Digital Edition

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Implementing Opioid Substitution Therapy (OST)

A Training Manual for Service Providers

National AIDS Control Organisation
Government of India

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Acknowledgements

The authors wish to acknowledge the contribution of all the organisations and individuals who have helped in developing this manual.

First and foremost, thanks are due to the National AIDS Control Organisation (NACO) for providing this opportunity and for providing constructive feedback on the first draft of this manual. Thanks are also due to the DFID - Technical Assistance Support Team (TAST) for their proactive role in coordinating all aspects of production of this manual.

The authors have relied upon a variety of resource material to develop this manual. Important among these are:

- *Manual for Long-term pharmacotherapy of alcohol and opiate dependence*, NDDTC, AIIMS, 2007
- *Substitution Therapy with Buprenorphine for Opioid Injecting Drug Users,* NACO, 2008
- *Standard Operating Procedure for Oral Substitution Therapy with Buprenorphine,* NACO, 2008
- *A Manual for Working with IDUs (Harm Reduction/Outreach Training Module),* NACO, 2009
- The resource material developed and used by the authors for providing training to various NGO OST sites, under NACO, 2009-2010
- The resource material used by the authors for providing training to the OST sites, under the UNODC supported multisite project on effectiveness of buprenorphine
- *Proceedings of the National Workshop on course curriculum for training on Against Maintenance Treatment,* NDDTC, AIIMS, 2009
- Other training manuals developed by the authors (Reaching Out to Female partners of IDUs – developed for UNODC and NACO - 2011; Substance Use Disorders: A Manual for Paramedical Personnel – developed for WHO [India] and Ministry of Health and Family Welfare, Government of India; Counseling in the context of IDU TIs: A Trainers Module – developed for Tata Institute of Social Sciences, UNODC and NACO, 2011)

The draft manual has undergone field-testing during two training programmes organised for government OST centres in Punjab. Additionally, it has also undergone peer review by eminent experts in the field. We are extremely thankful to the following experts who have provided their valuable feedback: Dr. Rajesh Kumar (SPYM, New Delhi), Dr. Rakesh Lal (NDDTC, AIIMS), Dr. Sonali Jhanjee (NDDTC, AIIMS) and Dr. Suresh Kumar (Chennai).

Rajat Ray
Anju Dhawan
Atul Ambekar

Message

सत्यमेव जयते

Sayan Chatterjee
Secretary & Director General
Department of AIDS Control, NACO, Ministry of Health and Family Welfare, Government of India

Message from Secretary & Director General, NACO

I am pleased to know that a manual for training of service providers on Opioid Substitution Therapy (OST) has been developed by experts from the National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi.

As far as the National AIDS Control Programme is concerned, Injecting Drug Users are one of the most important groups for interventions. The National AIDS Control Programme envisages reaching out to this population through a variety of means with an evidence-based package of preventive interventions. OST is one of the key interventions delivered as part of this package and NACO has initiated the process of a nation-wide expansion of this intervention. While preparing and planning for the scale-up of OST in the country, the need of a standard training tool in this area was being acutely felt.

I congratulate all the individuals and organisations who have contributed towards development of this manual. I am especially thankful to DFID-TAST for supporting the development of this valuable document. I am sure that this manual will prove to be an immensely usefulcapacity building tool by all service providersinvolved in opioid substitution programmes supported by NACO or by other departments and agencies. I hope that the manual shall also serve as a standard tool of reference for all stakeholders who deal with issues pertaining to drug use treatment in the country.

With best wishes ,

(Sayan Chatterjee)
IAS

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Foreword

सत्यमेव जयते

Aradhana Johri, IAS
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Foreword

The HIV epidemic in India is concentrated in certain marginalized sub-groups of population which includes people who inject drugs. Injecting Drug Users, due to their poor socio-economic status, criminalization of drug use and unsafe sexual practices are particularly vulnerable to the risk of acquiring HIV infection and also transmitting HIV to their sex partners. As per NACO surveillance data (2009), the HIV prevalence in IDU is 9.2% - the highest amongst all vulnerable groups, including female sex workers, men-who-have-sex-with-men, transgender, truckers and migrants. The National AIDS Control Programme (NACP) has made constant efforts to address the needs of this vulnerable population by engaging various stakeholders including members of the community.

Opioid Substitution Therapy (OST) is one of the internationally recognized and evidence-based interventions for preventing HIV among IDUs. OST also helps stabilize the lives of IDUs , leading ultimately to social reintegration of drug users. OST has been included in the comprehensive package of Harm Reduction services for IDUs under the third phase of India's AIDS control programme. Currently, OST is being provided in both NGO as well as public health care settings so that coverage can be scaled up across the country. Realizing the importance of OST and the need for sustainable interventions, NACO piloted a collaborative model of engaging both public health settings and NGOs for providing OST to IDU. Following the success of this pilot in five districts of Punjab, NACO is scaling up OST services across more than 100 districts in the country. The expanded programme will clearly require trained human resource, which is scarce at the moment. This manual has been developed as an initiative to address this challenge and build the capacity of service providers to effectively deliver this crucial intervention

The draft version of this manual has undergone an intense process of review by experts and NACO. The manual has also been field tested during training programmes organised for service providers implementing the OST programme. Developed by experts from the National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, the manual covers the various clinical and programmatic aspects of the OST. The manual serves the purpose of a useful technical tool for training and also to build capacities of a wide range of service providers – from clinical staff to programme managers in a wide-range of settings.

I hope that the manual will be used by a variety of organisations and individuals working with drug users and will serve as a standardized training tool for all OST programmes in the country and help streamline the services at OST centres.

(Aradhana Johri)

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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ
Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

Contents

Background

Injecting drug use (IDU) is one of the very important driving factors behind the spread of the HIV epidemic in India.[1] As per available estimates at the national level, about 1 in every 10 injecting drug users (IDUs) in India is HIV positive, with considerable variations between various states. India has an estimated 190,000 IDUs. The states disproportionately affected by IDU and HIV among IDUs in India include Manipur, Nagaland, Mizoram, Orissa, Kerala, Tamil Nadu, Delhi, Chandigarh and Punjab.

As a response to the problem of IDU and HIV, the National AIDS Control Organisation has set up (and is continually scaling up) targeted interventions (TIs) with injecting drug users. As of 2010, there were about 225 TI sites throughout the country, covering about 75 per cent of the estimated IDU population (Rao 2010).[2] For these targeted interventions, operational tools like costing and operational guidelines, training manuals are in place. The interventions offered through these TIs include needle exchange programme, outreach, education, abscess management, referral to various other services, etc.

Additionally, NACO is also implementing Opioid Substitution Therapy (OST) at about 51 sites throughout the country, through NGOs which are also implementing other components of IDU TIs. In the past three years, considerable progress has been made. Systems are in place for annual accreditation of these 51 NGO OST sites; also in place are clinical practice guidelines for OST with buprenorphine[3] and standard operating procedures[4] for implementing OST. However, India still remains among the countries, where the IDU-HIV problem is significant and coverage of evidence-based interventions like OST remains abysmally low (just about 3 per cent).[5]

One important gap in the response to the IDU-HIV epidemic has been absence of a training manual on implementing substitution therapy. While there are other practice guidelines for implementing OST in India[6] besides NACO's practice guidelines, the absence of a training manual has been acutely felt.

Besides having NGOs implementing OST at various sites, NACO is also looking at other options to scale-up the OST programme in the country. For this purpose, certain Government hospitals will be chosen, who in collaboration with the IDU TI in the neighbourhood will implement OST. For this unique model of government-NGO partnership to succeed, however, training of staff on OST is imperative.

Thus, to address these concerns, NACO has requested faculty from NDDTC, AIIMS, to develop this training manual on implementing opioid substitution therapy. While this manual has been developed in the context of the OST scheme to be implemented by NACO in government healthcare facilities, it can also be used for training of staff in other contexts.

About this Manual

This manual has been developed as a guide for facilitators. It is intended to be used for providing training to service providers (i.e., government hospital staff and NGO staff involved in delivery of OST for IDUs). It is important to clarify here that this manual is not a substitute for practice guidelines or operating

[1] Ambekar A and Vaswani M (2009), "Drug Abuse-related HIV/AIDS Epidemic in India: Situation and Responses", in Browne-Miller A. (ed) The Praeger International Collection on Addictions, Vol II, 2009. Westport, CT: Praeger Publishers.

[2] Rao R (2010). Presentation made to the meeting of the Technical Resource Group, NACO.

[3] Rao R (2008). "Substitution Therapy with Buprenorphine for Opioid Injecting Drug Users", available at http://www.nacoonline.org/Divisions/NGO__Targeted_Interventions2/NGO__Targeted_Interventions/

[4] Rao R and Sharma C (2008). "Standard Operating Procedure for Oral Substitution Therapy with Buprenorphine", available at http://www.nacoonline.org/Divisions/NGO__Targeted_Interventions2/NGO__Targeted_Interventions/

[5] Mathers et al (2010). "HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage", Lancet, published online March 1, 2010 DOI:10.1016/S0140-6736(10)60232-2

[6] Dhawan A and Jhanjee S (2007). Manual for Long-term pharmacotherapy of alcohol and opiate dependence, National Drug Dependence Treatment Centre. New Delhi: All India Institute of Medical Sciences.

procedures. Indeed, the three documents (clinical practice guidelines, standard operating procedures and this manual) complement each other.

A variety of staff needs to be trained for implementing OST. These include outreach workers (ORWs) of the NGO TI, who are entrusted with the task of finding IDUs in the community and helping them access OST services in the government hospital. Additionally, the programme managers of the IDU TIs also require orientation to OST in order to be able to effectively supervise the functioning of ORWs. The hospital staff – doctors, counsellors, nurses –also need to be trained on OST. All these staff members are likely to belong to a variety of educational and professional backgrounds. Their experience and knowledge about drug use issues is also likely to vary considerably – while outreach workers working with IDU TIs are likely to have some knowledge (particularly about the local situation) regarding IDU issues, it is likely that the government hospital staff may be quite unfamiliar with the field of IDU and addiction. Consequently, apart from the knowledge, the attitudes and skills of the staff will also vary considerably. The manual strives to address all three components – **knowledge, attitudes and skills.**

Thus, it is important to discuss whether these staff members should be trained together or in separate groups, as per their professional backgrounds? Both of these approaches have their own pros and cons. The experience of authors with training on OST[7] suggests that conducting training programmes with a **mixed group of participants** is not only *feasible* but also *desirable*. Having a mixed group ensures that even the most basic issues are addressed by the facilitators and not just assumed to be familiar to the trainees. It also encourages discussion from a variety of perspectives and provides an opportunity for participants to learn from each other. Even if certain issues are more relevant for one particular group of participants, others also benefit from the discussions on such issues. Finally, it also serves the purpose of building team spirit among participants – an essential aspect of a successful OST programme.

How to use this manual

The entire training programme has been designed to be participatory in nature. Most of the sessions involve PowerPoint presentations but the slides have been designed in a way that fosters interactions between the presenter and the audience. Enough clues and tips have been provided for the facilitators in the form of 'notes' associated with individual slides.

The manual will be available in two versions – the print version, which will have the manual proper and all the printed presentation slides (in the 'handout' format, along with notes), and in a digital version, which will have the manual as well as the presentations as ppt files, which can be used by the facilitators. Additionally, video clips have also been developed to serve as supplementary training material.

The manual has been designed largely as a guide. Enough flexibility has been retained for local adaptation, depending on the needs of the group, the setting, the culture, etc.

Terms of reference for facilitators

Desired qualities and qualifications of facilitator(s) for training service providers on implementing OST:

- Though OST is a multi disciplinary intervention, with people from various backgrounds playing their part, the doctor is the most important functionary in OST implementation. Consequently, the main facilitator for training on OST (using this manual) must be a qualified doctor, with at least an MBBS or equivalent degree. A psychiatrist as a facilitator is more preferable. People with other backgrounds, with specific expertise and experience in certain aspects of OST implementation (counselling, dispensing, programme management), can be involved as co-facilitators.

[7] The authors of this manual have been extensively involved in providing training on OST to NGOs and government institutions throughout the country.

- Ideally, the facilitators should have experience of implementing the OST programme themselves. It is preferable, if the facilitators are actively involved in OST implementation.
- The facilitator should themselves have undergone training in OST.
- The facilitator should have an aptitude for teaching / training. The person should be comfortable interacting with people from a variety of backgrounds. Strong communication skills and leadership skills are very important.
- The facilitator should be thoroughly familiar with using various training techniques and tools, including participatory approaches. The person should be comfortable using digital presentation software.
- It is desirable for the facilitator to be fluent in the local language, which is most comfortable for most participants. However, this obstacle can be overcome by a participant / co-facilitator who can act as a translator.
- Prior to the training, the facilitator is expected to have gone through this manual and the resource material thoroughly.

Preparation for the training programme

- Identify the facilitators as per the terms of reference suggested above and secure their availability
- Identify participants and secure their availability
- Ideal number of facilitators: 2-4, with at least one facilitator being the principal facilitator
- Ideal number of participants: 15 to 30, a mixed group
- Venue:
  - Training hall with adequate seating;
  - Furniture;
  - Facilities for projection;
  - Uninterrupted electricity supply; and
  - Arrangements for refreshment and food.
- Material required:
  - A computer, a projector, a screen, and a pointer;
  - White-board / flip-chart stand with markers and white board eraser;
  - Stationery for use by participants;
  - Adequate copies of practice guidelines, standard operating procedures and the 'scheme' document;
  - Adequate copies of registration forms, pre and post-training tests, evaluation and feedback sheets, and daily attendance sheets; and
- Accessibility to a functioning OST centre (for the field visit) should be ensured beforehand. A small meeting with the in-charge of OST centre must be held to brief them about the visit and preparations for it (as described in the session on Exposure Visit).

Notes for the Facilitator

Other settings: OST in a NGO TI

As mentioned earlier there are about 51 NGO TIs, who are implementing OST along with other components of TI. If the trainees happen to be the staff of such TIs, the facilitator should consider the following:

- Emphasize the importance of "referral and linkages" in the session of the same name. Facilitators should note that establishing linkages would be even more important for an OST centre in a TI (i.e. a standalone centre) as opposed to an OST centre, which is part of a general hospital.
- Role and composition of the staff will also be different in a TI-OST as opposed to a Government centre OST.
    - In case of a TI-OST, the project manager will assume most of the administrative responsibilities of the Nodal officer.
    - Availability of the doctor will be much more limited, since most TIs have provision of a 'part-time' doctor.
    - The nurse and counsellors will be involved in caring for not just clients on OST but clients receiving other TI services too.
- Finally it would be important for the TI to ensure that some PEs too are on OST. Additionally it would be important for the TI to ensure that both the interventions – NSEP and OST – are seen as not contradicting but complementing each other.

Other settings: OST in a government hospital without formal linkages to a NGO TI

As opposed to the scenario described above, there may be situations where an OST centre is functioning in a hospital without a formal linkage with an NGO TI or without any formal, structured outreach mechanisms. There are certain centres in the country which have been providing OST services to IDUs and non-IDUs alike without any formal, structured outreach. Since OST happens to be an attractive and effective treatment approach, just by word of mouth publicity, it has been possible to attract the clients towards OST centre. This fact must be highlighted if the trainees happen to be staff of such an OST centres.

In such centres, counsellors would have to play a very important role in assessing whether the client understands implications of being on OST, motivating him for OST and contacting the client / family in case of drop-out or non-compliance.

However, it must be understood that most of the clinical issues related to OST remain same, irrespective of the setting. The core clinical issues – thorough assessment of clients, preparing the clients for treatment, adequate dosages, appropriate and regular dispensing practices – would remain equally important whether the setting is of a stand-alone OST centre in a TI, a OST centre in a hospital with collaboration of a IDU TI or an OST centre in a hospital without collaboration with a TI.

Agenda

Training Programme on
Opioid Substitution Therapy (OST) with Buprenorphine

Approximate Duration	Topic	Presenter/ Facilitator
DAY ONE		
30 min	Registration of participants	Organisers
45 min	Inauguration of training programme • Introduction • Purpose of training • Pre-training assessment	Organisers and facilitators
15 min	Tea Break	
90 min	Overview of drugs and drug use disorders	Facilitators
45 min	Drug related problems and harms	Facilitators
60 min	Lunch Break	
90 min	Group discussion: 'Local drug abuse scenario: nature, extent, consequences, attitudes, available interventions and responses'	Participants and Facilitators
15 min	Tea Break	
60 min	General principles of drug treatment and harm reduction	Facilitators
DAY TWO		
15 min	Recap of previous day	Volunteers among participants
90 min	Opioid Substitution Therapy – overview (including opioid withdrawal, intoxication and other syndromes)	Facilitators
15 min	Tea Break	
60 min	Assessment and diagnosis	Facilitators
60 min	Lunch Break	
90 min (incorporating tea break)	Assessment and diagnosis role-play and case demonstration/ presentation	Facilitators
60 min	Buprenorphine-pharmacology (including side-effects, drug interactions, contraindications)	Facilitators
DAY THREE		
15 min	Recap of previous day	Volunteers among participants
120 min (incorporating tea break)	OST with buprenorphine: induction, stabilisation, discontinuation	Facilitators
60 min	Special clinical situations – adolescents; women; HIV; other medical conditions, dual diagnosis	Facilitators

Aproximate Duration	Topic	Presenter/ Facilitator
60 min	Lunch Break	
45 min	Psychosocial interventions	Facilitators
120 min (incorporating tea break)	Role-play / Demonstration of psychosocial interventions	Facilitators
45 min	Scheme for implementing OST in government centres: overview	Facilitators
DAY FOUR		
15 min	Recap of previous day	Volunteers among participants
180 min (incorporating tea break)	Exposure to the nearest OST clinic(s), including demonstration	Facilitators
60 min	Lunch Break	
60 min	Debriefing and experience sharing	Facilitators
15 min	Tea Break	
15 min	Programme management–I • Procurement and supplies	Facilitators
90 min	Programme management–II • Record maintenance and reporting • Stock Projection	Facilitators
DAY FIVE		
15 min	Recap of previous day	Volunteers among participants
30 min	Programme management-III • Referral and networking, engaging civil society	Facilitators
90 min (incorporating tea break)	Programme management-IV • Minimum standards of care, reporting	Facilitators
60 min	Lunch Break	
60 min	• Free session • Post-training assessment and feedback	Facilitators
60 min	Working together: meeting between stakeholders (TI staff, OST centre staff, NACO/SACS, Health Department)	Facilitators
30 min	Valedictory (including tea)	

DAY 1: Session 1

Introduction exercise: meeting strangers and building a rapport

Objectives

- **'Session for breaking the ice':** To facilitate the introduction of participants and to make them comfortable with one another
- To sensitise participants on the difficulties faced in meeting and striking a rapport with their clients

Material and Method

This session will require about 45-60 minutes, to be conducted with the aid of flip-charts / white-board and markers.

Steps

1. Welcome participants; thank them for attending the programme.
2. Ask them to pair up; ensure that they pair-up with a person they do not know. Preferably, they should pair up with a person who does not belong to their site / organisation and profession / designation.
3. Tell them that over the next 10 minutes they need to get acquainted with their partners and obtain personal information
4. This information should be adequate enough so that they can describe their partners and should not be written down (note: typically, some participants will ask 'what are the 'heads' in which they should obtain information about their partners?' Explain that there is no pre-decided format and they should use their own wisdom)
5. After they have talked to each other for about 10 minutes, call each of them to the front and ask to introduce his/her partner to the group.
6. While this process is going on, ask some participants to tell more about their partners (i.e., specifically the information they have not asked / not reported). For instance, while participant A is introducing B, ask 'Who is the boss in the family? Mrs B or her husband Mr B?'(Note: Be extremely careful in doing this exercise. It should be conducted in the manner of light-hearted banter. Any factual information on Mrs B's marital relationship is NOT required.)
7. Use this part of the exercise to emphasise that it is difficult to ask personal questions, particularly in the first meeting. However, in the course of their duty, they will be expected to develop rapport with their clients, get information and provide support and services.
8. Once all pairs have completed the exercise, ask each person how they felt talking to each other and then being introduced. Ask things such as 'how comfortable were you initiating a conversation with a stranger?' 'Did you feel any inhibitions asking / disclosing information about yourselves?' etc.
9. Make a list of these responses on the flip-chart.
10. Moderate a discussion on how can they apply the learning from this exercise to their routine duties. What are the similarities in this situation and their day-to-day working? What are the differences?

Highlight that communication between a patient and outreach worker will be substantially different from the communication between a patient and a doctor. Generate discussion on advantages and disadvantages of communication between people with similar status and those having a different status.

DAY 1: Session 2

Overview of drugs and drug use disorders

Objectives

- To familiarise participants with various drugs / substances of use, similarities and differences between their effects
- To bring about attitudinal changes in participants regarding drug users; specifically, to enable them to see drug dependence as an illness

Material and Method

This session will require about 90 minutes, to be conducted with the aid of flip-charts / white-board and markers and PowerPoint presentation.

Steps

1. Begin by asking participants the names of various addictive drugs that they know of. Note all the names on the flip-chart, in such a way that it helps in categorisation.
2. Ask 'what are the similarities among these drugs?' Generate discussion.
3. Stress the point that the "basic similarity among these drugs is that all of them produce certain effects in the brain/mind which are perceived as pleasurable or relaxing. Another similarity is that after repeatedly taking these drugs, the user gets habituated or 'addicted' to them."

Presentation: Basics of Drugs

4. Show the part-I, *types of drugs* of the presentation—basics of drugs—in an interactive manner.
5. Ask 'why do people take drugs?' Note the responses on a flip-chart in a manner, which permits easy grouping of the reasons into 'positive' (such as to feel happy, to enjoy, to enhance sexual pleasure, out of curiosity, etc.) and 'negative' (such as to relieve boredom, frustration, anxiety, sadness, mental-tension, etc.).
6. Proceed with part–II of the presentation

Presentation: Basics of Drugs

Contents of the presentation:

- Types of drugs and their effects
- Why people take drugs?
- Why people get addicted to drugs?
- Understanding the terminology (use, abuse, harmful use, dependence and addiction)

DAY 1: Session 3

Drug-related problems and harms

Objective

- To familiarise participants with the concept of hierarchy and prioritisation of harms
- To develop the skills of participants regarding prioritisation of risks and harms

Material and Method

This session will require about 45-60 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

1. The facilitator should begin by asking participants to list the possible harms associated with drug use according to their opinion/ experiences, using the mind-mapping technique. The facilitator should encourage participants to share anything that they might consider as a complication of drug use and not worry about it being right or wrong. At this stage, just listing of various 'harms' is more important rather than an analysis of how and why a particular harm occurs. Thus, discussions should be gently guided towards just listing the harms and participants should be told to wait for the discussion of 'why' and 'how' of harms.

2. While participants present their views, write down all the harms suggested by the trainees on a white-board / flip-chart. While doing so, the facilitator, based on his/her own knowledge and experience (and taking cue from the next slide), should take care to group together the harms caused in a particular domain, e.g., all physical complications of drug use cited by participants should be listed in one group.

3. Ensure participation of all the trainees in this activity and also encourage them to think about all the possible areas (physical/social/legal/ mental, etc.) in which a drug user's life can be affected by his substance use.

4. Proceed with the presentation, 'Drug related harms'

Presentation: Drug related Harms

- Discuss: *Are all harms independent of each other?* To illustrate the point, use flow-charts of consequences in the presentation
- Similarly, taking the help of PowerPoint slides, generate discussion on and illustrate the concept of hierarchy and priority of harms.
- Conclude the session by conducting the interactive group quiz. Use the slide with Community A, B and C to link with the next session on harm reduction.

Presentation: Drug-related Harms

Contents of the presentation:

- Consequences / harms of drug use
- Inter-relationship between various drug related harms
- Hierarchy of harms
- Prioritisation among harms
- Importance of drug related harms
- Interactive exercise

DAY 1: Sessson 4

Local drug abuse scenario

Objectives

- The overt objective of this session is for the facilitator and participants to understand the local situation and nuances of drug use in order to contextualise the OST for opioid dependent IDUs.

- Another objective is to promote team-work among the participants, particularly bringing together NGO service providers and government hospital service providers.

Material and method

This session requires group discussion. It will take about 60–90 minutes. As described below, the session can be conducted in any of the following two ways.

Steps

If conducted as a group work:

1. Divide participants into groups as per the sites they belong to. Ask the groups to deliberate among themselves on the following issues (with a focus on injecting drug use):
   - o *Common drugs used in their area*
   - o *Estimates of number of drug users (if any)*
   - o *Problems / consequences of drug use, they know of*
   - o *Available responses to the problem of drug use in their area*
   - o Ask the group to prepare a brief presentation (using flip charts) and present before the entire house.
2. Give about 15-20 minutes for discussion and preparation and about 5 minutes for each group to present, followed by about 5-10 minutes on discussion on the presentation.

If conducted as an unstructured discussion:

1. The facilitators should generate the discussion on the above-mentioned issues.
2. It must be ensured that people from all sites talk about their opinion on drug situation and responses in their area. Additionally, care must be taken to bring out different perspectives from participants with varied backgrounds.
3. Important issues must be noted by the facilitator on flip-charts.

While conducting this session, the facilitator must try to address the misconceptions and prejudices which NGOs and government hospitals, or doctors and non-medical professionals may have regarding each other. In the end, the commonalities of purpose and intentions (*general welfare of the community as a whole, control of drug- related HIV, improved access to healthcare for drug users*) must be brought out and highlighted.

DAY 1: Session 5

General principles of drug treatment and harm reduction

Objectives

- To familiarise the participants with basic principles and issues surrounding drug treatment and harm reduction
- To bring about attitudinal changes among participants regarding drug treatment and harm reduction*

Materials and Method

This session will require about 60-90 minutes, to be conducted with the aid of flip-charts / white-board and markers and PowerPoint presentation.

Steps

1 Begin by generating a discussion on 'what do you think is drug treatment (goals, approaches, modalities)'?

2. Conduct a brief mind-mapping. This brief discussion gives an idea to the facilitator of the level of understanding of participants regarding drug treatment.
3. Make the presentation, 'Principles of Drug Treatment'
4. Once the discussion on the presentation of drug treatment is over, steer the discussion on consequences of drug use and whether all drug users, all the time would be interested in quitting?
5. Link this to one of the earlier sessions on harms related to drug use.
6. Make the presentation on 'Harm Reduction'

Address the common misconceptions people may have about drug treatment:

- 'Drug treatment inevitably means getting admitted to a restrictive setting for a long term'
- 'Detoxification is removal of toxins from body'
- 'Relapse means treatment failure'
- 'A strong will-power is enough to quit drugs'
- 'Most medications for treating drug dependence are themselves addictive'

Presentation: Principles of Drug Treatment

Contents of the presentation:

- Goals of treatment
- Phases of treatment
- Motivation enhancement
- Modalities of treatment
- Relapse prevention
- Treatment decision

Presentation: Harm Reduction

Contents of the presentation:

- Drug abuse management strategies (supply, demand and harm reduction)
- Why harm reduction?
- Harm reduction strategies (NSEP, outreach, education, OST)

* Participants belonging to either of these two backgrounds
– drug treatment and harm reduction
– often tend to view both these approaches as contradicting each other. Hence, it is important to clear these misconceptions and bring about the understanding that both these approaches in fact complement each other.

DAY 2: Session 1

Opioid substitution therapy – overview (including opioid withdrawal, intoxication and other syndromes)

Objectives

- To familiarise participants with the general issues surrounding opioids and their effects
- To familiarise them with the concept behind OST and to explain its mechanism of action and effectiveness

Materials and Method

This session will require about 60-90 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

In this session, the discussion and presentation moves forward along with the slides.

Presentation: OST - General Overview

Contents of the presentation:

- Terminology
- Opioids and their general effects on body
- Principle of substitution treatment
- Options for substitution treatment
- Buprenorphine and its advantages
- Myths associated with OST

DAY 2: Session 2

Assessment and diagnosis

Objectives

- To familiarise participants with the steps involved in making assessment of an individual with an history of drug use
- To impart diagnostic interview skills among the participants

Materials and Methods

This session too will require about 60 minutes and must be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

In this session, the discussion and presentation moves forward along with the slides.

Presentation: Assessment and Diagnosis

Contents of the presentation:

- Purpose of assessment
- Stages of assessment
- Tools for assessment (clinical, laboratory, questionnaires)
- Format for taking clinical history
- Making diagnoses of intoxication, withdrawal, dependence (criteria)

DAY 2: Session 3

Assessment and diagnosis: role-play and case demonstration / presentation

Objectives

- To develop diagnostic interview skills among the participants

Materials and Methods

This session is purely interactive and participatory. It requires just some furniture to sit on, and includes role-plays involving the facilitator as a patient and another facilitator / participant as the doctor / service provider

Steps

1. The facilitator, who is playing the patient, must go through the suggested case vignettes[1] thoroughly and should present himself / herself as the fictional patient. However, there is ample scope for improvisation, taking cues from the interview.

2. Allow about 10 to 15 minutes for the mock interview. Even if the 'mock doctor' is steering the interview in a wrong direction, proceed with the interview.

3. If the mock doctor is uncomfortable, the facilitator may come out of the role and gently nudge / encourage / guide the mock doctor to proceed with the interview.

4. Once the interview is over, thank the volunteer and generate an open discussion on:

   4.1. General observations about the interview

   4.2. The 'good' or remarkable things about the interview techniques

   4.3. Limitations / shortcomings, if any

   4.4. The key clinical findings emerging from the interview

   4.5. The likely diagnosis

5. Sum-up the observations and provide recommendations for the following interviews

6. Repeat the steps with remaining two case vignettes

[1] It may be noted that three case vignettes have been provided here, with a progressive degree of complexity of clinical history. Depending on the circumstances, facilitators may use one or more of these case vignettes.

Case vignette 1

AA is a 37-year-old, 12th Standard pass, auto-rickshaw driver, who is married and staying with his wife and a 12-year-old daughter. He has presented himself to the clinic alone, after being referred by the outreach worker. He gives an history of initiating substance use in the form of smoking cigarettes, which has continued daily, multiple times, for the last 22 years; drinking whisky only occasionally for the last 17 years. He started chasing brown sugar about 15 years back and continued daily for about 8 years. For the last 7 years, he has been taking injection tidigesic, which he usually takes as a mixture with either one or more drugs like diazepam, avil and phenargan. On missing injections, he experiences typical opioid withdrawal symptoms. He knows that sharing needles can be dangerous; still at times he is forced to share needles with his friends. He has tried getting rid of this habit on his own and also through treatment at a NGO rehabilitation centre on three-four occasions, but suffered relapses soon after on every occasion. Now, since his wife has threatened to leave him, he wants to stop taking drugs completely.

Case vignette 2

RR is a 29-year-old male, who is a Class 8 pass labourer, originally resident of a village, but has for many years now been working here. He is married but his wife stays in the village. He stays here, sharing a small room with his friends. He presented himself to the clinic, with a history of alcohol use, which started about 12 years back. He started with small amounts taken occasionally, but progressed gradually to daily consuming one bottle, starting from the early morning itself. On missing, he would experience tremors in his hands, immense anxiety, sweating, palpitations and difficulty in sleeping. This pattern continued for the next 4-5 years and once when he went to a doctor for pain in the abdomen, he was given an injection, which gave him immediate relief and a sense of pleasure. He found out that the injections were called fortwin–phenargan, and he continued taking these even after his treatment was over. Now, he has gradually stopped drinking and has started injecting about 6-7 ampoules of fortwin–phenargan every day. He has now found a big circle of friends who inject together and sometimes share their injection equipment. He has never tried giving up till now and is not sure whether he will be able to. The sex worker, he often visits, has been reportedly found to be HIV positive. He is afraid he may have 'caught the disease called AIDS', and is now keen to 'stop all bad habits' and get himself tested for HIV.

Case vignette 3

BD is a 27-year-old unmarried male staying on the footpath. He did go to school but could not study beyond Class 5. He ran away from his home in a village when he was a child and since then has been staying on the footpath. He does not have a fixed job but has learned the work of a motorcycle mechanic. He also engages in stealing and pick-pocketing, and has been to jail three times. He presented himself with a history of starting smoking *bidi* at the age of 12 (continued till now), inhaling correction fluid, which he started at the age of 14, continued for 4 years and then stopped. When he was 18, he was introduced to cough syrups, corex and phensedyl, and since then has been taking it daily at multiple times, with a history of progressively increasing the amount of consumption. About 3 years back, when he could not procure cough syrup, a friend injected him with a drug which was pleasurable and quite similar in effect to the cough syrup. Since then, he continues to take cough syrups daily, but occasionally (about once in 7-8 days) has to go to his friends who give him this injection. He is neither aware of the name of the injection, nor is sure of being injected with a clean, sterile needle every time. However, he is now fed up of this habit and is looking for options to try reducing and stopping drugs.

DAY 2: Session 4

Buprenorphine - pharmacology

Objectives

- The purpose of this session is to familiarise participants to the basic pharmacology of buprenorphine.

- Though primarily meant for doctors, all participants will benefit from this session, since this will help them understand the basic pharmacology of buprenorphine and equip them with the necessary knowledge to deal with queries posed by the patients.

Materials and Methods

This session will require about 45-60 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

In this session, the discussion and presentation moves forward along with the slides.

Presentation: Pharmacology of Buprenorphine

Contents of the presentation:

- Buprenorphine, as a medication
- Pharmacokinetics and pharmacodynamics of buprenorphine
- Side-effects
- Precautions and contraindications

DAY 3: Session 1

Implementing OST with buprenorphine: induction, stabilisation, discontinuation

Objectives

- This session is the most important session of the training on OST. The objective of this session is to familiarise all participants with and develop their skills on induction, stabilisation and discontinuation of buprenorphine.

Materials and Methods

This session will require about 90-120 minutes (with a break of about 15 minutes), to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation. Depending upon the availability of facilitators, two facilitators can hold the session in two / three parts. However, to ensure continuity, it is advisable that one facilitator conducts the entire session.

Steps

In this session, the discussion and presentation moves forward along with the slides.

Presentation: Implementing Substitution Treatment

Contents of the presentation:

- Steps in implementing OST
  - Recruitment
  - Assessment
  - Psycho-education
  - Informed consent
- Phases of treatment
  - Pre-induction
  - Induction
  - Maintenance / stabilisation
    - FOLLOW-UP ASSESSMENTS
    - DISPENSING
    - MONITORING
    - RECORD MAINTENANCE
  - Discontinuation
- Tips for a successful programme

DAY 3: Session 2

Special clinical situations – adolescents; women; HIV; other medical conditions; dual diagnosis

Objectives

- This session is intended to develop participants' knowledge about and skills to deal with certain specific clinical situations, likely to be routinely encountered while implementing OST.

Materials and Methods

This session will require about 40-60 minutes, to be conducted with the aid of flip-charts / white-board and markers, and Powerpoint presentation.

Steps

1. Since the participants have just gone through the treatment guidelines with buprenorphine for routine cases, it will be advisable to quickly recap the various steps involved in OST.

2. Introduce the session. Emphasise that there are certain specific clinical situations, the participants need to be familiar with.

3. Make the presentation: special clinical situations

Presentation: Special Clinical Situations and Considerations

Contents of the presentation:

- HIV
- Tuberculosis
- Psychiatric co-morbidities
- Women
- Children and adolescents
- Hospitalisation / incarceration during OST
- Overdose and its management

DAY 3: Session 3

Psychosocial Interventions

Objectives

- The objective of this session is to familiarise participants with major types of psychosocial interventions, which are delivered as part of the OST. It must be noted that while providing some of these interventions will be the main task of the counsellors, ALL participants need to gain required knowledge and skills.

Materials and Methods

This session will require about 45-60 minutes, to be conducted with the aid of flip-charts / white-board and markers, and Powerpoint presentation.

Steps

In this session, the discussion and presentation moves forward along with the slides.

Presentation: Psychosocial Interventions

Contents of the presentation:

- Psychosocial interventions: an introduction
- Motivation Enhancement
  - Feedback
  - Decision balancing
  - Developing discrepancy
  - Supporting self-efficacy
- Psycho education
- Relapse prevention
  - High-risk situations
  - Coping strategies
- Support / self-help groups
  - Handling drop-out

DAY 3: Session 4

Role-play/Demonstration of psychosocial interventions

Objectives

- The objective of this session is to develop the skills of participants to deliver the major types of psychosocial interventions discussed in the previous session. As noted earlier, while providing some of these interventions will be the main task of the counsellors, ALL participants need to gain the required knowledge and skills.

Materials and Methods

This session is purely interactive and participatory. It requires just some furniture to sit on, and role-plays involving a facilitator as a patient and another facilitator / participant as the doctor / service provider.

Steps

1. The facilitator, who is playing the role of a patient, must go through the suggested case vignettes* thoroughly and should present himself / herself as the fictional patient. However, there is ample scope for improvisation, taking cues from the session.
2. Allow about 10 to 15 minutes for the mock session. Even if the 'mock doctor / counsellor' is steering the session in a wrong direction, proceed with the session.
3. If the mock doctor / counsellor is uncomfortable, the facilitator may come out of the role and gently nudge / encourage the mock doctor / counsellor to proceed with the session.
4. If one of the participants (the mock service provider) has failed to take the session forward, invite someone else to join the session as a colleague of the service provider and encourage him to proceed with the session.
5. Once the session is over, thank the volunteers and generate an open discussion on

   5.1. General observations about the session

   5.2. The 'good' or remarkable things about the techniques in the session

   5.3. Limitations / shortcomings, if any
6. Sum-up the observations and provide recommendations for the next sessions.
7. Repeat the steps with the remaining two case vignettes

*It may be noted that three case vignettes have been provided here. The same cases which were demonstrated during the session on 'Assessment and Diagnosis' will now be interviewed for the purpose of providing different types of interventions.

Case vignette 1: Psycho education in the field by an outreach worker

AA is a 37-year-old, 12th Standard pass, auto-rickshaw driver, who is married and staying with his wife and a 12-year-old daughter. He gives an history of initiating substance use in the form on smoking cigarettes, daily, multiple times, for the last 22 years; drinking whisky only occasionally for the last 17 years. He started chasing brown sugar about 15 years back and continued daily for about 8 years. For the last 7 years, he has been taking injection tidigesic which he usually takes as a mixture with either one or more drugs like diazepam, avil and phenargan. On missing injections, he experiences typical withdrawal symptoms. He knows sharing needles can be dangerous, still at times he is forced to share needles with his friends. He has tried getting rid of this habit on his own and also through treatment at a NGO rehabilitation centre on three-four occasions, but suffered relapses soon after on every occasion. Now, since his wife has threatened to leave him, he wants to stop taking drugs completely.

He has just met the outreach worker in the field, sharing a cup of tea at a tea-stall. Now the outreach worker is trying to explain to him how OST may be beneficial for him.

Case vignette 2: Motivation Enhancement by the counsellor in the clinic

RR is a 29-year-old male, who is a Class VIII 8 pass labourer, originally resident of a village, but has for many years now been working here. He is married but his wife stays in the village. He stays here, sharing a small room with his friends. He has a history of alcohol use which started about 12 years back. He started with small amounts, taken occasionally, but progressed gradually to daily consuming about one bottle, starting from the early morning itself. On missing, he would experience tremors of hands, immense anxiety, sweating, palpitations and difficulty in sleeping. This pattern continued for the next 4-5 years and once when he went to a doctor for pain in the abdomen, he was given an injection, which gave him immediate relief and a sense of pleasure. He found out that the injections were called fortwin–phenargan, and he continued taking these even after his treatment was over. Now he gradually stopped drinking and started injecting about 6-7 ampoules of fortwin–phenargan every day. He has now found a big circle of friends who inject together and sometimes share their injection equipment. He has never tried giving up till now, but now he has heard that the sex worker he often visits has been found to be HIV positive. He is afraid he may have 'caught the disease called AIDS', and is now keen to get himself tested.

He presented himself to the clinic, with the request for just 'AIDS testing' to be conducted. He is sure that with so many years of drug use, he cannot quit taking drugs. Now, the counsellor is trying to enhance his motivation to quit drugs.

Case vignette 3: Relapse Prevention session by a Doctor / Counsellor

BD is a 27-year-old unmarried male, Class 5 pass, staying alone on the footpath. He had presented with a history of starting smoking bidi at the age of 12 (continued till now), inhaling correction fluid from the age of 14 to 18 years, cough syrups (corex and phensedyl) use, since 18 years of age and history of taking some unknown opioid injections occasionally for the last three years. He has been on buprenorphine 6 mg per day for the last two months and has stopped taking all illegal drugs for the last one-and-a- half months. He has also recently found work as a motorcycle mechanic. However, he still experiences occasional craving and is worried that he may relapse again. He now reports that previously too, he did manage to stop taking drugs for two months but relapsed in the third month.

The doctor / counsellor is trying to guide him in preventing a relapse.

DAY 3: Session 5

Scheme for implementing OST in Government centres: an overview

Objectives

- To familiarise participants with the NACO scheme for implementing OST at government centres
- To stimulate their thinking about how to implement the scheme at their own sites

Materials and Methods

This session will require about 60 minutes, to be conducted with the aid of flip-charts / white-board and markers, and Power-point presentation. A copy of the draft of the 'Scheme for Implementing OST at Government Centres' and 'Practice guideline on *Substitution Therapy with Buprenorphine for Opioid Injecting Drug User'* prepared by NACO will be required. Each participant should have a note-pad.

Steps

1. Distribute a copy of the draft of 'Scheme for Implementing OST at Government Centres' in the beginning of the training programme to allow participants to familiarise themselves with the key aspects of the scheme.
2. Begin the session by asking the participants whether they have been able to go through the draft scheme document.
3. Inform the participants that the session will start with a presentation of the key elements of the scheme followed by interaction/discussion on its various elements.
4. Make a presentation showing an overview of the scheme for implementing OST at government centres.

Presentation: OST Scheme at Government Centres

Contents of the presentation:

- NACO OST programme
- Overview of the scheme
- Selection of the government health care facility
- Role of the Targeted Intervention (TI) and the outreach worker in the TI
- Providing OST services
- Commodities and supply chain management
- Record maintenance
- Monitoring and supervision (internal and external monitoring mechanism)
- Financial and procurement management

5. During the presentation, ask participants about what they think can be the basis of deciding in which districts OST services should be initiated. Note their responses on the flip chart and identify the responses that are included in the scheme for implementing OST in Government Centres. Similarly, ask them to what they think can be the basis of choosing a health care facility for starting OST. Note their responses on the flip-chart and identify the responses that are included in the scheme for implementing OST in government centres. If any responses are missing based on the scheme document, they should be supplemented by the presenter and these can then be shown on a slide during the presentation.

6. After presenting the infrastructure requirements, amenities, clinic timings, equipment and staffing, participants should be asked to note down which of these they think is missing/ inadequate/needs modification in their centre.

7. Elicit the responses on the responsibilities of each category of staff in the government centre (nodal officer, doctor, nurse, counsellor, data manager and office support staff), TI and outreach worker before showing the slide on this.

8. Ask participants about their familiarity with stock-keeping of medicines and its importance before presenting the requirements for stock keeping.

9. Once the record to be maintained are listed, inform the participants that this will be dealt with in greater detail in a later session.

- A discussion on need to involve both the government centres and the NGOs in implementing OST is important.
- Participants must understand that involvement of government centres in implementing OST is important if adequate coverage and scale-up of OST has to be achieved. Also, the advantage of having referral facilities to ART, ICTC, STI, DOTS facilities within the government set-up should be discussed.
- The drawbacks of government centres, including difficulty in access and lack of patient friendly environment at times for which the support of NGOs is important, should also be discussed. Thus, the presentation highlights how the scheme envisages utilising the strengths of both these institutions to provide optimal OST services to the IDU.
- Although the scheme discusses termination of treatment after stabilisation of occupational and psychosocial problems by 1-2 years, it should be emphasised that the duration of treatment should be flexible and often last for several years although some clients may need OST for a shorter duration. The duration of treatment should be determined in an ongoing manner in consultation with the client.
- The need for adequate monitoring (both internal and external) needs to be emphasised.

DAY 4: Session 1

Exposure to the OST clinic, including demonstration

Objectives

- To familiarise participants with various programme management and clinical issues related to OST (especially demonstration of the benefit from OST)
- To familiarise participants with record maintenance related to OST
- To help participants observe the procedures at an OST clinic and to help them get a 'feel' of an OST clinic.

Material and Methods

This session will require about 3-4 hours with a coffee break of 15 minutes. The session will require the presence of the project manager and staff of the OST clinic, some clients in various stages of treatment with OST (induction, stabilisation and termination), family members of clients and records that are being maintained.

Choice of OST centre

As far as possible, the visit should be conducted at an OST centre that most closely resembles the settings where participants are working. Additionally, logistic and feasibility issues also govern the choice of an OST centre for the exposure visit.

Steps

Before the session

1. The preparation for this session should start a day or two in advance. The facilitators for the training programme should contact the OST clinic to be visited and inform them of the purpose of the visit and the number of persons that will be visiting the clinic, the seating arrangements required and also other requirements as listed above. They should also select clients for case demonstrations. The project manager of the clinic and the staff should be aware of what may be expected of them during the visit. If possible, a visit to the OST clinic should be made a day in advance by one of the resource persons to facilitate demonstration on the day of the visit.

During the session

2. Facilitate a round of introductions of the participants and the staff in the OST clinic.

3. This will be an interactive session and will require about one hour.

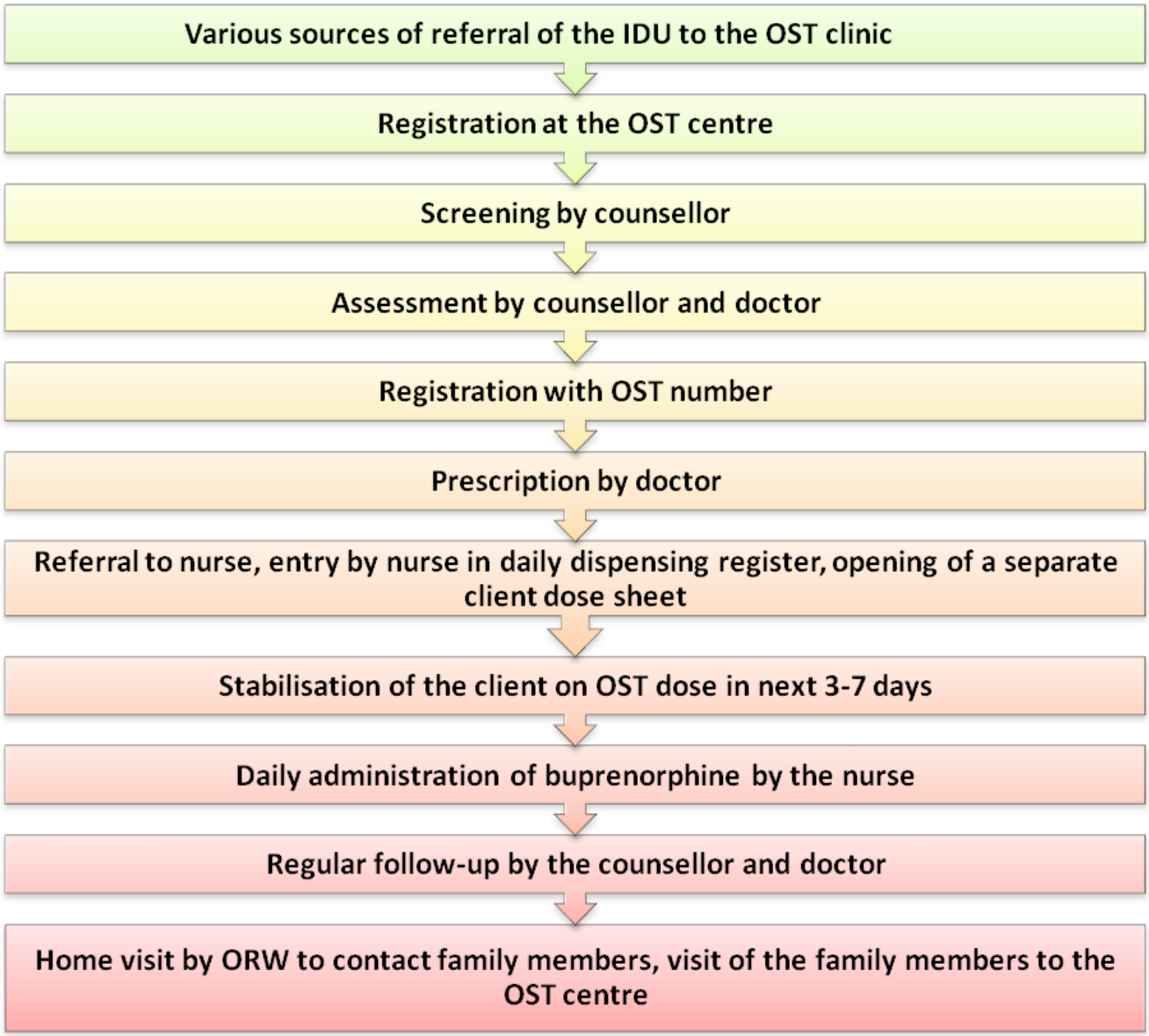
   3.1 Invite the project manager of the OST clinic to give a brief background of the clinic and the facilities available.

   3.2 Invite each of the staff in the OST clinic to talk about their duties, responsibilities and experiences while providing OST to clients. Allow free flow of questions from the participants.

   3.3 This session should also provide participants with an understanding of the patient flow chart - on next page of the 'Scheme for Implementing OST at Government Centres' (i.e., the entry, assessment, induction, stabilisation, continuation and termination of OST)

   3.4 The process of referral for other health problems or for detoxification at termination should also be discussed.

   3.5 Also facilitate a discussion on termination of therapy and what is done in case of dropout.



4. Allow the project manager to take the participants on a round of the OST clinic. This process will also take an hour.

   a. Give them an opportunity to closely examine the records being maintained by each category of staff and allow a free flow of interaction to clarify any doubts that they may have.
   b. Also allow them to note the caution exercised in keeping stocks.

   The participants can then break into smaller groups based on their roles and responsibilities –doctors, nurses, counsellors. Data managers can be in the group with the nurses. This process can be for about 30 minutes

   c. Doctors in the participant group-Give them an opportunity to watch the process of assessment by the doctor and provision of prescription for OST

   d. Nurses in the participant group - Give them an opportunity to watch the process of administration of medication by DOT by the nursing staff

   e. Counsellors in the participant group- Give them an opportunity to watch the process of counselling of a client/family member. Adequate privacy during the session should be demonstrated.

5. Finally, a demonstration of clients in various stages of treatment will be conducted by the staff at the OST clinic. This should include a presentation of a summary of the client's history by the staff at the OST clinic followed by an interaction with the patient and his family member. The cases should include clients whose family members can be involved in treatment and those whose family members cannot be involved in the treatment, patients with variable severity and background, those with marked high-risk behaviour, clients in various stages of treatment, re-entry of dropouts, etc. At least 3-4 such case demonstrations should be done to highlight the following aspects:

   5.1 Improvement in the quality of life of the patient in terms of reduction in drug use, risk behaviour, financial problems, legal problems, occupational difficulties, family conflict and stigma due to drug use;

   5.2 Clients' understanding of OST, how it works, duration of treatment, their own role in treatment and requirements to be a participant of OST (regular visits, DOT and involvement of family member where feasible);

   5.3 Improvement in quality of life of the family members;

   5.4 Family members' understanding of OST and the support extended by them in terms of logistics (travel expenses, encouraging the patient to comply with medication and supporting continuation of medication, appreciating the improvement in his life, etc.);

   5.5 Process of induction and number of days it takes to stabilise on medication;

   5.6 Process of termination; and

   5.7 Involvement of the client in the process of treatment and the positive relationship that the client and the family members have with the OST staff.

DAY 4: Session 2

Debriefing and experience sharing

Objectives

- To recapitulate the highlights of the exposure visit to the OST clinic
- To allow participants to ruminate on new leanings and also dwell on preparedness/steps that will be required by them to initiate OST

Material and Methods

This session will require 60 minutes, to be conducted with the aid of flip-charts/ white-board and markers.

Steps

1. Ask the participants to recapitulate what all they learned during the visit.
2. Provide all participants with small slips of paper (about the size of a post card). Ask them to write down the following:
   - At least one thing which was a new learning for them, especially in terms of their own roles in their OST centres
   - At least one thing which they feel can be improved upon (in the centre just visited, and which can apply to their centre as well)
   - Any other remarkable aspect of the visit
3. Ensure that all participants get a chance to speak and read out their responses.
4. Capture the responses on the flip-chart and note them down so that issues with similar content are put together for categorising them theme-wise. Some of the themes can be:
   - Improvement in quality of life of the patient and family member
   - Various sources of referral to OST services
   - Patient flow chart
   - Dose and duration of OST
   - Compliance and efforts made to ensure compliance
   - Process of DOT, dispensing, counselling and prescribing
   - Record keeping
   - Stock-keeping
   - Referral for health problems or detoxification
   - Roles and responsibilities of various categories of staff
   - What is done in case of dropout
   - Termination of treatment
   - Involvement of client in treatment
   - Client friendly services

Ask participants about similarities and differences from their clinical setting. Also ask them to think of the possible challenges in implementing OST in their centre and how they will handle those challenges.

DAY 4: Session 3

Programme Management–I
Procurement and Supplies

Objectives

- To familiarize the participants with the process of procurement of buprenorphine and other supplies.
- To explain the process of "stock projection"

Material and Methods

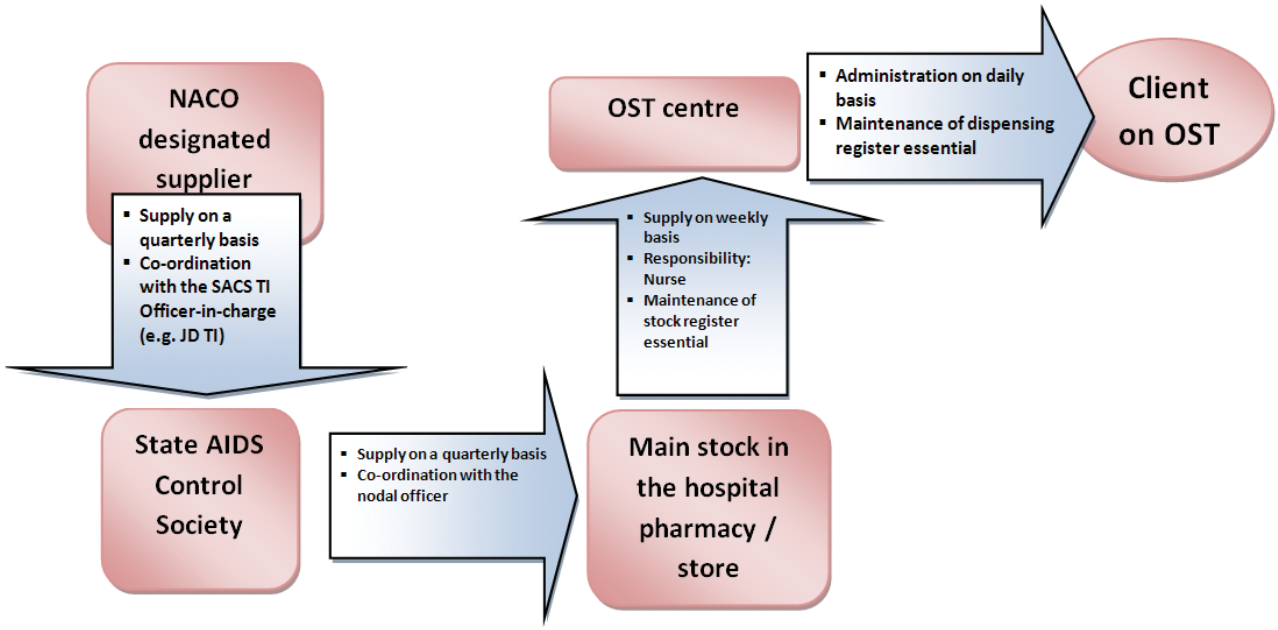
This session will require about 15 minutesand involves group discussion.

Steps

Display and explain the following flow chart as provided in the "Scheme for Implementing OST at Government Centres". Key highlights :

1. The procurement of buprenorphine will be through NACO designated supplier to State AIDS Control Society and will be supplied to the hospital on a quarterly basis by SACS. For this, an indent book will have to be maintained by the hospital in which the request for medicines will be written by the nurse and duly signed by the nodal officer. A duplicate copy of the indent form will be retained at SACS for their records. At the time of procurement, a form 6 is sent by the pharmaceutical company with the buprenorphine consignment and this form after being signed has to be sent back to the pharmaceutical company by **SACS or NACO**.
2. The purchase of adjunctive medicines or other goods will have to be handled in collaboration of the local hospital administration as per the local standard operating procedures.

Presentation: Stock Projection



DAY 4: Session 4

Programme Management–II

Record maintenance and reporting

Objectives

To familiarise participants with the records to be maintained for OST services

Material and Methods

This session will take 60–90 minutes. A copy of the draft of the 'Scheme for Implementing OST at Government Centres' and 'Practice Guideline on *Substitution Therapy with Buprenorphine for Opioid Injecting Drug User'* prepared by NACO will be required for each participant. Besides this, any other reporting formats that are to be filled up should be available as handouts.

Steps

1. This session will involve the entire group breaking up into smaller groups based on their roles: nodal officers, doctors, nurses, counsellors, data managers and outreach workers.

2. Allow participants to discuss among themselves and go through the record formats that will be maintained by them in the small groups for about 15 minutes. Then, the group will come together and each record will be discussed one by one. It is important for the whole group to have some familiarity with all records but each staff will be asked to focus on records that will be maintained by them. A summary of the records to be maintained are provided in the adjoining table. Formats for all individual records (as described in the various source documents – Practice Guidelines, Standard Operating Procedure and the 'Scheme' document) have been attached as an Annexure with this document.

3. The facilitators should display and explain all these formats. It will also help if all the groups are asked to make these formats on chart papers and display sheets, and explain them to all the other participants.

S. No.	Record	Description in brief	Staff responsible
1	**Client register - New**	Register of ALL NEW CLIENTS VISITING OST CENTRE containing names, age/ sex and address of clients along with client Id. no.	Data manager
2	**Client register – Follow up**	Register of ALL OLD CLIENTS VISITING OST CENTRE FOR FOLLOW-UP containing names, age/sex along with client ID no.	Data manager
3	**Client register – OST**	Register of ALL CLIENTS BEING PUT ON OST containing names, age/sex and address of clients along with client ID no.	Data manager
4	**Client file**	A file containing **Client intake form, Consent form, Follow up form and notes, Side-effects checklist, prescription slip, counseling notes**	Data manager (for organisation)
	4.1 Client intake form (a part of client file)	Detailed history and examination of the client	Counsellor and doctor
	4.2 Format for ascertaining suitability for OST (a part of client file)	A format which lists the criteria on the basis of which the client has been found suitable for OST	Counsellor and doctor
	4.3 Consent form (a part of client file)	A sheet with basic information on OST with signature of patient and doctor	Counsellor
	4.4 Follow up form (a part of client file)	Format for filling the information obtained during follow-up	Physician
	4.5 Side-effects checklist (a part of client file)	Format for monitoring side-effects	Physician
5	**Referral Register**	Format for filling up data on referral	Physician/Counsellor
6	**Group discussion register**	Format for filling up records in group discussion	Outreach worker
7	**Counselling register**	Format for recording the counselling sessions	Counsellor
8	**Clients' dose sheet**	One sheet for each client containing the date and dose of medication received	Nurse
9	**Dispensing register**	Details of dispensing carried out by the nurse every day	Nurse
10	**Daily stock register**	Details of stock in and stock out every day	Nurse
11	**Central stock register**	Details of stock in and stock out once a week	Nurse and Nodal Officer
12	**Monthly Report**	To be compiled and sent to SACS/NACO every month	Nodal Officer (aided by others)

DAY 5: Session 1

Programme Management-III

Referral and networking, engaging civil society

Objectives

- This session has been designed to familiarise participants with the concept of networking. It will also develop their skills regarding planning and implementing referral services

Materials and Method

The session will last for about 30-45 minutes and is largely participatory in nature, involving mind-mapping exercise, along with a brief Powerpoint presentation. The facilitator will require flip charts / whiteboard, marker pens and PowerPoint presentation.

Steps

1. Start with a mind-mapping exercise: what are the various services an IDU may require?

2. After a list of services an IDU may require has been generated, ask participants to break up into groups as per the sites and prepare a small directory of service providers they know of, in their sites. At this juncture, just a list of names of service provider organisations is required.

3. Ask each group to present their list of service providers

4. Generate a discussion on:

   4.1. Do they personally know these service providers?

   4.2. Do they know the details of services provided? (timing, costs, eligibility to access services, quality of services, etc.)

   4.3. Can they satisfy all the queries and clarifications a client may have about these services?

5. **Proceed with the presentation: referral and networking.**

6. After the presentation, highlight the importance of a directory of service providers. Entrust some people from the implementing sites with the task of developing /maintaining the directory, and advocacy and networking activities.

Presentation: Referral and Networking

Contents of the presentation:

- What is networking?
- Why networking?
- Potential entities of networking
- Steps in referral and networking
- Referral analysis

DAY 5: Session 2

Programme Management-IV

Minimum standards of care, reporting

Objectives:

- To encourage participants and help them in planning the minimum standards of care, which should be maintained in OST implementation

Materials and Method

This session is a small group activity, which will require about 90 minutes, to be conducted with the aid of flip-charts / white-board.

Steps

1. Ask participants to break up into small groups depending on their role: nodal officers, doctors, nurses, counsellors/outreach workers, data managers.

2. Ask them to brainstorm within the group and come up with responses on what aspects they need to pay attention to ensure minimum standards of care. Ask them to choose a leader who will make a presentation on behalf of the group with the aid of a flip-chart.

Doctor

1. Ensuring that each patient is being thoroughly assessed before recruitment. Recruitment to OST is only after following the criteria. Patients not found suitable for OST are also provided appropriate available services
2. Ensuring that proper procedures for induction, maintenance and tapering of buprenorphine are being followed as per the clinical practice guidelines
3. Ensuring that the dosage prescribed are adequate and dose modifications are being done in case of requirement
4. Ensuring that even in the stable phase, patients are being followed-up regularly
5. Ensuring that duration of treatment is long enough to bring tangible changes in patient's drug use status, psycho-socio-occupational status and quality of life
6. Ensuring that patients who require other ancillary services (Referrals, to ICTC, ART, DOTS for TB etc.) are able to access those services
7. Ensuring that patients off OST (after OST completion) are also able to access services required by them
8. Ensuring adequate record keeping

Nurse

1. Ensuring continuous availability of medicines and keeping the nodal officer informed, well in advance
2. Ensuring Safekeeping of medication
3. Ensuring adequate dispensing procedure: Confirming patients' intoxication status, patients' identity, dose, current prescription, dispensing buprenorphine in directly observed manner and ensuring that no diversion is taking place
4. Informing the doctor of any pertinent clinical issue noted by the nurse
5. Ensuring adequate record keeping

Counsellor

1. Ensuring that each patient is being thoroughly assessed before recruitment. Recruitment to OST is only after following the criteria.
2. Counselling sessions
   a. At intake: Motivation enhancement, if required, Psycho-education (i.e. explaining rationale, process of treatment, adherence) Discussing logistics and ensuring that the patient is adequately *informed* prior to obtaining his consent
   b. Ensuring that even in the stable phase, patients are being followed-up regularly. During follow up
      i. Addressing adherence
      ii. Efforts at rehabilitation
      iii. Relapse Prevention

c. Attempting involvement of family members

d. Addressing substitution with other substances such as alcohol and benzodiazepines

e. Addressing high risk behaviour

3. Making efforts to bring dropouts back in treatment (through maintaining close liaison with the outreach worker)
4. Ensuring adequate record keeping

Outreach Worker

1. During routine outreach work keeping a lookout for clients suitable for OST. Providing routine information and services for even those not likely to be suitable for OST
2. Making rapport with the clients and facilitating their access to OST centre (accompanied as far as possible)
3. Facilitating referral and access to other than OST services
4. Keeping contact with clients on OST and their family members in the field
5. Reporting regularly to the staff in Government OST centre and serving as a link between the Government OST centre and the IDU TI

Additional Overarching Principles for Minimum Standards of Care

- Licensing / accreditation
- Compatibility with existing health services framework
- Sensitivity and adaptability to local culture
- Promoting service utilisation
- A patient-friendly atmosphere
- Ongoing efforts for improvement
- Systems for accountability

After the group presentations are over, monitoring and evaluation indicators should also be discussed. Initially, the responses may be elicited from the group and then the following indicators may be presented:

- Total number of clients contacted
- Total number of clients who reached the centre
- Total number of clients registered for OST
- Proportion of clients referred to (and accessed) other services
- Average dosage received and the dose range
- Average duration of treatment and the range
- Percentage of days of staff attendance
- Number of instances of buprenorphine 'not-available'
- Number of stakeholders / advocacy meetings held
- Proportion of clients receiving psycho-social interventions as per the frequency decided
- Proportion of patients retained in the treatment
- Proportion of patients compliant / adherent (e.g., having received OST for >80% of days)
- Proportion of patients reporting abstinence from illicit drugs
- Proportion of patients reporting reduction in risky injecting / sexual behaviour
- Proportion of patients reporting improvement in psycho-social status

Finally, the monthly report format must be discussed with the entire group.

Monitoring and Evaluation: Basic Issues

- M&E must not be seen as an additional burden, but built into routine systems
- Simple, unequivocal and objective indicators should be used
- M&E must be an ongoing, periodic activity
- M&E should be seen as opportunity to improve capacity
- Necessary resources should be allocated for M&E
- Perspective of the service beneficiaries (patients) is an essential component

Annexures

Annexure -1

Client Reg. No: _____

OST File No: _____

OPIOID SUBSTITUTION THERAPY PROGRAMME

_____

(Name of the Centre)

CLIENT FILE

Name of the Patient: _____

TI UID No: _____

Date of Registration: _____

Date of OST Registration: _____

National AIDS Control Organization
Ministry of Health and Family Welfare
Government of India

1. INTAKE PROFORMA - COUNSELLOR

Name of interviewer:Designation:
Date of Interview:

Source of referral:	1	Self-Referred		
(Tick one)	2	Other hospital department	Specify the department	
	3	IDU TI	IDU TI Unique Code: (If referred by IDU TI)	
	4	Others	Specify the source:	

Accompanied by:

1. REGISTRATION DETAILS

Client Registration Number:

Date of Registration:

D	**D**	**M**	**M**	**Y**	**Y**

Date of OST file creation:

D	**D**	**M**	**M**	**Y**	**Y**

OST File Number / OST ID:

City Code			**Y**	**Y**			**Number**	

2. PERSONAL DETAILS

Name:

Father's / Husband's / Mother's Name :

Age: Years **Sex:** M F Other

Address:

Phone Number:

Alternate Number:

3. SOCIO-DEMOGRAPHIC PROFILE

3.1 Marital Status:

1	Never married
2	Married
3	Widow/widower
4	Divorced
5	Separated (due to other reasons)
6	Separated (due to drug use)
7	Not known

3.2 Education

1	Illiterate
2	Literature (read and write)
3	Primary education (5 yrs of schooling)
4	Middle (8 yrs of schooling)
5	Matriculation / Higher Secondary (10 yrs of schooling)
6	Graduate
7	Post-graduate / Technical / Professional education
8	Not known

3.3 Employment Status

1	Never employed
2	Currently unemployed
3	Full time employed
4	Part time employed
5	Self-employed
6	Student
7	Housewife
8	Others (pensioner, retired etc.)
9	Not known

3.4 Monthly Income:

1	<Rs. 1500
2	Rs. 1500 – 3000
3	Rs. 3000 – 4500
4	Rs. 4500 – 6000
5	Rs. 6000 - 10000
6	>Rs. 10000
7	Not known

3.5. Profession/Occupation (If employed presently or in past):

Brief Occupational history:

4. DETAILS OF SUBSTANCE USE

4.1 PATTERN OF SUBSTANCE USE

S.No.	Substance	Ever Use (Y/N)	Duration of Use	Current Use (Y/N)	Current Pattern of use	Usual Dose	Injecting Use-Ever (Y/N)	Duration of Injecting Drug Use
1	Alcohol							
2	Cannabis							
3	Heroin							
4	Dextropropoxyphene							
5	Buprenorphine							
6	Pentazocine							
7	Opium (Afeem)							
8	Other opioids							
9	Sedative/ Hypnotics							
10	Cocaine							
11	Amphetamine and other ATS							
12	Inhalants							
13	Any other substance (except tobacco)							

4.2 RECENT INJECTING PRACTICES

Injecting Use in last 3 months: [1] Yes [2] No

Frequency of Injecting in last 1 month:

[1] Daily
[2] 3-4 times per week
[3] 1-2 times per week
[4] less than once per week
[5] None

No. of injections per day (usual range):

Route of administration: 1 IV 2 IM 3 Any other

Injecting practices: 1 Alone 2 Group

Sharing of Syringe/Needle: 1 Yes 2 No

Frequency of sharing of Syringe/Needle:

1 Never
2 Rarely
3 Sometimes (1-2 times in 10 injecting episodes)
4 Often (> 2 times in 10 injecting episodes)
5 Every time

Sharing of Paraphernalia: 1 Yes 2 No

Frequency of sharing of Paraphernalia:

1 Never
2 Rarely
3 Sometimes (1-2 times in 10 injecting episodes)
4 Often (>2 times in 10 injecting episodes)
5 Every time

Number of people shared with:

Sharing during last injecting act: 1 Yes 2 No

5. SEXUAL HISTORY

5.1 Age at sexual debut: (in years)

5.2 History of:

Paid sex	1	Yes	2	No
Heterosexual intercourse	1	Yes	2	No
Had sex in exchange of money / drugs	1	Yes	2	No

5.3 Recent Sexual Practices

Currently sexually active (last 1 month)	1. Yes			2. No	
	Sex in last month with	Number of partners	Sexual frequency - last one month	Condom Usage	Condom use during last sex act
Regular Partner / spouse	1. Yes 2. No				1. Yes 2. No
Irregular / casual partner	1. Yes 2. No				1. Yes 2. No
Female Sex Worker	1. Yes 2. No				1. Yes 2. No
Paying Partner	1. Yes 2. No.				1. Yes 2. No
Same sex partner	1. Yes 2. No				1. Yes 2. No

6. KNOWLEDGE AND PRACTICES RELATING HIV AND AIDS

6.1 HIV / AIDS Awareness

Have you heard about STI?	**1** Yes		**2** No	**3** Not sure	
Have you ever been to a STI clinic?	**1** Yes		**2** No		
Have you ever heard about HIV/AIDS?	**1** Yes **2** No	If YES, from where did you get this information?	**1** Friends/Peers **2** TV/ Media **3** NGOs/CBOs **4** Others (specify)		

How is HIV transmitted?	**1** Unsafe sexual contacts	**4** Infected mother to child
	2 Sharing contaminated needle /syringes	**5** All of the above
	3 Through infected blood & blood products	**6** Any other (Please specify)

Are you aware of ways to prevent transmission of HIV?	**1** Yes **2** No	Note the response if YES is selected
Do you know about the facility where you can get testing done?	**1** Yes **2** No	Note the response if YES is selected

6.2 HIV Status

Have you ever undergone HIV testing?	1 Yes 2 No 3 Not sure	Are you aware of your HIV status?	1 Yes 2 No 3 Not sure	Time since last HIV test (in month)	

Why did you feel the need to undergo the same? Record the response

HIV status	**1** Positive		**2** Negative		
Are you registered with ART Centre?	**1** **Yes** 2 No	Are you currently on ART?	**1** **Yes** 2 No		
Last CD4 count (with date)		Next CD4 count due (Month and Year)			

7. COMPLICATIONS DUE TO DRUG USE

7.1 Psychological [1] Yes [2] No
Details if any

7.2 Marital [1] Yes [2] No
Details if any

7.3 Familial [1] Yes [2] No
Details if any

7.4 Occupational [1] Yes [2] No
Details if any

7.5 Financial

Average daily expenditure on substance use (in rupees):

Primary source of financing substance use: [1] Legal earnings [2] Borrowings from family [3] Borrowings from others [4] Illegal activities [5] Other means

Any other relevant details:

7.6 Legal

Nature of illegal activities: [1] Stealing [2] Pickpocketing [3] Selling drugs [4] Vehicular theft [5] Gang activities [6] Others

History of incarceration: [1] Yes [2] No
Details of last incarceration:

Any legal cases pending: [1] Yes [2] No
Details of pending cases:

Ever booked under NDPS Act: [1] Yes [2] No

8. PSYCHOSOCIAL STATUS

8.1 Current Living Arrangement

1	Joint family	5	Homeless
2	Nuclear family	6	Cohabitating with a partner
3	Alone – at home	7	At workplace
4	With friends	8	Any other (please specify)
		9	Not known

8.2 Psycho-social Support

Relationship with family members	
Relationship with spouse	
Relationship with non-drug using friends	

8.3 Source of Financial Support

1	Own legal earning
2	Own earning through illegal activities
3	Family earning
4`	Friends
5	Others (please specify)

9. ABSTINENCE ATTEMPTS

9.1 Ever attempted to give up drug use Yes / No

9.2 Details of previous abstinence attempts

Year of Attempt	Duration of abstinence (number of months)	Type of help / intervention	Reasons of relapse

10. MOTIVATION

Reasons for wanting to abstain:			
Recent significant abstinence attempts	1. Yes	2. No	
Overall grading of motivation	1. Good	2. Fair	3. Poor

11. COUNSELLOR'S NOTES

11.1 Drugs Use Issues
11.2 Psycho-social Issues
11.3 Occupational Issues
11.4 Facilitating factors and Barriers to recovery
12. PLAN FOR TREATMENT AND PSYCHOSOCIAL REHABILITATION

Signature of the Interviewer

Page 8

2. INTAKE PROFORMA - DOCTOR

(To be filled by the doctor only after reviewing the counsellor's intake form)

Name of physician: **Designation:**

Client Regn. No: **Date of assessment:**

1. ASSESSMENT OF SUBSTANCE USE PATTERN

Substance	Current Pattern of use	Usual Dose	Last Dose	Primary Route	Dependent Use (Current)	Criteria fulfilled for dependence	Dependent Use (Past) (Y/N)
Alcohol							
Cannabis							
Heroin							
Dextropropoxyphene							
Buprenorphine							
Pentazocine							
Opium (*Afeem*)							
Other opioids							
Sedative/ Hypnotics Cocaine							
Amphetamine and other ATS							
Inhalants							
Any other substance (except tobacco)							

2. PHYSICAL COMPLICATIONS WITH DRUG USE

Abscesses / Ulcers	1	Yes	2	No
Respiratory Problems (chronic airway disease/ Tuberculosis)	1	Yes	2	No
Hepatitis/ other abdominal complaints	1	Yes	2	No
HBV status	1	Positive	2	Negative
HCV status	1	Positive	2	Negative
Cardiovascular (emboli)	1	Yes	2	No
Neurological (forgetfulness, headache, seizures, etc.)	1	Yes	2	No

If Yes, please record details

Symptoms suggesting STI in last 12 months	1	Yes	2	No		
If Yes, please tick the symptom(s) reported	1	Genital ulcer Growth	2	Burning urination	3	Urethral Discharge
	4	Vaginal Discharge	5	Rectal pain, discharge	6	Itching around genital organs

Any other physical symptoms reported:

3. GENERAL PHYSICAL EXAMINATION:

Pulse rate		BPM	Pallor	1	Yes	2 No
Blood Pressure	/	mm Hg	Cyanosis	1	Yes	2 No
Respiratory Rate		/ min	Icterus	1	Yes	2 No
Temperature	1 Febrile	if FEBRILE ^Fahrenheit	Oedema	1	Yes	2 No
	2 Afebrile		Clubbing	1	Yes	2 No
Weight		Kg				

Lymphadenopathy 1 Yes 2 No If YES, please indicate whether 1 Cervical, 2 Axillary, 3 Inguinal

Skin
Fresh needle marks 1 Yes 2 No If Yes, please provide details

Old scars	1 Yes	2 No	If Yes, please provide details
Abscess	1 Yes	2 No	If Yes, please provide details
Open wounds	1 Yes	2 No	If Yes, please provide details
Any other findings	1 Yes	2 No	If Yes, please provide details
Nutritional status	1 Good	2 Average	3 Poor

4. SYSTEMIC EXAMINATION:

- **Respiratory System**
  - Breath sounds
  - Adventitious sounds
  - Any other finding
- **Cardio-vascular System**
  - Heart Sounds
  - Murmurs
  - Any other finding
- **Abdomen**
  - Tenderness
  - Organomegaly
  - Any other finding
- **Neurological examination**
  - Higher Mental Functions
  - Cranial Nerves
  - Any other finding

5. MENTAL STATUS EXAMINATION(mention positive findings):

6. DIAGNOSIS

1.	**Dependence** (to record dependent substance use):	
2.	**Any other diagnosis** (to record non-dependent substance use):	
3.	**Medical diagnosis** (to record medical comorbidities):	

7. SUITABILITY TO OST

Essential:

Diagnosis of Opioid Dependence	1	Yes
	2	No
Current IDU (at least once in past three months)	1	Yes
	2	No
Absence of medical contraindications	1	Yes
	2	No
Willingness and ability to provide a valid consent	1	Yes
	2	No
Willingness to come daily for OST	1	Yes
	2	No

Additional:

Age of client (>18 years)	1	Yes
	2	No
Long history of opioid use (> 3 years)	1	Yes
	2	No
Failed abstinence attempts in the past	1	Yes
	2	No
Motivation to stop drug use	1	Yes
	2	No
Feasibility as assessed by the doctor	1	Yes
	2	No

Additional comments (if any)

8. TREATMENT PLAN

1. Substitution treatment	1	Yes	Whether initiated on OST today?	1 Yes
	2	No		2 No
2. Other medical treatment	1	Yes	If Yes, please provide details	
	2	No		
3. Referrals	1	Yes	If Yes, please provide details	
	2	No		
4. Investigations	1	Yes	If Yes, please provide details	
	2	No		

Signature of the Physician

Page 4

3. FOLLOW-UP FORM – PSYCHOSOCIAL

Date of Follow-up: **Client Regn. No. / OST File No.:**

Date of OST Initiation:

ISSUES IDENTIFIED (at treatment entry):

CURRENT STATUS:

- **Psycho-social support**

- **Financial support**

- **Other issues**

- **Living Arrangement**

RECENT SUBSTANCE USE (since last follow-up):

- Drugs used

- Injecting drug use 1. Yes 2. No
- Last injecting act

RECENT SEXUAL PRACTICES:

Currently sexually active (since last follow-up)			1. Yes 2. No		
	Sex in last month with	Number of partners	Sexual frequency - last one month	Condom Usage	Condom use last sex act
Regular Partner / spouse	1. Yes 2. No				1. Yes 2. No
Irregular / casual partner	1. Yes 2. No				1. Yes 2. No
Female Sex Worker	1. Yes 2. No				1. Yes 2. No
Paying Partner	1. Yes 2. No.				1. Yes 2. No
Same sex partner	1. Yes 2. No				1. Yes 2. No

CURRENT COMPLICATIONS DUE TO DRUG USE:

INJECTING PRACTICES(if injected since last follow-up):

Injecting frequency	Before last follow-up	
	Since last follow-up	
Sharing of Syringe/Needle	1. Yes	2. No
Frequency of sharing of Syringe/Needle	Before last follow-up	
	Since last follow-up	
Number of people shared with		
Sharing during last injecting act	1. Yes	2. No

HIV STATUS:

If HIV negative / status not known:	Time since the last HIV test (in months)	
	Date for next HIV test	
If HIV positive:	Last CD4 count (with date)	
	Next CD4 count due (Month and Year)	
If on ART:	Last follow-up with ART clinic	
	Adherence to ART	

KEY FINDINGS FROM DOCTOR'S FOLLOW-UP PROFORMA (since last psychosocial follow-up):

PLAN FOR FURTHER TREATMENT AND REHABILITATION

Next follow-up after …….. Days / weeks with ……

Signatureof the counsellor

4. FOLLOW-UP FORM – CLINICAL

Name: Client Regn. No. / OST File No.:

Diagnosis: Current dose:

Date of OST Initiation: Date of Follow-up:

RECENT SUBSTANCE USE (since last follow-up):OPIOIDS

Sl. No.	Opioid Drug	Use	Frequency of use	Usual dose	Last dose (time and amount)	Injecting drug use
1	Heroin					
2	Dextropropoxyphene					
3	Buprenorphine					
4	Pentazocine					
5	Opium (*Afeem*)					
6	Other opioids					

RECENT SUBSTANCE USE (since last follow-up): OTHERS

Sl. No.	Substance	Use	Frequency of use	Usual dose	Last dose (time and amount)	Injecting drug use
1	Alcohol					
2	Cannabis					
3	Sedative/ Hypnotics					
4	Cocaine					
5	ATS					
6	Inhalants					
7	Any other substance					

PHYSICAL COMPLICATIONS DUE TO DRUG USE (at present):

Treatment Adherence since last follow-up:

1	**Regular (>24 /25 days in 31/31 days)**
2	**Irregular (15-24/25 days in 31/31 days)**
3	**Very Irregular (<15 days in 31/31 days)**
4	**Absent**

Dosage missed since last follow-up:

SIDE-EFFECTS OF MEDICATION (experienced since last follow-up;refer to the checklist):

EFFECTIVENESS OF THE CURRENT DOSE (please tick one in each):

Craving for the street drugs:	1	Yes	2	No	
Opioid Withdrawals:	1	Yes	2	No	
Sleep:	1	Adequate	2	Disturbed	3 Insomnia
Blocking effect on street drug: (if opioids used while taking treatment)	1	Yes	2	No	

KEY FINDINGS FROM COUNSELLOR'S FOLLOW-UP PROFORMA (since last clinical follow-up):

ANY STI SYMPTOMS REPORTED:

GENERAL PHYSICAL AND SYSTEMIC EXAMINATION(mention current findings):

TREATMENT PLAN (record any changes in the plan)

- **Substitution Treatment**
- **Other Medical Treatment**
- **Investigations and Referrals**

Next follow-up after ……. Days / weeks **Signature of the Physician**

5. CONSENT FORM

I , …… consent to start Tablet Buprenorphine for Opioid Substitution Therapy (OST).

Regarding OST, I have been explained that:

- Buprenorphine is being initiated as a part of the comprehensive package of harm reduction services offered by National AIDS Control Organization to people who inject drugs.
- As an opioid agonist (action similar to opium), Buprenorphine maintenance treatment will substitute an illicit, medically unsafe, short acting, opiate such as heroin with a medically safer, long acting drug with similar effect i.e. buprenorphine.
- This treatment will eliminate drug hunger and block the effect of the drug I was using. When taken regularly as per prescription, I will not experience any withdrawal symptoms and there will be no craving for the opioid drugs.
- When combined with psychosocial interventions, it will minimize dysfunction, help me to become productive and improve my self-esteem and personal dignity. My attendance to group sessions will improve the chances of successful outcome.

Regarding the treatment process, I have understood that

- The treatment will continue for a long duration (1-2 years) and I need to take the medicines regularly to obtain the maximum benefit from the same.
- I will be required to come daily to receive the treatment under supervision and need to periodically follow-up with by the doctor and the counsellor.
- During follow-up visits with the doctor / counsellor, I should be honest about medication side effects, craving for opioid use, use of drugs especially injecting drugs and psycho-social stressors with them.
- Support from family is extremely important in the successful completion of treatment and I should involve them in the treatment process and bring them with me for follow-up visits.
- If I discontinue treatment in between or relapse to opioid use, I have the option restart OST after assessment by doctor and counsellor and I have been advised, in such an event, to return back to treatment as early as possible.

In addition, I have been given to understand that

- The use of other drugs (such as alcohol, tranquillisers, sleeping pills, heroin or other opioids) in combination with OST, and can lead to overdose, breathing failure and even death.
- I should inform my treating physician about any other treatment being taken by meand I should also inform other physicians about my treatment with OST.

I understand that my treatment may be stopped without my consent for reasons such as:

- Violence, threatened violence, or verbal abuse towards other patients or staff
- Failure to follow-up with the doctor for repeat prescription
- Unlawful entry onto the premises
- Presenting to the centre intoxicated with alcohol or other drugs
- Diversion of buprenorphine doses
- Engaging in unlawful activity such as drug dealing around the clinic or pharmacy

I have fully understood the above mentioned information. I am willing to start buprenorphine and follow the instructions explained to me.

Patient's signature Date and time	Signature of Family Member / Witness
Signature of treating physician / counsellor Date and time	Name of the Family Member / Witness Relationship with the patient Date and time

OST Format No. - FF / 5

6. PRESCRIPTION SLIP

Date	
Name of the Patient	**OST File No.**
Advise **Signature** **Name of the treating physician**	

OST Format No. - FF / 6

7. CHECKLIST FOR SIDEEFFECTS OF BUPRENORPHINE

S. No.	Symptom / Sign	Yes / No
1	Sedation	
2	Diplopia	
3	Giddiness	
4	Headaches	
5	Confusion	
6	Lightheadedness	
7	Blurred Vision	
8	Hallucination	
9	Drowsiness	
10	Incoordination	
11	Slurred Speech	
12	Itching	
13	Oral Ulceration	
14	Constipation	
15	Weakness	
16	Sexual Problem	
17	Other(specify)	

8. CLIENT DOSE SHEET

Name of the Patient: OST File No:

Date of OST initiation: Current Dose:

Month of Dispensing:

Day	Date	Number of Buprenorphine tablets dispensed			Total dose consumed	Signature of the Nurse/ Pharmacist
		0.2 mg	0.4 mg	2 mg		
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
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19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						
27.						
28.						
29.						
30.						
31.						

OST Format No. - FF / 8

Annexure -2

OPIOID SUBSTITUTION THERAPY PROGRAMME

_____

(Name of the Register)

_____

(Name of the Centre)

National AIDS Control Organization
Ministry of Health and Family Welfare
Government of India

1. CLIENT REGISTER: NEW CLIENTS

Date	Client Regn. No.	Name	Age	Sex	Address	Source of Referral	UID No. (if referred by TI)

OST Format No. - RF / 1

2. CLIENT REGISTER: OST CLIENTS

Date	OST File No.	Client Regn. No.	Date of Regn.	Name	Age	Sex

OST Format No. - RF / 2

3. CLIENT REGISTER: FOLLOW-UP CLIENTS

Date:

S. No.	Client Regn. No. / OST File No.	Name	Age	Sex	Accompanied by

OST Format No. - RF / 3

4. COUNSELLING REGISTER

S.No.	Date	Name of the Patient (with Client Regn. No. / OST File No.)	Accompanied by	Topic Discussed	Remarks (including next appointment)	Signature of Counsellor

OST Format No. - RF / 4

5. GROUP DISCUSSION REGISTER

S. No.	Date	Number of Participants	Names (with Client Regn. No. / OST File No.)	Topic Discussed	Remarks	Signature of Counsellor / Doctor

OST Format No. - RF / 5

6. REFERRAL REGISTER

S. No.	Date	Name	Client Regn. No. / . OST File No	Referred to	Accompanied	Remarks by	Referred by (Signature)	Outcome

OST Format No. - RF / 6

7. OTHER SERVICES REGISTER

Date	Name	OST File No.	Services Received (Record actual utilization of services by clients e.g. commodities distributed, testing done, etc.)								
			ICTC	ART	STI	Syphilis	Condom	DOTS	General OPD (Medicine, skin, surgery, etc.)	Drug Detoxification	Community Care Centre

OST Format No. - RF / 7

8. DAILY DISPENSING REGISTER

Month of Dispensing -													
S. No.	OST File No.	Name	Date				Date				Date		
			0.2 mg	0.4 mg	2 mg	Initials	0.2 mg	0.4 mg	2 mg	Initials	0.2 mg	0.4 mg	Initials
1													
2													
3													
4													
5													
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45													
46													
47													
48													
49													
50													
	TOTAL												

Signature of the Nurse

OST Format No. - RF / 8

9. DAILY STOCK REGISTER

Date	Stock	Number of Buprenorphine Tablets			Signature of Nurse / Pharmacist
		0.2 mg	0.4 mg	2 mg	
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				
	Opening Stock				
	Stock Dispensed				
	Remaining Stock				

OST Format No. - RF / 9

10. OST CENTRE STOCK REGISTER

Date	Strength	Batch Details		A. Total Stock at the OST Centre (at the end of last entry)	B. Stock received from the Pharmacy (on day of entry)	C. Stock dispensed to the OST clients (since last entry)	D. Balance stock at the OST Centre = A+B-C (at the time of entry)	Initials
		Batch No.	Expiry Date					
	0.2 mg							Signature of the Nurse
		Total Stock (0.2 mg)						
	0.4 mg							
		Total Stock (0.4 mg)						Signature of the Medical Officer
	2 mg							
		Total Stock (2 mg)						

OST Format No. - RF / 10

11. CENTRAL STOCK REGISTER

Date	Strength	Batch Details		A. Opening Stock at the Pharmacy	B. Stock received from / returned to SACS	C. Stock supplied to the OST centre	D. Balance Stock at the Pharmacy	Initials
		Batch No.	Expiry date					
	0.2 mg							Signature of the Store In-charge
		Total Stock (0.2 mg)						
	0.4 mg							
								Signature of the Nodal Officer - OST
		Total Stock (0.4 mg)						
	2 mg							
		Total Stock (2 mg)						

12. SACS STOCK REGISTER

DATE:							
Strength	Batch Details		A. Opening stock at athe SACS store	B. Stock received from the supplier	C. Stock supplied to / received from OST centre	D. Stock supplied to / received from Other SACS	E. Balance stock at the SACS store
	Batch No.	Expiry date					
0.2 mg							
	Total Stock (0.2 mg)						
0.4 mg							
	Total Stock (0.4 mg)						
2 mg							
	Total Stock (2 mg)						
Name of the OST Centre (which received / returned the stock):							
Name of the concerned SACS (which received / supplied the stock):							
Signature of the SACS Store In-charge				Signature of SACS TI Officer (JD/DD/AD - TI			

OST Format No. - RF / 12

Annexure -3

Monthly Reporting Format for the OST Centres

(To be filled by 30th of every month)

Name of the Hospital where the OST centre is located:

Name of the Reporting Officer:

Reporting for the month:

1. Staff details

Staff allotted (as per the contract)	Staff in place Yes-Y No- N	Name of the training organisation
Doctor		
Nurse – 1		
Counsellor		
Data Manager		
ORW		

2. Client details

Sl.No.	Indicators	Numbers Achieved	Remarks
2a.	Total number of slots allocated to the centre		
2 b.	Total no. of clients registered for OST till this month (Cumulative)		
2 c.	Total number of clients regularly accessing OST in the month ('Regular' defined as >24/30 days or >25/31 days)		
2d.	Total no. of clients dropped out (drop out defined as clients not receiving the medicines for 7 days continuously)		
2e	No. of dropped-out who were followed up		
2f.	No. of clients whose family were contacted and counselled		
2g.	Total no. of clients completed the treatment		

3. Medication record details

Stock details	No. of 2 mg tablets	No. of 0.4 mg tablets	No. of 0.2 mg tablets
Stock received from SACS at the beginning of the month			

Stock dispensed in the month			
Stock remaining at the end of the month			

4. Service uptake by the OST clients

No. of condoms distributed	
No. of clients accessing the STI services	

5. Referral & linkages made for the OST clients

Services	No. of referrals made	No. of clients who used the referred services	Follow- up plan/ Remarks
ICTC			
ART			
Detoxification			
Rehabilitation			
Others (like welfare services, legal aid, etc)			

Annexure -4

Evaluation and feedback sheets

The following set of questions can be used for pre and post training test of the participants to assess the impact of the training.

MCQs for training on OST (Buprenorphine)

Mark with "✓" the response, which you think is correct.

1. Which of the following has the highest concentration of alcohol?
   - ❒ Beer
   - ❒ Wine
   - ❒ country liquor
   - ❒ Gin

2. Which of the following is NOT a criterion for Drug Dependence?
   - ❒ Using drugs in large amount over long duration of time
   - ❒ Taking illegal drugs
   - ❒ Desire or efforts to reduce drug use
   - ❒ Not being able to fulfill responsibilities

The following statements pertain to drug use. Based on your understanding, please mark true/false against each:

3.	Inhalants ('fluids') are relatively safe because user is not drinking or injecting them	True	False
4.	In the dependent users, sudden cessation of heroin use causes severe withdrawals that can be dangerous and even fatal	True	False
5.	In the dependent users, sudden cessation of Alcohol use causes severe withdrawals that can be dangerous and even fatal	True	False
6.	Drug addiction can be treated only by placing a person in restrictive environment	True	False
7.	Buprenorphine maintenance treatment is also effective for treating dependence on alcohol and other drugs	True	False
8.	Since Buprenorphine has many long-term side effects, the duration of treatment should be as small as possible	True	False
9.	In the absence of a doctor, a trained nurse can modify the dose of Buprenorphine of a patient if required	True	False
10.	Buprenorphine maintenance treatment can be discontinued as soon as the patient has completed 12 months free of any illegal heroin / opioid use	True	False
11.	During Stabilisation phase, the dose of Buprenorphine should be kept as low as possible	True	False
12.	A patient was started on 2 mg of Buprenorphine. On the second day after starting Buprenorphine, he is complaining of discomfort and withdrawal symptoms. His Dose should not be increased on the second day.	True	False
13.	In India, Buprenorphine is the only medication available for OST	True	False

14. Which of the following statements about drug-related harms is false?

- ❒ Drugs cause disruption of every aspect of the users' life
- ❒ Drug use is associated with risky behaviours which predisposes individual to more harms
- ❒ Drug-related harms are inter-related
- ❒ Drug use affects life of only those who use them

15. Which of the following drug-related harms is a public health priority?

- ❒ Loss of job, heavy debt
- ❒ Involvement in illegal activities
- ❒ Infections like HIV, HBV
- ❒ Frequent arguments with family members

16. Which of the following communities is in need of harm reduction services?

- ❒ Community A: less IDU, increasing number of wine shops in residential areas and alcohol using adults
- ❒ Community B: large number of IDUs, high prevalence of HIV/AIDS amongst IDUs
- ❒ Community C: recent trend of adolescents getting into smoking and occasional ganja use
- ❒ All of the above

17. Which of the following is an example of harm reduction?

- ❒ Closing down wine-shops
- ❒ Arresting people who sell smack and ganja
- ❒ Teaching injecting drug users to inject drugs safely
- ❒ Organising a campaign for school children in which they pledge not to take drugs

18. Which of the following is true about needle syringe exchange programmes (NSEP)?

- ❒ They reduce HIV risk but encourage drug users to use more drugs
- ❒ They alone are enough to stop the drug problems in a city
- ❒ They encourage drug users to adopt safe behaviours
- ❒ They are illegal under the law

19. Which of the following is NOT an acute effect of administration of opioids?

- ❒ Constriction of Pupils
- ❒ Diarrhoea
- ❒ Vomiting
- ❒ Sedation

20. Which of the following is not generally categorised as a 'harm reduction' approach?

- ❒ Methadone maintenance treatment
- ❒ Needle Syringe Exchange Programme
- ❒ Injection Room
- ❒ Therapeutic Community

Format for Evaluation Sheet

Please provide your honest and critical feedback on this training programme. Did you find the following sessions useful?

Session	Useful	Can't Say	Not Useful	Any remarks?
Introduction exercise: meeting strangers and building a rapport				
Overview of Drugs and Drug use disorders				
Drug related problems and harms				
Local Drug abuse scenario				
General principles of Drug treatment and Harm reduction				
Opioid Substitution Therapy – overview (including Opioid withdrawal, intoxication and other syndromes)				
Assessment and Diagnosis				
Assessment and Diagnosis: Role Play and case demonstration / presentation				
Buprenorphine- Pharmacology				
Implementing OST with Buprenorphine: Induction, Stabilization, Discontinuation				
Special clinical situations – Adolescents; Women; HIV; other medical conditions, dual diagnosis)				
Psychosocial Interventions				
Role Play / Demonstration of Psychosocial interventions				

Session	Useful	Can't Say	Not Useful	Any remarks?
Scheme for implementing OST at Government Centres: Overview				
Exposure to the OST clinic, including demonstration				
Debriefing and experience sharing				
Programme management–I *Procurement and Supplies*				
Programme management–II *Record maintenance and reporting*				
Programme management-III *Referral and networking, Engaging the civil society*				
Programme management-IV *Minimum standards of care, M & E*				

Please provide us your feedback / suggestions on the entire training programme

National AIDS Control Organisation

India's voice against AIDS

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