gynaecologist and later their parents found out about it. Often, adolescents are just denied services when they come to a doctor without their parents or other adults representing their interests.

Another crucial barrier in working with adolescents who use drugs and their parents is lack of trust to government agencies. People do not trust public officials and fear them (as opposed to non-governmental bodies, such as civil society organisations).



*“[They most often fail to seek services] because they are afraid they will be reported or put in a register. As for civil society organisations, those are just people, who will provide them support with no consequences at the government agencies, no registration, no reports to parents or school, etc.” (Focus group participant).*

In some settings, the professionals, who took part in focus group discussions, demonstrated that they were used to the vertical system of communication and were not ready to initiate any programmes or activities to protect the interests of adolescents. If there are instruction “from above,” these people are ready to do the work. However, they are not used to initiating changes themselves. The existing coordination among different institutions and organisations is built rather on personal contacts and interactions and mostly covers the most problematic cases of adolescents, which require emergency response.

More detailed information about the research results can be found in the report: <http://afew.org.ua/en/research5/>.



Based on the research results, 29 towns and villages were selected to pilot service delivery in rural and remote areas (three or four for each of the nine participating CSOs) based on the following criteria:

- population of about or under 30 thousand people;
- low social and economic status of local people (general standard of living, poverty rate, lack of big enterprises and production facilities, unemployment level);
- inconvenient transport connection with large cities (distance over 50 km, quality of roads, types and frequency of public transportation, etc.);
- relatively big number of adolescents who live and/or study in the community, presence of technical or vocation schools;
- relatively high level of HIV/AIDS prevalence in the local population;
- number of registered drug users;

- pregnancy rate among adolescents;
- number of families in difficult life circumstances;
- number of adolescents registered in probation programmes;
- no local civil society organisations or charities offering services to adolescents;
- lack of professionals qualified to work with adolescents;
- demand in the community to work with youth and adolescents, willingness to cooperate.

If project organisations, when working in a certain location, observed significant positive changes and additional resources allocated as well as support of the local government through the existing institutions, such location was changed into another one. However, it did not mean it was fully excluded from the project: CSOs stayed in touch and supported the created partner network, in particular engaged their partners to awareness-raising activities and provided them with information and resources. Besides, CSOs maintained contact with adolescents, especially those who became project leaders (mostly online, through social media, Viber groups or telephone).

Project activities were first of all aimed at adolescents aged 14 to 19 years old, but were not restricted to this age group. The key criterion to engage clients in the project was risky behaviours related to drug use and/or sexual practices.

Based on the study results and many years of experience in implementing prevention projects for adolescents in larger cities, a pilot model was developed to implement activities in rural and remote areas. It should be noted that this model can be easily adapted to the local context of a particular settlement.

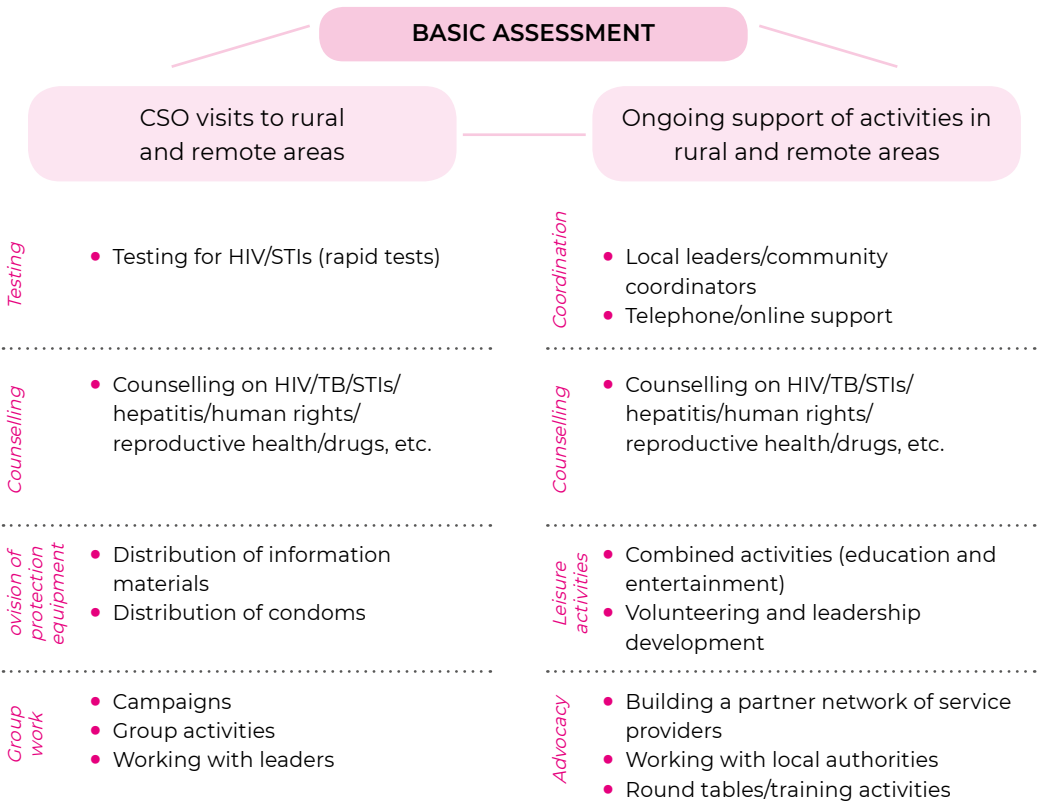
The key interrelated components of the model include basic assessment, visits of implementing partner CSOs to the target settlements and ongoing support of prevention activities at the selected sites. As mentioned above, basic assessment should be carried out prior to the project activities or at the same time with project implementation and should define the content and the format of any interventions. However, even if the assessment is carried out at the start, certain components of such assessment can be used on an ongoing basis within the monitoring and assessment system. For instance, surveys to track any changes in the knowledge of clients or focus

group discussions with members of the partner network on the efficiency of cooperation and allocation of available resources can be carried out every six or twelve months.

**The pilot model to be implemented in rural and remote areas includes the following components:**

1. Studying the project target group at the local level, defining its key needs and problems, analysing the existing resources and services.
2. Presenting the project and getting acquainted with the local authorities through organising a round table or a meeting with local public officials in another format.
3. Defining the key decision-makers and the local community leaders and building cooperation with them.
4. Identifying potential local partners, building a partner network and a referral network for clients to receive a range of services (signing relevant memoranda, developing guidelines, selecting convenient communication channels).
5. Organising training for local community leaders and members of the partner network (on the forms and methods of working with adolescents), supporting them with information and resources.
6. Working in rural and remote areas: regular visits to provide services to project clients, adaptation of services and approaches.
7. Working in rural and remote areas: organizing campaigns for adolescents and local communities (e.g. in educational institutions).
8. Defining leaders from among the project clients and engaging them to improve service delivery and advocate for allocation of funding for the required services from the local budget.
9. Advocating for the sustainability of services at the local level by organising campaigns, round tables, etc.

Schematically, this model can be depicted as follows:



A peculiar feature of working in the selected rural and remote areas was the fact that in those areas there were initially no providers of prevention services for adolescents (even if they existed on paper). So such services had to be “brought” from larger cities. Every organisation developed a plan and a schedule of site visits. The first visits were aimed at getting to know local administrations and potential partners. Round table discussions were organised to build partnerships. Initially, it was planned to organise round tables at the regional level, inviting key representatives of local administrations and potential partner organisations from all the selected settlements to the larger cities where CSOs worked. Thus, potential partners could get to know each other as well as CSOs and visit youth centres in the large cities to see the practices and methods of work. However, this option had to be abandoned due to a number of reasons. Firstly, the selected sites were located rather far from large cities, which made it very difficult to organise the logistics and to agree on the date and time of such visit to be held within

one day. Secondly, it was problematic for public officials from the local administrations to dedicate a whole day to take part in such meetings. Besides, the initial assessment as well as the practical experience showed that every settlement had its own specifics, which had to be discussed at separate meetings. In particular, it is about the specifics of relations between local decision-makers, infrastructure and resources. That is why it was decided to organise separate round table discussions in every target settlement.

After people got to know each other and contacts were established, the activities were launched, which included regular visits of CSO and research team to the sites. The component of site visits is comprised of two stages – preparations and the visit itself. Preparations include coordination of the dates and agenda of each visit with the local partners and informing adolescents about the services they will be able to receive. The general schedule of site visits can be approved for three or even six months. However, in practice it has to be revised and updated as it can depend on the quarantine measures in educational institutions, where lectures are organised, weather conditions, which may hinder street campaigns, etc. Usually, the team going on a site visit includes a social worker or a psychologist, a nurse and a coordinator. There can also be other social workers and educators as well as other professionals (e.g. lawyers) who join the team. Depending on the objectives of the visit and the resources available, site visits can be conducted using mobile vans or other own or rented vehicles (then there should also be a driver) or public transport. Usually, the CSO team pays visits to every site two to four times a month. Every visit takes a whole day (8–11 hours), as the road to the site can take from one to three hours one way.

During the visit, the team typically covers some or all of the following areas:

- Activities in educational institutions (1–2 hours). Usually they include interactive group classes, individual and group consultations, training for leaders, surveys, distribution of information materials and individual protection equipment, rapid testing for HIV/STIs. Besides, there is a possibility to organise campaigns and quests in the premises of such institutions as well as additional training for professionals, such as teachers, psychologists, social workers from government agencies, etc.
- Outreach work (1–2 hours). If there are some venues where adolescents gather after or instead of classes, the CSO team can initiate outreach activities there (e.g. in a park or near an abandoned construction site). Adolescents can be offered individual or group consultations, information materials and individual protection equipment. If there is a mobile van and/or good weather conditions, rapid testing for HIV/STIs can

also be organised. If it is possible, it is good to engage peer counsellors from among adolescents (volunteers and leaders). Motivation kits, which most often include food products, sweets, mobile phone vouchers, hygiene items and shopping certificates, can be used as incentives for adolescents.

- Street campaigns (1–2 hours). Usually, CSOs install their tents in central squares or parks, distribute information materials and visit cards, provide consultations, and if possible organise rapid testing for HIV/STIs. Street campaigns can also be organised in the format of quests, picnics or as part of music or other festivals.
- Meetings with local community leaders and members of the partner network (1–2 hours).

When planning site visits, it is important to take into account seasonal peculiarities. At the sites, where there are vocational schools with dormitories, it should be considered that in summer adolescents go home, so the format of work in the summer time should be revised, with the number and duration of visits reduced. Vice versa, at the sites, where there are summer camps and/or outdoor music and art festivals, activities should be intensified in summer. It is important to coordinate any activities with local administrations and obtain all the necessary permits.

The most difficult step when starting to work in rural and remote areas is reaching the target audience and establishing initial contact with vulnerable adolescents – those who use drugs and their sexual partners. To cope with this task, it is worth engaging local community leaders – people from the local community who work with adolescents and are aware of the local situation. They can help the project team to find adolescent leaders who will take part in the basic assessment and will further share information about the project among their friends and acquaintances. Another good entry point is organising classes and campaigns in educational institutions.

When the project is up and going, it becomes easier to find and engage clients. Generally, the engagement channels are the same as in larger cities:

- referrals from partners (juvenile prevention and probation departments, social services, secondary and vocational schools);
- self-referral (parents);
- friends' recommendations;
- peer counsellors;

- interactive classes and lectures in educational institutions;
- street campaigns, quests, contests, and flash mobs;
- social media and messengers (e.g. Instagram, Telegram, Viber);
- referral from “adult” harm reduction programmes (in places where such programmes are implemented);
- advertising (e.g. in local newspapers and local internet platforms).

Counselling and other project services are provided according to the standards of service delivery to adolescents with experience of using psychoactive substances (“Monitoring and Evaluation of the Quality of Services”) and include: counselling on HIV/STI/hepatitis, rights of the child, psychoactive substances and consequences of their use; individual and group activities; HIV testing; social support; distribution of information materials and personal protection equipment; referral to other service providers.

Considering that all settlements differ greatly in terms of their geographic position, population size, infrastructure and available resources, CSO adapted the pilot model to the local context and, in particular, introduced the following formats of work:

- Counselling sites for uninterrupted prevention services. Such sites operate in the settlements, where local administrations or partner organisations provided premises for ongoing work with clients and where there is a local leader or another professional, who can dedicate enough time to the project together with volunteers and young leaders from the local community.
- “Prevention over coffee” to engage new clients. This approach includes meeting clients in a café with a nice atmosphere, where they can order tea/coffee/pizza. To take part in such a meeting, an adolescent has to bring a new friend. This approach allows reaching new adolescents and building informal relations with them.
- Motivation kits for adolescent leaders. To motivate regular volunteers and leaders from among adolescents to take part in the project (engage new clients, provider peer counselling, help in organising and conducting activities), the project team can use motivation kits, which usually include food products, hygiene items, and mobile phone vouchers. It is a very good incentive for adolescents in areas with challenging social and economic conditions.

- Cooperation with youth hubs. In the areas, where there are youth hubs (centres or spaces for young people) or where there are possibilities to open such hubs, they can become safe spaces for adolescents to spend their leisure time as well as good platforms to provide services and offer personal development opportunities.
- Cooperation with educational institutions. In places, where the project team was able to build effective partnerships with education departments, educational institutions can become a platform for conducting prevention activities. For instance, a first aid room at school can be used to provide regular HIV/STI testing and distribute condoms and corridor walls – to place awareness-raising posters. Besides, the project team can agree with local psychologists/social workers to organise ongoing prevention activities and offer them additional training to build their competence.
- Outreach activities in parks. If there is no possibility to find premises for prevention activities (e.g. any attempts to establish cooperation with educational institutions failed and there is no room available to use or rent), outreach activities can become the main format of work. Ideally, such outreach activities should be organised in a mobile van, which would allow to bring a large stock of materials and provide access to testing for the adolescents.

As CSOs are not present at the project sites all the time, it is crucial to maintain regular contact with the local community. Such contact can be maintained through ongoing communication with every project site through local community leaders, volunteers or leaders among the clients. Every organisation can choose the most convenient ways of communication – phone, email or chats in messengers (such as Viber or Telegram).

The key assistants of the research team and the CSOs when reaching and engaging adolescents are the local community leaders, who should be selected at every site when launching the project activities. Such leaders can be local psychologists, teachers or other people working at educational institutions, social services, libraries, youth clubs, etc. Local community leaders can be selected with the help of local partner organisations, for instance, during round table discussions or interviews held at the start of the project. The leaders should become a bridge between the CSO implementing the project and the local community. In-between site visits of the project team they can provide basic consultations to adolescents, distribute information materials and personal protection equipment provided by the CSO and even support the adolescents to receive other services in the community. Local community leaders should also become advocates

of the prevention services for adolescents, contribute to sharing information about the interventions and help create conditions for their implementation after the end of the project.

## **Mechanism of engagement with local community leaders in rural and remote areas**

### **1. Project coordinators together with the heads of partner CSOs define potential local community leaders at the project sites.**

Criteria to select potential local community leaders:

- They live and work in the rural or remote area where the project is implemented.
- They have a good reputation and strong links with the community members.
- They have time and willingness to implement joint activities with the CSO.
- They can strengthen the CSO's activities at the site.
- They are aware of the situation and have contacts with adolescents, in particular know the venues where adolescents get together.
- They are able to build contact with different adolescents, including those with the experience of drug use; they are good communicators and have basic counselling skills or willingness to acquire such skills; they are ready to work in a team together with the project social workers.
- They understand the principles of HIV prevention and harm reduction and share the same values and approaches.
- They are ready to learn.

### **2. Project coordinators from the partner CSOs organise training for the potential local community leaders.**

It can be a mini-training delivered by a CSO expert (social worker, psychologist or project coordinator), e.g. using education modules available at online platforms (in Ukrainian): <https://profihealth.org.ua/courses/1/program> and <http://knowledge.org.ua/obuchenie/>.



Nº	Mini training topics	Training outcomes
1.	Goals and objectives of prevention among adolescents: risky behaviour and its prevention, health promotion and healthy lifestyle, volunteering, leadership, personal growth and development	Local leaders are able to tell about the project, its goals and objectives clearly and concisely, in their own words; explain what this project is about; they understand the target group of the project and the services that the adolescents are able to receive within the project.
2.	The goal of engaging adolescents in the project	Trained local leaders are able to motivate adolescents to seek services, engage in project activities and bring their friends and acquaintances.
3.	Services offered to adolescents at the site by the CSO and its partners	Local leaders are able to tell about the project services clearly and concisely, in their own words, explain what each service is about, who provides each service, when and where it can be received. They also know to which organisations the project clients can be referred.
4.	Harm reduction principles and approaches; primary, secondary and tertiary prevention; peculiarities of drug use among adolescents (risk factors and protectors)	Local leaders understand the general harm reduction principles and approaches, know about primary, secondary and tertiary prevention, have basic knowledge about the peculiarities of drug use among adolescents (risk factors and protectors).
5.	Routes of HIV transmission, “window period,” importance of testing	Local leaders understand the importance of testing, have knowledge of HIV and can share their knowledge with others.
6.	Ethics and confidentiality: client data are never disclosed	Local leaders understand that client data should never be disclosed, they comply with the principles of ethics and confidentiality.
7.	Documentation and job description: contract, job description, data, payment for work, work schedule, mentor/supervisor from the project team	Local leaders are aware of their work conditions, understand their rights and duties, know what records they need to keep and how they can receive support from the CSO.
8.	Interaction with the CSO project team	Local leaders understand their duties, ways and formats of communication with the project team.
9.	Safety arrangements	Local leaders are aware of the safety arrangements, in particular in terms of working with the target group and implementing outreach activities.

Apart from theory, the training should always include practical skills (such as communication with adolescents and providing them with basic consultations).

### **3. After the local community leaders are trained, CSOs sign contracts with them.**

CSOs sign contracts with the local community leaders, defining their duties and responsibilities as well as their work schedule.

Key components of the contract:

- position title, purpose of work, linkage with the organisation objectives;
- duties and obligations of the parties;
- personal requirements; confidentiality requirements, etc.;
- expected duration and schedule of work;
- term of cooperation and conditions to revise work arrangements;
- occupational safety;
- remuneration.

Functions, which local community leaders can perform in the prevention activities:

- represent the project interests at the site on behalf of the CSO;
- help social workers to organise services at the outreach routes (identify the venues, where target group members gather, define an outreach route, determine the best timing for outreach activities, tell about the peculiarities of the target group, etc.);
- participate in weekly working meetings of the project team;
- build contact with target group members at the outreach route, communicate with clients, inform them about the project, help to establish contact between the target group members and the social workers representing the partner CSO;
- distribute information materials and personal protection equipment in the target group;
- maintain contact with the local partner network on behalf of the CSO (help to organise meetings, round tables, campaigns, lectures, etc.);
- contribute to managing social media accounts;

- support the project team when conducting group activities and campaigns at the site;
- other activities in line with the project goals.

The work should be performed according to the schedule set forth in the contract and should be supervised by the project coordinator from the partner CSO.

#### **4. Project coordinators monitor and evaluate the efficiency of local leaders engagement.**

Project coordinators also provide resources and help resolve any issues, which may arise, though individual supervision.

While the local community leaders take over some functions when CSOs are not present at the site, CSOs continue their work in remote and online formats. CSOs organise and conduct online training (e.g. Zoom webinars). Such training can be organised both for the specialists and for the most active adolescents at each site. The format of online training allows engaging a wider range of experts and trainers and share a variety of online resources.

To support ongoing work at the sites, it is necessary to use social media and implement other online activities. In the course of the study, researchers found out that most project clients use social media on a daily basis, so it is crucial for CSOs to offer high-quality online resources, in particular use social media, to stay in touch with the adolescents engaged in the project. The most popular social media and messengers to maintain contact with the project clients are Instagram, Viber, and Telegram. The best approach is to have a separate person – a regional communication manager – to create pages in social media and manage them (offering attractive content to maintain and expand the audience and communicate with subscribers). Posts in social media can be used to inform adolescents about the schedule of site visits, provide useful health-related information and motivate adolescents to engage in project activities and campaigns. To successfully reach the clients, it is important to select the social network or the messenger, which they already use. For instance, in 2019–2020 Instagram was the best social network to maintain contact with adolescents, and Facebook – to communicate with the partner organisations.

Instagram offers a lot of opportunities to share information, which can be useful for adolescents, in engaging formats. In particular, the project can use pages in social media to present information and entertain clients.

Information content (helps to build the knowledge of adolescents):

- schedule of site visits, contacts of partner organisations offering services;
- event announcements;
- myths and facts;
- answers to questions;
- personal stories;
- live streams with project representatives and local leaders;
- surveys on prevention and quality of services;
- sharing general information on HIV/STI/TB, hepatitis and drug use.

Entertainment content (helps to engage and retain subscribers/clients by keeping their interest):

- contests and give-aways;
- quests/marathons/flash mobs;
- life hacks and useful tips;
- funny pictures to draw attention (memes);
- motivational photos and videos;
- greetings;
- quotes;
- jokes.

Direct (private) messages allow effectively using this network to provide individual consultations to adolescents. In particular, counsellors can initiate such consultations based on the answers to surveys, which go straight to private messages. Consultations can be offered to the clients who fail to give correct answers to one or more survey questions.

Online counselling has a number of advantages:

- Adolescents feel that the conversation is anonymous and can be as open as possible.
- Adolescents control the situation and can stop the consultation at any point or come back to it later.
- There are no strict time restrictions. There is more time for the counsellor to respond.
- There is a possibility to go back to the conversation to check the information at any point.
- All consultations are recorded. There is a possibility to go back to the previous conversation.
- There is no need to control one's facial expressions, gestures or tone of conversation.
- When typing the text, adolescents enhance their reflective analytical skills as they need to express all their thoughts in a few words (concisely and clearly).
- One question can be answered by several counsellors. Besides, a counsellor can ask other specialists for advice when preparing an answer.

Besides, consultations can be provided through special platforms (e.g. Free2Ask app).

[App Store](#)



[Google Play](#)



Examples of Instagram pages:

 [kompas\\_7/](#);

 [dream\\_team\\_group/](#);

 [5\\_kirovohradschyna/](#);

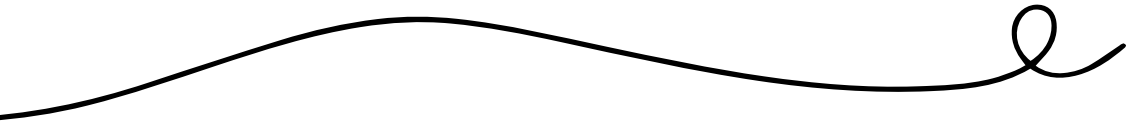
 [newfamiily/](#);

 [clubstreetpower/](#).

10



*Effective partnerships*



Key tasks of the partner network at the local level include coordination of the joint efforts, creating an effective system to refer clients to friendly services, consolidating resources for joint activities and drawing attention to the most burning problems. It is an opportunity for partners to jointly contribute to the desired changes, in particular in developing local policies and procedures. Besides, successful activities of the partner network improve the visibility of each organisation being a member of such network, increase the level of trust from the side of community, and promote the ideas supported by partners at the local level. For CSOs, it is an additional opportunity to promote its expertise in certain issues as well as its activities.

Governmental and non-governmental organisations sharing the same goals should be engaged to join the partner network. In our case, such goal should be to improve the lives of adolescents and their families, protect their health and contribute to their comprehensive development.

The partner network may include the following organisations and institutions:

- centres of social services for family, children and youth;
- resource and education centres;
- educational institutions (secondary and vocational schools);
- juvenile prevention departments;
- probation departments;
- police;
- health facilities (in particular, youth-friendly clinics);
- youth and sports departments of the municipal councils;
- free legal aid centres;
- human rights organisations;
- employment bureaus;
- HIV service providers;
- youth organisations;
- youth clubs;
- children and youth libraries.

Usually, partnerships start with defining a list of strategic partners, sending them official letters and organising meetings with their representatives. Alternatively, first contact with the potential partners can take place at official events (conferences, round tables or high-level events).



*“From the start, our goal was to build contact with friends and partners with whom we could work together. In 2014, we reached out to everyone and told them we could help them with their tasks. We went to the technical schools as we needed an access to our target group, established contact with the probation department, with the juvenile inspection, started working with the patrol police” (project coordinator).*

Building partnerships with government agencies requires a more formal approach. For instance, the first person to be contacted in an education institution is always its director. Before the meeting, it is a good idea to send an official letter, tell about your organisation and explain what resources you have and how you can help (e.g. carry out awareness-raising campaigns among students). Usually, administrators welcome such initiatives as it is their obligation to organise such awareness-raising activities and you can partly take over their duties. Meanwhile, you need to understand what resources your potential partners need to offer them the help they require. When building cooperation with educational institutions, it is important to establish partner relations with school police officers. Together with social workers, they can deliver classes, lectures, distribute materials or organise onsite training. They can also inform students about their rights, obligations and interaction with police. Partnerships with Youth and Sports Departments, Centres of Social Services for Family, Children and Youth, and juvenile prevention institutions are built in the same way. Members of the partner network can offer services, which are not provided by the CSO, contribute their resources, which can add to the resources of the CSO and strengthen their joint activities, and vice versa. When conducting joint activities, partners can make contributions in the form of free premises, transport, fuel, food and gifts for participants. Besides, representatives of

partner organisations can take part in training activities as trainers and experts and write reviews on the programmes and guides developed within the project. When a CSO is able to build effective partnerships, it wins a good reputation and other organisations can reach out to it with cooperation proposals.

Usually, members of the partner network sign memoranda of understanding (MoU), where they define key obligations of the parties and the areas of joint activities. Often, MoU also contain certain schemes of cooperation, e.g. for referring clients or for communicating with partners. Later, such algorithms often become part of city and municipal programmes (such as drug policy and/or HIV prevention programmes). At the working meetings with the members of partner network, comprehensive information is shared about partners and their services, so that if needed counsellors could make a quick call and agree to refer their client to a certain service provider. In such cases, clients either receive a referral or are accompanied to partner organisations to receive additional services meeting their needs.

In most cases, referral schemes within the partner network consist of the following steps:

1. When providing counselling to adolescents at outreach routes or youth centres, social workers (or other representatives of the partner network) define the need in providing additional services.
2. With the adolescents' consent, social workers contact relevant organisations and refer the adolescents to such organisations or accompany them if needed.
3. If adolescents are not ready to seek such additional services straight away, social workers or other specialists provide them with contacts of the organisations, where they can seek such services if they decide to do so.
4. When adolescents seek any additional services, they say by whom they were referred and this information is recorded. In some regions, there is a system of paper slips, when adolescents receive referral slips ("coupons" or "cards").

In addition to face-to-face meetings, another convenient communication tool is groups in social media or messengers.



*“We created a Viber group called “Dialogue” to improve communication with our partners. The group includes representatives of social services and police, education facilities and our organization (all our team), who are engaged in implementing any project activities or engaging with adolescents, in particular those who use drugs and their inner circle. The issues raised in the group include coordinating the routes and the schedule of outreach visits; discussing the issues of adolescents, which require collective engagement or consultation/ advice of any experts” (project coordinator).*

To build effective partnerships, representatives of different organisations have to establish good interpersonal relations, understand their common goals and see themselves as a team. It can be achieved through planning and conducting joint activities, taking part in joint workshops or other events, going on joint work trips. Support and positive examples of cooperation are vital. People from the partner network should be invited to all the key events held by partner organisations and they should see the success stories of the project clients (e.g. results of the leadership projects). Besides, partners can be invited to take part in workshops and other training events where adolescents are engaged as co-trainers, facilitators or active participants.

There should be a separate focus on the informal communications of the partner network members. They can include invitations to celebrate some memorable dates of the organisation, personal acknowledgements, certificates of appreciation, letters of recognition, souvenirs and even posts of gratitude in social media.

Another exciting and effective tool to build closer interpersonal relations is the Summer Schools. As opposed to standard training activities, such schools are usually comprised of a number of short-term workshops followed by interactive leisure activities aimed at

team building and developing creativity. Every such school has its topic and its legend (e.g. Magic School inspired by the Harry Potter universe or SocioOlympic Games). All the participants are divided into teams and perform certain tasks, which they present in the afternoon within their extracurricular programme. Such events are a rich source of positive emotions and always become memorable. Besides, training is combined with active summertime activities, which is a good balance of formal and informal engagement models. Usually, summer schools bring together 30-40 participants from several regions. When planning such an event, it is a good idea to define its dates beforehand remembering that summer is a vacation time.

There are many other tools to build effective cooperation: workshops, conferences, round tables, study visits. Let's have a closer look at the last two options.

Round tables are an important tool both to start cooperation with new partners or with local stakeholders at a new venue and to resolve any urgent issues. At such round tables, partners can plan joint prevention activities, share information about the resources available and prepare any future events. They can become a platform to do long-term planning and discuss the priorities for allocation of funding from local and national budgets. Such meetings can result in making decisions in the format of joint action plans or resolutions.

Examples of the decisions, which can be included in the resolution of the (initial) round table:

1. Cover the need in specific HIV/STI/drug dependence prevention services for the adolescents who use PAS through cooperation with CSO...
2. Create and approve... a partner network consisting of... (names of organisations and focal points) in [city/village]...
3. Develop and launch a model of work with vulnerable adolescents in [city/village]...
4. Allow and approve the programme and the schedule of prevention classes for adolescents (and their parents) of the following educational institutions of [city/village]...
5. Facilitate street prevention campaigns to be held for the residents of [city/village]...
6. Provide an opportunity for the advanced training of local specialists working with adolescents, engaging experts from the civil society organisation...
7. Allow to conduct and contribute to a research study among adolescents and professionals of [city/village]...

A good example of building cooperation at the interregional level is conducting study visits to ensure knowledge exchange among different CSOs and their partners implementing prevention projects with similar goals and approaches. Such visits usually last from one to three days and allow professionals from various regions of Ukraine to exchange experience in providing services to adolescents, look at the routine work from a different angle and find possible options for cooperation. The number of study visit participants is usually three or four people, preferably one or two representatives of the CSO and one or two members of the partner network. Participation in such visits can be an incentive or a reward for the selected specialists of partner organisations.

Knowledge sharing study visits allow partners to find similarities in their work and see that such cooperation is effective in other places, too. Besides, changing the location helps to look at routine things with new eyes and get inspired for new achievements.



*“During such visits, we got acquainted with directors of the centres of social services for family, children and youth. Our partners had a chance to talk to them and learn how cooperation is organised. Besides, we could see similarities in our activities. After the visit, our partners became even more interested in cooperation and are actively offering their ideas and support, for instance in organising joint visits and lectures in education facilities or providing their premises to test clients for HIV, hepatitis C, B, syphilis as well as conducting public campaigns” (study visit participant, social worker).*

For the representatives of government agencies, a crucial component of such visits is meeting colleagues from other regions and sharing their practical experience. During the study visits, they can discuss the most vital issues face-to-face and improve their qualification:



*"This was my first study visit to Poltava region. I was impressed with the high level of trust and cooperation between CSOs and government agencies in providing services to the adolescents who use drugs and practice risky behaviours. In professional terms, it was useful for me to share and learn the experience of working with families in difficult life circumstances, where children use drugs, with the specialists of Poltava regional and city centres of social services for family, children and youth. We discussed the issue of funding and the mechanisms used to procure the services. I had a very positive impression of this visit. I would like to thank the Public Health CSO for organising the visit and my colleagues from the government agencies for their openness and friendliness!" (project participant, director of a city centre of social services for family, children and youth).*

Often partners bring new ideas of cooperation from such study visits.



*"I really liked the decorations at the Compass Youth Centre, which were made by project officers and adolescents. Besides, people from the CBO Blago together with the leaders from among adolescents organised monitoring of the services offered to adolescents in healthcare facilities located at the site. It is a very good idea as it allows adolescents to find out what services are available to them in healthcare facilities. We would like to implement the experience of our colleagues in monitoring the services in our city and at project sites" (project participant, social worker).*

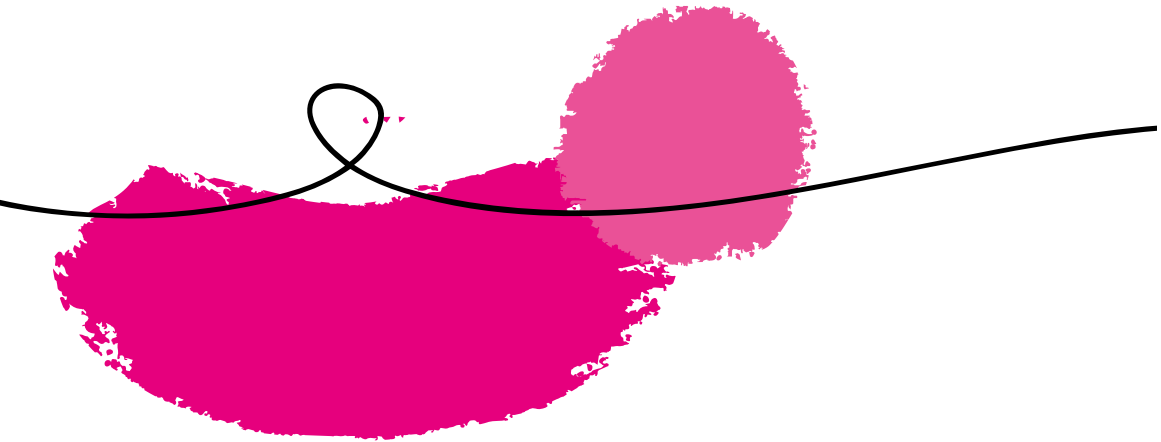
The range of activities within such cooperation of the partner network often helps to achieve additional results: public servants change their attitude to the target group – adolescents who use drugs. In their turn, adolescents also start to have more trust to the government agencies.

### **Success story – partnership with police**

Our local partners have been closely working with police within the projects they implement. The goal of such cooperation was to build trust between law-enforcement agencies and vulnerable populations and tolerance of police to the vulnerable populations, in particular adolescents who use drugs. The start of police reforms in Ukraine gave a start to new formats of such cooperation. The most interesting form of cooperation was carrying out joint prevention activities, such as workshops, quests and tours to police departments with adolescents from the most-at-risk groups. Police officers were not just co-organisers, but equal participants of those activities. For instance, a quest was held in one of the cities, where adolescents formed joint teams with police officers and went around the city visiting various sites offering services for adolescents and coping with various tasks together. After the quest, the adolescents had a very positive feedback on their experience. They said that they no longer felt scared of police officers and saw that they were just ordinary people. Besides, the adolescents said that they liked it very much taking part in the quest together with police officers and it even got them thinking about a career with law-enforcement bodies. Another example of positive cooperation was regular training workshops for police on the protection of the rights of adolescents and on effective methods to reduce risky behaviours and prevent crime. The activities also included regular coaching and study visits of police officers to various youth-friendly organisations. It helped to achieve positive changes in the attitude of police officers to adolescents and allowed them to more meaningfully engage in the development of city programmes on drugs as well as prevention of HIV and other diseases. The trust built between adolescents and police officers also had a positive impact on the operation of the local referral system and improved the access of adolescents to the services offered by the partner network.

# 11

## *Safety of the counsellors and their clients*



We included this section in our guidelines for a reason. All professionals working with people sometimes experience challenges when interacting with clients. There are particularly many ethical issues in working with adolescents who use drugs or practice other risky behaviours. In what cases can we tell parents about the problems of their children? Do we have to inform the police about the offences committed by adolescents or should we first of all care about the safety of our clients? Can we test adolescents for HIV or give them condoms without the consent of their parents? In such cases, service providers rely on laws and regulations as well as their own upbringing, religious norms or cultural values. Most often, service providers try to avoid making any decisions and refrain from any solutions or actions, which they see as wrong. Those challenges are often related to morale. Stereotypes and bias about the people we work with can push us to making wrong decisions and despite our own will such decisions can lead to stigma and discrimination and some of them can have negative consequences. When we are talking about the safety of counsellors and their clients, we mean a set of conditions, which help to decrease the probability of any situations, which may affect the quality of services, trust between counsellors and their clients as well as emotional and mental condition of both clients and counsellors.

We suggest adhering to the following principles when working with adolescents:

- All adolescents, irrespective of their background and place of living, their religious views, gender identity, sexual orientation, culture, profession, social status, family situation, drug use or HIV status, deserve their human rights to be respected and have a right to treatment and care not undermining their dignity.
- When providing services, we first of all care about the rights and the needs of our clients, not about our own needs.
- Equal participation of girls and boys: providing services from the perspective of gender equality.
- Confidentiality requirements. Confidentiality means that counsellors should keep the content of counselling as well as any information about the health and life of adolescents confidential. Safety and confidentiality are the key requirements when working with adolescents. Some adolescents need extra guarantees of safety and security, in particular those who live with HIV, have an experience of drug use or sexual exploitation. Most often, adolescents are afraid that when peers and family members learn about their status/problems, they will push them away. For older

girls, confidentiality can be directly linked to their autonomy and independence of their families, for older boys – with vulnerability in front of their peers and parents. Adolescents with various gender identities and manifestations (gay, lesbian, bisexual, transgender, etc.) usually have higher requirements to confidentiality as related to their gender identity and sexual orientation. If their personal information is disclosed, it can put them in danger of isolation. Pregnant adolescents or adolescents who have children can also be concerned about their safety. Young parents are usually under a lot of pressure and can avoid seeking help if their confidentiality is not guaranteed. The only situation, when confidential information can be disclosed, is risk to the life of your client or to the lives of other people because of your client's actions.

- Respect of adolescents. When adolescents are treated with respect, it guarantees the quality of services and contributes to the engagement and retention of clients. It becomes particularly important when there is a need to provide counselling on such sensitive topics as sexual health, contraception, drug use, violence or mental health. Every adolescent has to be treated as an integral personality able to manage his or her own health. Counsellors need to remember that autonomy is extremely important for adolescents.
- Maximum services with minimum efforts. Service delivery should be organised to make sure that adolescents can receive maximum services with minimum investment of time.
- Avoiding intersections. Quite often, especially in smaller towns, counsellors may be acquainted with the parents of their clients or may meet them in situations not related to their work, e.g. their children may go to the same school, they may live in the same neighbourhood or have mutual friends. It is very important to track such intersections and avoid informal interaction with the clients' parents. If it is not possible, the adolescent should be referred to another counsellor.
- Possibility to complain. Adolescents should know how they can complain about the actions of project workers or other clients with no negative consequences for them.

The approach, which can help adhere to the principles described above, stipulates regular supervision of the project staff. Supervision can be divided into the administrative component (to discuss any issues related to work planning and implementation, service delivery, work schedule, training needs of project staff, etc.) and programmatic

component (resolving any problems related to the relations among project staff members or with clients). All project staff should be subject to supervision irrespective of their role. Supervision can be conducted either by managers of the organisation or by external consultants. Organisation managers can conduct only administrative supervision, while programmatic supervision should only be delivered by external experts. The main task of supervision is to help counsellors deal with difficult situations and define if the services provided are in line with ethical and professional requirements. There is a number of conditions for supervision:

- It should be regular, at least once a month.
- It can be either group or individual.
- Programmatic supervision can only be conducted by a properly trained external expert.
- Supervisor should be a professional, who has no personal or professional links to the person under supervision.
- Any information shared within supervision sessions should remain confidential.

Another tool used to create safe space is defining the rules for adolescents they should follow when coming to your site. It is crucial to have those rules on a visible spot and share them with all new clients. Usually, such rules regulate the behaviour of adolescents and staff members describing what can and cannot be done.

Both tools (supervision and ground rules) help to ensure safety and security of both clients and counsellors.

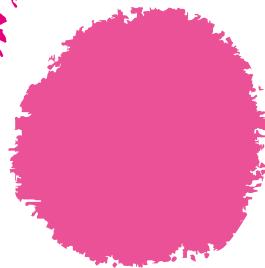
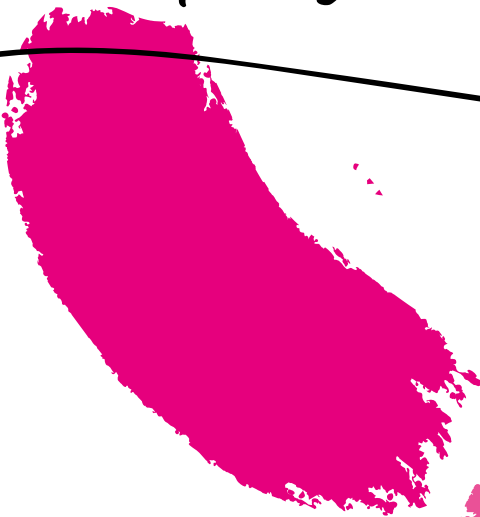
You can assume that adolescents do not feel safe in your centre if they have frequent conflicts with project staff or other clients, are not engaged or not willing to take part in the activities you organise, if they use offensive words or are aggressive to others.

As for the counsellors, if they are under constant pressure due to the lack of safety at work, it can lead to their professional burnout. You can learn about the reasons of burnout and about how to deal with it in the lecture of Yadgar Turehanov (available in Russian): <http://afew.org.ua/turehanov-yagdar-profesijne-vigorannya-novi-pidhodi-v-profilakticzita-psihologichnij-korekczi/>.



12

*Monitoring and evaluation  
of the quality of services*



Monitoring and evaluation are integral components of any activities and stipulate systematic or occasional collection of information to assess the efficiency (or performance) of certain processes or actions. Monitoring and evaluation concept is widely used in the implementation of various programmes. There are quantitative and qualitative performance indicators, which allow to assess if we get the expected result of our actions and the resources we invest.

**Quantitative indicators** are measures: absolute number, index, percentage, correlation. The advantage of quantitative indicators is that they do not attach any sentiments to the phenomena we study, but allow to objectively record them.

**Qualitative indicators** do not contain any measurements, but rather describe the state. Those indicators are more difficult to collect and evaluate. However, they allow to organise the programme and the service delivery in the best possible way.

Ideally, monitoring and evaluation should be conducted at different levels of programme implementation: at the level of programme management and at the level of service delivery.

The main components to be evaluated at the level of programme management are:

- knowledge and skills of staff members;
- attitude of staff to adolescents (presence/lack of stigma on the grounds of gender identity, race, religious beliefs, behaviour, social and economic situation or any other characteristics);
- compliance with the code of ethics;
- availability of a partner network with friendly services and a referral system;
- presence of organisational policies and procedures.

As for the level of service delivery, the following components can be evaluated:

- compliance of services with the needs of the target group;
- clients' satisfaction with the services;
- risky behaviours of adolescents (sexual behaviours, using psychoactive substances, etc.);

- knowledge and perceptions of adolescents in the area of sexual and reproductive health and human rights;
- awareness of where adolescents can seek the help they need.

All the above-mentioned aspects can be evaluated both from the qualitative and the quantitative point of view. For instance, to evaluate clients' satisfaction with the services such quantitative indicators can be used as the number of clients surveyed or the percentage of clients who rated the services highly. Qualitative indicators would be the feedback provided by the clients: what they liked or didn't like, what needs are satisfied by a certain service, etc.

Monitoring and evaluation of the quality of services should be conducted on an ongoing basis throughout the whole period of programme implementation. As a rule, quantitative indicators are collected daily and are summed up in quarterly reports. Qualitative indicators are collected less often. The interval of data collection depends on the objectives. Three months is the most widely used interval to track certain trends.

To make monitoring and evaluation of your project performance most effective, you should define the standards of service delivery, i.e. the conditions, which would allow you to achieve the expected results. When we talk about the conditions, we mean the availability and the essence of services as well as the skills and the knowledge, which adolescents should acquire after receiving those services. In Ukraine, there are no national standards of the services to be provided to adolescents, so we had to develop our own document to evaluate the quality of our work. Despite the fact that those standards have been developed based on the objectives of a specific project, they are rather universal and can be adjusted to other contexts. Below you can find the standards of providing a comprehensive package of services to adolescents within our project.

## **STANDARDS OF PROVIDING A COMPREHENSIVE PACKAGE OF SERVICES**

**Target group of the project:** children, adolescents and young people who have an experience of using psychoactive substances (PAS), with a focus on the age group of 14–19 years old, but not more than 24 years old.

**Project clients** are adolescents aged 10 to 19 years old (as defined by the WHO) with an experience of using psychoactive substances, who provided basic information about

themselves, received at least a basic package of services and acquired a minimum (basic) set of knowledge and skills.

Important! Adolescents who are not ready to provide basic information about themselves and who have not received a basic package of services cannot be considered project clients.

**Basic information** about project clients (to fill in primary documents and to be entered in the database) for receiving a basic package of services:

1. Data of registration in the project
2. Client code
3. Age
4. Gender
5. How the client learned about the project
6. Reason for seeking services (reported by the client)
7. Experience of using narcotic drugs (yes/no)
8. Experience and ways of using narcotic drugs in the recent 30 days
9. Sexual experience in the recent 30 days (to define the needs in reproductive health services)
10. HIV testing experience

**The basic package of services** to be provided to a client during the first consultation\*:

1. Information materials.
2. Consultation of a social worker:
  - on the client's risky behaviours in the context of HIV/STI/TB/hepatitis B, C; offering the client to get tested for HIV/STI;
  - on reproductive health; offering means of personal protection (condoms, lubricants);
  - on the individual risks of using psychoactive substances; offering personal protection equipment (syringes, alcohol wipes) or referral to get such equipment.

3. Information about the available project services and about the range of services offered by the partner network. If necessary – referral to receive at least one service needed by the client (within the projects implemented by the organisation and/or offered by the partner network).

\*It should be noted that in practice not all those services can be provided and not all this information can be collected during the first consultation. Some clients may need some time to get used to new conditions, new people and be ready to talk to the counsellor. In such cases, we always focus on the needs and opportunities of adolescents, but before they provide us basic information about themselves and receive a basic package of services, we do not register them as project clients.

**Minimum set of knowledge and skills** to be acquired by the project clients:

Knowledge	Skills
Name of the organisation/project and contacts of the social worker.	Skills required to seek the necessary services on their own.
Knowledge about social, psychological, health and legal services available in the organisation and within the partner network (name of the facility, working days and hours, contact persons, etc.).	
Being aware of where to get tested for HIV	
Basic knowledge about the routes of transmission and ways of protecting oneself from HIV/STI/TB/hepatitis B and C.	Skills required to seek the necessary information on their own.

After clients receive a basic package of services, they should be offered to enrol into a case management programme and/or psycho-correction programme (if available). If the client refuses or is not ready to any comprehensive interventions, the client can continue receiving some project services.

**Case management programme clients** are adolescents aged 10 to 19 years old with an experience of using psychoactive substances, who found themselves in a difficult life situation, which has to be resolved in a comprehensive way during three to six months,

during which clients share more information about themselves, receive an extended package of services and acquire the knowledge and the skills they need.

Important! If in the course of initial consultation, a client is willing and gives consent to entering a case management/psycho-correction programme, the social worker should start with collecting basic information about the client and providing a basic package of services as for any other project client.

**Basic information** about a case management programme client (to fill in primary documents and to be entered in the database):

1. Reasons to enrol in the case management programme.
2. Education (education facility – school/vocational school/university/does not attend school).
3. Family (complete/incomplete/orphan, etc.) and family status.
4. Place of residence.
5. Employment.
6. Criminal record (no record of conviction/record of probation/conviction).
7. Chronic diseases.
8. Record of drug use:
  - total record of drug use (age of the first drug use experience);
  - experience of using drugs in the recent 30 days: drug type, frequency of use, way of administration, last time of use, overdose experience.
9. Sexual behaviour:
  - sexual partners (male/female, regular/casual);
  - experience of sexual contacts in the recent 30 days;
  - condom use during the last sexual intercourse.
10. HIV testing (yes/no, result).
11. Diagnostics of tuberculosis (yes/no, result).
12. Hepatitis B, C testing (yes/no, result).

Basic package of services, which should be received by case management programme clients:

1. Consultation of a social worker on the conditions of enrolment in the case management programme (documents, conditions of discharge, confidentiality, responsibilities of the client and the project staff, etc.).
2. Needs assessment, setting the goals and objectives together with the client.
3. Information materials.
4. HIV/STI/TB/hepatitis B and C:
  - individual risk assessment;
  - learning about safer behaviours;
  - motivation to regular testing/diagnostics;
  - informing on the services related to the above-mentioned diseases available within the project and in partner organisations; learning about self-referral to seek services;
  - if needed, referral/accompanying clients to other service providers.
5. PAS use:
  - individual risk assessment;
  - learning about safer behaviours, in particular about harm reduction model; handing out individual protection equipment (syringes, alcohol wipes) or referral to get such equipment;
  - informing on the services available within the project and in partner organisations; learning self-referral skills;
  - if needed, referral/accompanying clients to other service providers.
6. Sexual and reproductive health:
  - basic knowledge about male and female reproductive system and hygiene;
  - adolescence and pregnancy (risks, peculiarities, right to abortion, etc.);
  - sexual activity and relations with partners, responsibility, impact of PAS on sexual behaviour;
  - reproductive and sexual rights and responsibilities;

- building the skills of responsible behaviour;
  - types and use of contraception; distribution of condoms, counselling on their correct use;
  - sharing information about the relevant services available within the project and from partner organisations; teaching clients to seek such services;
  - if needed, referral/accompanying clients to other service providers.
7. Counselling on the rights of clients and the course of action in case if such rights are violated (including completion of the screening form).
  8. Counselling on the additional opportunities available within the project (volunteer programme, self-help groups, leisure activities, quests, training of leaders, etc.) and motivation for further active engagement in the project in other roles.

Extended package of services, which can be provided to a case management client if needed or requested:

1. Counselling of a social workers and/or a psychologist on violence or trauma experienced by the client, defining the possible formats of support to be provided.
2. Counselling the client's parents and engaging them (self-help groups, family group conferences, etc.).
3. Group activities/classes on various topics.
4. Leisure activities.

**Minimum set of knowledge and skills** to be acquired by the case management programme clients:

Knowledge	Skills
Knowing the conditions of participation in the case management programme, understanding programme goals and objectives as well as possibilities and responsibilities of both parties.	Skills required to seek the necessary services on their own.
Knowing their own short-term and long-term goals of working with project staff, understanding the time limits and other peculiarities of the project.	Ability to express their needs, define the issues and the reasons of seeking help.
<p>Knowing their risks and means of protection in terms of HIV/STI/TB/hepatitis B and C.</p> <p>Knowledge of the services available within the project and the partner network, including diagnostics and medical support as well as the conditions to receive such services.</p>	<p>Skills to take care of their own health and practice safer behaviour models.</p> <p>Skills required to seek necessary information and services.</p> <p>Skills to seek information related to their health.</p> <p>Regular testing for HIV/STI/TB/hepatitis B and C.</p>
<p>Knowing their risks related to the use of drugs and ways to protect their health.</p> <p>Knowledge of the services available within the project and the partner network and the conditions to receive such services.</p>	<p>Skills to take care of their own health and practice safer behaviour models in the context of drug use.</p> <p>Skills required to seek necessary information and services.</p> <p>Skills to seek information related to their health.</p>
<p>Basic knowledge about male and female reproductive system and hygiene.</p> <p>Knowledge about adolescence and pregnancy (risks, peculiarities, right to abortion, etc.).</p> <p>Knowledge about different types of contraception and their use.</p> <p>Knowledge about various aspects of relations with partner(s), responsibility, impact of PAS on sexual behaviour.</p> <p>Reproductive and sexual rights and responsibilities.</p> <p>Knowledge of the services available within the project and the partner network and the conditions to receive such services.</p>	<p>Safer sexual behaviour skills.</p> <p>Ability to discuss and offer the use of contraception with/to partners.</p> <p>Skills to use and dispose of condoms correctly.</p> <p>Skills required to seek necessary information and services.</p> <p>Skills to seek information related to their health.</p> <p>Regular visits to a gynaecologist (for girls) or a urologist (for boys).</p>
Knowing their rights and responsibilities, course of action in case of their violation.	Skills of rights protection, in particular seeking help in case of rights violation.

Standards of rehabilitation services for adolescents at the age of 14-18 years old who have experience of psychoactive substance use developed by New Family NGO and Blago Kharkiv Charitable Foundation are available here (in Ukrainian):

- <http://afew.org.ua/standarti-programi-korektsiyi-deviantnoyi-povedinki-pidlitkiv-vikom-14-18-rokiv-yaki-mayut-dosvid-vzhivannya-psihoaktivnih-rechovin/>;
- <http://afew.org.ua/prezentovano-programu-reabilitaczi-pidlitkiv-yaki-zlovzhivayut-abo-znahodyatsya-v-zalezhnosti-vid-psihoaktivnih-rechovin/>.



Monitoring and evaluation are important components of the programme implementation. If we do not evaluate what we do, we cannot be confident that our actions make a positive impact. Whichever aspect we evaluate, for us it is essential to know how clients assess the changes in their own life, if they are satisfied with the results of their work with project staff, how the knowledge and skills they acquired influenced the quality of their life and if they achieved the goals they set for themselves. Clients' satisfaction with the services they received and with their own achievements should be the main project performance indicator. More information about how to evaluate the results of individual work with clients can be found in the section "Stages and tools in working with adolescents."

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## WEB RESOURCES

- <http://afew.org.ua/category/biblioteka/materialy-konferencii-dlya-ta-pro-pidlitkiy-virtualno-pro-realne/> – materials of the Conference for and about teens “Through Virtual to Real.”
- <http://www.sfbta.org/> – website of the American Solution-Focused Brief Therapy Association (SFBTA). Contains a wide range of information about the approach, its history and current developments in the USA.
- <https://www.brief.org.uk/> – website of London-based BRIEF centre. Offers information about training courses, articles on solution-focused brief therapy, etc.
- <https://narrlibrus.wordpress.com/> – narrative practices in community work (in Russian).
- <http://narrativepractice.ru/> – website of the Russian-speaking narrative practitioners’ community (in Russian).
- <http://www.narrative.ru/> – website of The Centre for Narrative Psychology and Practice (in Russian).
- <http://dulwichcentre.com.au> – website of the Dulwich Centre founded by Michael White.
- <http://www.kidsskills.org/> – website of the Mission Possible Programme.
- <https://narrlibrus.wordpress.com/2009/01/18/tree-of-life/> – blog on the narrative practices (Tree of Life).
- <http://www.motivationalinterviewing.org> – website of the motivational interviewing trainers’ network.

**Guidelines**

# **Best Practices in Working with Adolescents. Guidelines**

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**BRIDGING THE GAPS**  
Health and rights  for key populations



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