

## Original Report

## Social Work Guidelines for Street Children with Substance Use Disorders

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This study was designed with the purpose of providing organized instructions on how to improve the psychological, medical, and social circumstances of street children with concurrent substance use disorders. Due to the special vulnerabilities of these children, customized guidelines are required in order to maximize the treatment outcomes. Systemic review of literature was applied on a large number of national and international journal articles available on the phenomenon of substance use among street children. The literature review was followed by a qualitative study using in-depth interviews in order to record and analyze the experience of experts working in this field. The preliminary draft was reviewed by the experts and final modifications were applied. The ultimate guideline presents practical recommendations for different stages of providing service for the target population including case finding, motivational interventions, assessment, care and intervention planning, and follow-ups. Street children face various physical, psychological, and social complications. Substance use disorders can exacerbate their circumstances and add to the complexity of their problems. The current guideline is an initial step to better understanding and treating street children who use drugs. Further research is required to investigate the effectiveness and long term results of this guideline. Considering the fact that Iran is one of the many countries dealing with this phenomenon, adjustments should be made for application in different cultures.

**Keywords:** Social Work, Guidelines, Street Children, Substance Use Disorders

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### Introduction

Substance use among street children is a critical and yet largely neglected issue that requires further consideration and care when developing health and social support strategies for this socially disadvantaged population. High prevalence of substance use has been documented among street children. According to a meta-analysis on data derived from studies in 22 countries, the overall prevalence of substance use among street children was estimated to be around 60 percent (1). In Iran, even though there is no official report on this matter, there are some reports indicating alarming rates of substance use among street children in Iran (2, 3). The significant rate of substance use among street children, their special developmental characteristics and the circumstances of living on the street, renders this population vulnerable to different medical and psychological problems such as violence, sexual abuse and sexually transmitted disease (3,4).

Development and implementation of social work guideline is an imperative in order to fully address the special needs of this marginalized population participating in substance use disorders treatment programs. Even though previous guidelines developed by National Institute of Social Defense (NISD) and World Health Organization (WHO) have provided recommendations on treatment of substance use disorders and addressing other health needs of street children, there remains a lot of ambiguities on how social work services need to be planned and implemented for street children (5, 6). This document was developed with the aim of providing social work guidelines for street children with substance use disorders based on best available evidence and adapted to sociocultural, health and social support system context in the country. This guideline is primarily intended for social workers, psychologists, counselors, and other health

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care providers working in child serving organizations providing for street children who have substance use disorders. The main audiences of these guidelines are health care providers and social support staff working in Ministry of Health (MOHME), state welfare organization, criminal justice and municipality run-away youth settings.

### Methods

In order to develop practice social work guidelines for street children with substance use disorders, we undertook the following six steps: 1) conducted searches to identify scientific documents; 2) screened documents to identify eligible guidelines and studies; 3) qualitative inquiries on experiences of experts providing services for street children with substance use disorders; 4) developed draft of the guidelines; 5) shared the draft with experts and gathered their opinion; and 6) finalized guidelines. Below, we have provided details for these steps.

To find relevant scientific documents we searched 1) international databases (Medline, Web of Science, CINAHL, PsycINFO), 2) international databases for indexing guidelines including National Institute for Health and Care Excellence (NICE) and National Guideline Clearinghouse (NCG), 3) Persian databases (Noormags, MagIran, Iranmedex, Iranpsych, SID), 4) websites of relevant international organizations including World Health Organization (WHO), United Nation Office on Drug and Crime (UNODC), and United Nation Children Fund (UNICEF) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 5) websites of relevant national organizations including Ministry of Health and Medical Education, State Welfare Organization, Ministry of Education, Non-Governmental Organizations (NGOs) involved in providing service for street children, and State Prisons and Security and Corrective Measures Organization with following keywords in English and Persian: street, children, youth, adolescent, drug, addiction, substance, treatment, therapy, intervention, support, service, and protection. We found no relevant practice guidelines on social work issues among children with substance use disorders. From the pool of 52 articles, 16 of them were relevant and used for synthesis of the guideline recommendations.

Qualitative study on the experiences of experts providing services for street children with substance use disorders was conducted as part of the process for adapting international evidence with national

context. In addition to review of literature, we documented and categorized the experiences of experts in the field by means of semi-structured in-depth interviews and focus group discussions (FGD). Full details of the qualitative study results were described elsewhere. The interviewees included experts active in providing support and protection for street children and sampling continued until saturation. 17 individuals were interviewed during the FGD sessions. The data were summarized and evaluated through content analysis. Following the collection and analysis of data an initial draft was developed which was then reviewed by 9 experts and required modifications were applied. A Focus group discussion session was held with the presence of experts active in providing support and protection for street children to review the next draft in the presence of experts. The results of the FGD session were reviewed and the guideline recommendations were finalized.

### Results and discussion

The guideline recommendations were categorized in five areas including: 1) case finding, 2) motivational interventions, 3) assessment 4) care planning and interventions, and 5) Follow-up.

*Case Finding:* Street children have limited access to their needed health services including substance abuse treatment, because of their poor socioeconomic background and family support. This is why, active case finding is highly recommended in the case of street children, for which a team uses information and reports provided by governmental and non-governmental organizations to identify street children and try to gain their trust. The team conducts interviews in order to screen children for possible substance use. If drug use is suspected they motivate such children to enter treatment. The guideline development group strongly recommended that, active case finding is always more effective than passive case finding since there are many caregivers who are not qualified or reluctant to enter their children into treatment. Some of these parents are drug users themselves and use their children's addiction to assist them with panhandling and begging.

*Motivational Interventions:* Because of a lifelong experience with illicit drugs and due to being dislocated from school and community, street children might show negative attitudes towards entering substance abuse treatment programs. In such cases it is essential to hold the sessions in other

environments. Based on each child's special circumstances the alternative environments could be their house, working place, and etc. Families are an integral part of motivational interventions. Social workers must engage in a professional yet sympathetic relationship with children's parents in order to efficiently motivate them towards supporting their child for getting the proper treatment. Intensive Family Preservation Services (IFPS) is one of the models of short-term (4 to 6 weeks), home-based interventions designed to provide immediate assistance to families at crisis point. In addition to families, children require to be motivated to receive treatment. A lot of these children have dropped out of school and in many cases their legal guardians are also addicted to drugs, so outside pressures to enter treatment are not existent. It is important to engage and motivate children with concrete rewards and provide an attractive and safe environment for them in the treatment centers. Providing food, snacks and entertainments for children must not be contingent upon them entering treatment for substance use. Even though engaging the family in children's treatment process is a priority, in some cases it is inevitable to take the custody from parents. For instance, parents might restrain their child from getting treatment, or they may be drug users themselves and unwilling to enter treatment. In these circumstances it is essential to take legal action and give the custody of the child to qualified foster parents if necessary.

*Assessment:* Primary evaluation of children must take place on the day they enter the treatment center. Parents should sign the informed consent form and they must be complete information about the services provided, the center and parents' commitments and the treatment procedures. The required information could be attained by means of individual interviews, FGD sessions with children and professionals who have been in contact with children, and local individuals who are well-informed about the circumstances of children. The main aspects that must be assessed during these sessions are demographics such as age, gender and cultural background, history of drug use such as last use, withdrawal symptoms, etc, sexual health, physical and mental health, and illegal activities.

*Planning the Interventions:* A team of professionals should organize an individualized treatment plan for each child. A case management approach is implemented due to the multifaceted issues that street

children with substance use disorders face. In the WHO Substance Use Street Children Project, case management refers to a set of skills needed to work with a child. The skills include the ability to determine a child's needs, recognize when the child is in a crisis, plan a response to the child's needs, and recognize when the child no longer needs the services (7). According to Godley et al (1994) case management for adolescents includes three stages: screening, residential treatment, and continuing care (8).

- *Crisis Interventions* - Because of their living conditions street children face various threatening and risky situations. Emergency services for drug related crises such as intoxication and withdrawal are of top priorities for this population. Moreover, the presence of psychological, social, and legal emergency services can help ameliorate the harms street children commonly face.
- *Responding to Basic Needs* - Many street children are deprived of their basic needs for housing, proper nutrition, and clothing. The prevalence of substance use is significantly higher among homeless youth than the ones that are housed (9). The majority of youth who use illicit drugs consider the existing abstinence-focused shelters as impractical options (10). Housing-first approach must be taken if the child is homeless, meaning providing accommodation must not be contingent upon drug cessation. Furthermore, street children may increase their drug intake to suppress the feeling of hunger and to stay vigilant in the case of possible threats (9). Therefore, at least one healthy nutritious meal per day should be made available for the children who come to treatment centers.
- *Referring children to medical centers* - According to WHO a number of factors impede the provision of medical support for street children. They might not get medical service due to fear of peer judgments and getting arrested upon entering medical centers. Sometimes the low accessibility and of medical center lack of financial support can be a burden in getting treatment. Also, because of the pervasive social stigma, some medical centers might avoid providing service to street children. Negative attitudes of children themselves towards getting treatment and feelings of hopelessness can prevent them from referring to medical centers.

In order to surpass the mentioned barriers, the close involvement of a social worker through the medical treatment process is essential. They should accompany children when referring to treatment center, follow up on their treatment process during hospitalization and be present at the time of their release. Street children must be referred to medical centers if they show symptoms of withdrawal, in the case of severe intoxication and other physical pathologies and illnesses. They should be referred to mental health centers in case of chronic sadness, suicide attempt or contemplation, violent behaviors, and the presence of paranoia or other delusions (5, 6). A variety of treatment can be suggested. Some of them are as follow:

*Counseling* - Individual counseling is helpful when encouraging children to share their personal and often painful experiences. However, it is important to begin with general information before turning focus to sensitive subjects. Play therapy is recommended in case of children (11). Group counseling especially twelve-step groups are thought to be effective in treating adolescents with substance use disorders (12). Psycho-educational groups are effective in treating street children. Other than being a means of delivering treatment, joining groups such as sports and entertainment groups can have implications for forming stronger group and personal identities in children (11).

*Family-based interventions* are of top priority in treating street children with substance use disorders (11). Among these interventions Multidimensional Family Therapy (MDFT) has proven to have significant results in a large number of studies (13-16). Brief Strategic Family Therapy (BSFT) has also been effective in treating these individuals (17-20). In addition to these interventions, Adolescent Community Reinforcement Approach (A-CRA) has successfully decreased the amount of drug intake and levels of depression among homeless youth in drop-in centers (21). In families where parents are drug users themselves, it is necessary for them to receive treatment in order to prevent child's relapse upon return to home (11). Since street children often face legal charges for committing felonies, legal consult should be made available for them and a social worker must accompany the child if they have to be present at a court of law. Finally, proper educational consult after treatment must be provided as a large number of these children drop out of school due to their circumstances.

*Advocacy* - Advocacy can set the ground for a variety of need-based services. In providing advocacy the basic needs of a client should be given priority along with providing psychological, social, educational, vocational, and financial support. It should be noted that during contact with potential advocates, the client's confidentiality must be protected. Disclosure of confidential information can only be possible by means of an informed consent from the client. Different resources inside and outside the organization can serve as potential advocates. For instance, Non-Governmental Organizations (NGOs) that support street children, friends, relatives and neighbors, State Welfare Organization, Ministry of Education, Law Enforcement, social work and counseling clinics, Municipality, and etc.

*Education* - A lot of street children drop out of school and some of them are illiterate or have poor reading and writing skills. After receiving treatment social workers must make sure that children can return to school. Moreover, skill training can help reduce the probability of an overdose (7), prevent relapse (11), enhance self-efficacy (5, 6), educate children about the negative effects of drug use and sexually transmitted diseases (STDs), and etc. even though street children often have odd jobs that put them at risk for various physical and psychological harms, these jobs can also serve as a protective factor that reduces the amount of substance use. According to harm-reduction strategies, children should not be prevented from working in these circumstances; instead they should receive free and accessible training to improve skills related to their occupation. Also, sexual training and proper education for prevention of sexual abuse are required in order to ensure children's survival in their threatening working environment. Other than educating the children, extra measures must be taken for prevention of physical, sexual and psychological abuse that children frequently face. In many cases, possible threats against an unborn child may be identified. Examples are pregnant women with a history of abusing other children in the family. In these cases legal actions are essential to provide foster care after birth of the child until their parents are qualified to take the custody of the child (11).

*Community-centered interventions* - Community-based interventions have help accelerate the treatment and reduce the possibility of relapse after treatment. These steps must be taken in order to implement these interventions: 1) Evaluation of

local community: conduct interviews with potential and active advocates to obtain information about the risk and protective factors in the community. 2) Community mobilization: arrange meeting with the advocates to sensitize them to the threats and negative effects of a possible relapse on the recovering child and their families, provide information about community-based relapse prevention methods, and encourage them to participate in these interventions. 3) Forming local teams for relapse prevention: divide the volunteers into small teams. Note that the social worker only serves as a facilitator and team members are responsible for organizing their activities. Children who are recovered from their addiction can also join these teams. However, current drug users or sellers are not allowed to take part in these groups. 4) Planning interventions for to prevent relapse among children: review the relapse prevention strategies with the teams and teach them how to organize the projects if necessary. Social workers are only allowed to give consult and should not provide pre-planned projects. 5) Executing local projects for relapse prevention: explain that the team members are the sole executors of the project and the social worker functions as a facilitator. Social workers should be present at weekly meetings and arrange to visit the community sometime during the execution process. 6) Collaborative evaluation and monitoring: teach the evaluation process to the teams and supervise the weekly evaluations and document the reports. 7) Leaving the community: explain to the local people that the presence of social workers is temporary. During the intervention, train a number of local individuals to work as facilitators after social workers leave the community. 8) Follow-up: keep your contact with the local team especially the local facilitator for a minimum of three months after leaving the community. Ask them to give you the weekly reports of the process.

*Reinforcement of the advocacy network* - In order to accelerate the recovery process, modifications must be applied to the advocacy network with the help of

## References

1. Embleton L, Mwangi A, Vreeman R, Ayuku D, Braitstein P. The epidemiology of substance use among street children in resource-constrained settings: a systematic review and meta-analysis. *Addiction*. 2013;108(10):1722-33.
2. Khaniha ARA, Shoostari MH, Mohammadian M, Bidaki R, Boshraadi AP. Familial characteristics of street children in Tehran, Iran. *Iranian journal of psychiatry and behavioral sciences*. 2014;8(2):86.
3. Ghasemzadeh F. Street children in Tehran. *Social Welfare Quarterly*. 2003;2(7):249-63.
4. Kamieniecki GW. Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review. *Australian and New Zealand Journal of Psychiatry*. 2001;35(3):352-8.
5. Policy USDoLOotASf. *America in Jeopardy: The Young Employee and Drugs in the Workplace: Trainer's Manual*. U.S. Department of Labor, Office of the Assistant Secretary

the child and their families. Social workers must keep contact with the members of the advocacy network and teach them how to react to different circumstances (11). Rebuilding peer networks at school and the treatment center can also be effective in the treatment process.

*Release* - Reunification is a long-term process and usually takes longer than anticipated (22) and is not limited to intoxication. Most treatment programs do not provide services after the release of children (23). The services provided after release must be developed during the treatment process and they should be adjusted to each individual's special circumstances. Routine procedures will not be effective for such services.

*Follow-up*: In order to maximize the effects of treatment, social work and other interventions must continue up to five years after release and a holistic, comprehensive approach is an integral part of a successful treatment (2). Active follow-ups: the psychosocial intervention team arranges regular visits to children's living and working environment; this is especially important for children who are at high risk of relapse. Local communities can also assist in active follow-ups by providing reports from their assessments to the intervention team (11). Passive follow-ups: even though follow-ups can take place by children's visits to treatment centers after release, this method is not recommended for street children.

## Conclusion

This guideline can be used for planning and providing social care and services to improve street children health.

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- for Policy; 1994.
6. Drugs UNOo, Asia CROfS, Prevention NCfDA. A Trainer's Manual on Drug Use Prevention, Treatment and Care for Street Children.
  7. WHO. Working With Street Children: Monitoring and Evaluation of a Street Children Project. Geneva, Switzerland: WHO; 2002 [cited 2015 Sep. 17]; Available from: <http://apps.who.int/iris/bitstream/10665/42589/1/924159036X.pdf>.
  8. Godley SH, Godley MD, Pratt A, Wallace JL. Case management services for adolescent substance abusers: A program description. *Journal of Substance Abuse Treatment*. 1994;11(4):309-17.
  9. Cheng T, Wood E, Nguyen P, Kerr T, DeBeck K. Increases and decreases in drug use attributed to housing status among street-involved youth in a Canadian setting. *Harm reduction journal*. 2014;11(1):1.
  10. Krüsi A, Fast D, Small W, Wood E, Kerr T. Social and structural barriers to housing among street-involved youth who use illicit drugs. *Health & social care in the community*. 2010;18(3):282-8.
  11. Maarefvand M, Shariatirad S, Daneshmand R, et.al. Social Work Guidelines for Street Children with Substance Use Disorders (final report). Tehran, Iran: University of Social Welfare and Rehabilitation Sciences; 2015.
  12. Chi FW, Sterling S, Campbell CI, Weisner C. 12-step participation and outcomes over 7 years among adolescent substance use patients with and without psychiatric comorbidity. *Substance abuse*. 2013;34(1):33-42.
  13. Liddle HA, Dakof GA, Parker K, Diamond GS, Barrett K, Tejada M. Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *The American journal of drug and alcohol abuse*. 2001;27(4):651-88.
  14. Liddle HA, Dakof GA, Turner RM, Henderson CE, Greenbaum PE. Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction*. 2008;103(10):1660-70.
  15. Liddle HA, Rowe CL, Dakof GA, Henderson CE, Greenbaum PE. Multidimensional family therapy for young adolescent substance abuse: twelve-month outcomes of a randomized controlled trial. *Journal of consulting and clinical psychology*. 2009;77(1):12.
  16. Hendriks V, van der Schee E, Blanken P. Treatment of adolescents with a cannabis use disorder: Main findings of a randomized controlled trial comparing multidimensional family therapy and cognitive behavioral therapy in The Netherlands. *Drug and Alcohol Dependence*. 2011;119(1):64-71.
  17. Horigian VE, Feaster DJ, Brincks A, Robbins MS, Perez MA, Szapocznik J. The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive behaviors*. 2015;42:44-50.
  18. Horigian VE, Feaster DJ, Robbins MS, Brincks AM, Ucha J, Rohrbaugh MJ, et al. A cross-sectional assessment of the long term effects of brief strategic family therapy for adolescent substance use. *The American Journal on Addictions*. 2015;24(7):637-45.
  19. Robbins MS, Feaster DJ, Horigian VE, Puccinelli MJ, Henderson C, Szapocznik J. Therapist adherence in brief strategic family therapy for adolescent drug abusers. *Journal of consulting and clinical psychology*. 2011;79(1):43.
  20. Robbins MS, Szapocznik J, Horigian VE, Feaster DJ, Puccinelli M, Jacobs P, et al. Brief strategic family therapy™ for adolescent drug abusers: A multi-site effectiveness study. *Contemporary clinical trials*. 2009;30(3):269-78.
  21. Slesnick N, Prestopnik JL, Meyers RJ, Glassman M. Treatment Outcome for Street-Living, Homeless Youth. *Addictive behaviors*. 2007;32(6):1237-51.
  22. Brook J, McDonald TP. Evaluating the effects of comprehensive substance abuse intervention on successful reunification. *Research on social work practice*. 2007.
  23. Austin AM, Macgowan MJ, Wagner EF. Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on social work practice*. 2005;15(2):67-83.