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Buprenorphine-based OpioidSubstitution Therapy Under National AIDS Control Organization

A Training Manual for Service Providers

National AIDS Control Organization
Government of India

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Background

Drug use by injection route or Injection drug use (IDU) is one of the very important driving factors behind the spread of HIV epidemic in India.As per the recent available estimates at the national level, 6.26% of people who inject drugs (PWID) or Injecting Drug Users (IDUs) arepositive for HIV, the highest among the various high-risk groups in India (HIV Sentinel Surveillance 2016-17).

There are an estimated around 8.5 lakh PWID in India (as per the recent National Survey on Magnitude of Substance use in India), and the predominant drug injected by PWID are Opioids. About half of PWIDin India report injecting heroin while another half report injecting pharmaceutical opioids. The states with highest population ofPWIDaccording to the national survey are Uttar Pradesh, Punjab, Delhi, Andhra Pradesh, Telangana, Haryana, Karnataka, Maharashtra, Manipur and Mizoram.Among these states, Mizoram (19.81%), Delhi (16.21%) and Punjab (12.09%) are disproportionately affected by HIV among PWID.

As a response to the problem of Injection drug use and the risk of HIV among them, the National AIDS ControlOrganization has set up (and is continually scaling up) targeted interventions (TIs) with PWID. As of April 2021, there are about 327 IDU TI sites throughout the country, covering about 1.49 lakh PWID.For these targeted interventions, operational tools like costing and operational guidelines and training manuals are in place. Theinterventions offered through these TIs include needle syringe exchange programme, outreach, information education and counselling (IEC), abscess management, referral to various other services, etc.

Additionally, NACO is also implementing Opioid Substitution Therapy (OST) at about 233 sites throughout the country along with 58 satellite OST centers. OST is provided by 46 NGOs run OST clinics as well as 187 government hospitals run OST clinics. NGOs providing OST arealso implementing other components of IDU TIs. Considerable progress has been made in this regard. Resource documents like clinical practice guidelines for OST with buprenorphineand standard operating proceduresfor implementing OST are in place. However, India still remains among the countries, where the IDU-HIV problemissignificant and coverage of evidence-based interventions like OST remains abysmally low.

A training manual (for use of facilitators) on implementing substitution therapy was developed in 2011 to guide the training of service providers. This manual played an important role in training the OST staffs from both government and NGO sectors till now.

However, there have been certain changes since the introduction of this training manual. The clinical practice guidelines have undergone modifications. There have been certain changes at the level of program design and implementation as well. For instance, the OST program with buprenorphine which was limited to only the 'Daily, supervised dispensing' till recently, has now been modified to allow 'take-home' dispensing as well for the stable clients (with Buprenorphine + Naloxone sublingual tablets).

Thus, to address such concerns, NACO,in collaboration with the authors (the faculty from the National Drug Dependence Treatment Centre, AIIMS and from other institutions) has revisedthis 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 standardoperating 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 PWID 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 ofORWs. 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. Theirexperience 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 thegovernment 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.**

It is also important to discuss whether the diverse categories of staff members should be trained together or in separate groups, as per their professional backgrounds? Both approaches have their own pros and cons.The decade-long experience of authors as well as all the facilitators with training on OSTsuggests 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 amongparticipants – 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 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 preferably a psychiatrist. In addition, a qualified doctor, with at least an MBBS or equivalent degree – but with experience of having been involved in the OST program may also be a facilitator. People with otherbackgrounds, with specific expertise and experience in certain aspects of OST implementation (counselling, dispensing, programme management), can be involved as co-facilitators.

- Ideally, the facilitators should have experience of implementing the OST programme themselves. It is preferable, if the facilitatorsare actively involved in OSTimplementation.

- The facilitator should themselves have undergone training inOST.

- The facilitator should have an aptitude for teaching / training. The person should be comfortable interacting with people from a variety of backgrounds.Strongcommunication skills and leadership skills are very important. For this reason, psychiatrists working as faculty members in teaching medical institutions could be excellent facilitators.

- 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 mostcomfortable for most participants. However, this obstacle can be overcome by a participant / co-facilitatorwhocanactasatranslator.

- Prior to the training, the facilitator is expected to have gone through this manual and the resource materialthoroughly.

Preparation for the training programme

- Identify the facilitators as per the terms of referencesuggestedaboveandsecuretheir availability

- Identify participants and secure theiravailability

- Ideal number of facilitators: 2-4, with atleast one facilitator being the principalfacilitator

- Ideal number of participants: 15 to 30, a mixed group

- Venue:
  - Training hall with adequateseating;
  - Furniture;
  - Facilities forprojection;
  - Uninterrupted electricity supply;and
  - Arrangements for refreshment andfood.

- Materialsrequired:
  - A computer, a projector, a screen, and apointer;
  - White-board / flip-chart stand with markers and white boarderaser;
  - Stationery for use by participants;
  - Adequate copies of practice guidelines, standard operating procedures andthe ‘scheme’document;
  - Adequate copies of registration forms, preand 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 ExposureVisit).
- In the case the prevailing situation does not permit holding physical, in-person program, the same manual along with the slides can be used for the online training as well.

Notes for the Facilitator

Other settings: OST in an NGO TI

As mentioned earlier there are about 46 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 centreOST.
    - 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 only.
    - The nurse and counsellors willbe involved in caring for not just clients on OST but clients receiving other TI servicestoo.
- Finally,it would be important for the TI to ensure that some PEs too are on OST. Additionally, it would be critical for the TI to ensure that both the interventions – NSEP and OST – are seen as not contradicting but complementing eachother.

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, an OST centre in a hospital with collaboration of an 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	Organizers
30 min	Inauguration of training programme	Organizers
60min	Ice Breaker Session • Introduction • Purpose oftraining • NACO HIV Programme • Pre-trainingassessment	Facilitators
15 min	Tea Break	
90 min	Basics of drugs – Addictive substances and Drug use disorder overview	Facilitators
60 min	Drug related harms and problems	Facilitators
60 min	Lunch Break	
75 min	Group discussion: 'Local drug use scenario: nature, extent, consequences, attitudes, available interventions and responses'	Participants and Facilitators
15 min	Tea Break	
45 min	Drug use disorder Management Strategies	Facilitators
45 min	Treatment principles and Approaches	Facilitators
DAY TWO		
15 min	Recap of previous day	Volunteers among participants
60 min	Basics of Opioids – Overview of Opioids and Opioid dependence	Facilitators
60 min	Opioid Substitution Therapy – overview	Facilitators
15 min	Tea Break	
90 min	Assessment and diagnosis	Facilitators
60 min	Lunch Break	
90 min	Assessment and diagnosis role-play and case demonstration/ presentation	Facilitators
15 min	Tea Break	
60 min	Clinical pharmacology of Buprenorphine & Buprenorphine + Naloxone	Facilitators
DAY THREE		
15 min	Recap of previous day	Volunteers among participants
120 min	OST with Buprenorphine – Clinical Implementation	
15 min	Tea Break	
60 min	Buprenorphine dispensing (Including take home dispensing)	Facilitators
60 min	Lunch Break	Facilitators

Approximate Duration	Topic	Presenter/ Facilitator
90 min	Psychosocial interventions as part of OST	Facilitators
15 min	Tea Break	
90 min	Role play – Demonstration of Psychosocial interventions	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[1]	Facilitators
60 min	Lunch Break	
60 min	Debriefing and experience sharing	Facilitators
15 min	Tea Break	
30 min	Management of Common conditions	
60 min	Special Population / Special clinical considerations	Facilitators
15 min	Programme management–I Operationalising of OST, Roles and Responsibilities of OST staff	Facilitators
DAY FIVE		
15 min	Recap of previous day	Volunteers among participants
90 min	Programme management–II • Client Flow, Related Procedures and Records	Facilitators
30 min	Programme management-III • Referral and networking, engaging civilsociety	Facilitators
15 min	Tea Break	
90 min	Programme management-IV • Minimum standards of care, reporting	Facilitators
60 min	Lunch Break	
60 min	• Freesession • Post-training assessment andfeedback	Facilitators
60 min	Working together: meeting between stakeholders (TI staff, OST centre staff, NACO/SACS, Health Department)	Facilitators
30 min	Valedictory (including tea)	

[1]Can be conducted through a video demonstration, in case the training is taking place virtually or if the field visit is not possible.

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 oneanother
- To sensitize participants on the difficultiesfaced in meeting and striking a rapport with their clients
- To provide an orientation to the training programme and NACO HIV programme

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 power point presentation.

Steps

1. Welcomeparticipants;thankthemforattending theprogramme.
2. Ask them to pair up; ensure that they pair-up with a person they do not know.
3. Tell them that over the next 10 minutes they need to get acquainted with their partnersand obtain personalinformation
4. This information should be adequate enough so that they can describe their partners andshould 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 thegroup
6. While this process is going on, ask some participants to tellmore about their partners (i.e., specifically the information they have notasked/ 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 manner. Any factual information on Mrs B's marital relationship is NOT required.)
7. Use this part of the exercise to emphasize that it is difficult to ask personal questions, particularly in the first meeting.
8. It would help if resource persons too can introduce themselves in such a manner.
9. 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.
10. Make a list of these responses on theflip-chart.
11. 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?
12. Explain the objectives and agenda of the training.
13. Provide the 'rules' to be followed during training.
14. Provide details of NACO HIV Programme using a PowerPoint presentation.
15. End with pre-training assessment.

Highlightthatcommunicationbetweenapatientandoutreachworkerwillbesubstantiallydifferent fromthecommunicationbetweenapatientandadoctor.Generatediscussiononadvantagesand disadvantagesofcommunicationbetweenpeoplewithsimilarstatusandthosehavingadifferent status.

DAY 1: Session 2

Basics of drugs - Addictive substances and drug use disorders overview

Objectives

- To familiarize participants with various drugs / substances of use, similarities and differences between theireffects
- To bring about attitudinal changesinparticipants regarding people who use drugs; 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 incategorization.

2. Ask 'what are the similarities amongthese drugs?' Generatediscussion. Also discuss the differences in substances in terms of chemical class, mode of intake, source of drug (natural/semi-synthetic/synthetic), availability (legal/illegal), and broad actions on brain (stimulant/depressant).

3. Stress the point that the "basicsimilarityamong 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' tothem."

Presentation: Overview of addictive substances
Drug use Disorders

4. Show the first presentation, *overview of addictive substances'* —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 reasonsinto '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.). Discuss about the positive and negative reinforcement for continued drug use.

6. Proceed with the second presentation – 'Drug use disorders'

Presentation: Overview of Addictive substances

Contents of the presentation:
- What are drugs / addictive substances
- Types of drugs/addictive substances and their effects

Presentation: Drug use disorders

Contents of the presentation:
- Understanding why people take drugs?
- Understanding why people get addicted to drugs?
- Understanding the terminology (use, abuse, harmful use, dependence, drug use disorder andaddiction)

DAY 1: Session 3

Drug-related harms and problems

Objective

- To familiarizethe participants with the concept of hierarchy and prioritization ofharms
- To develop the skills of participants regarding prioritization of risks andharms

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' ofharms.

2. While participants present their views, write down all the harms suggested by the traineeson 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 substanceuse.

4. Proceedwiththepresentation,'Drugrelated harms'

Presentation: Drug related Harms and Problems

- Discuss: *Are all harms independent of each other?* To illustrate the point, use flow-charts of consequences in thepresentation
- Similarly, taking the help of PowerPoint slides, generate discussion on and illustrate the concept of hierarchy and priority ofharms.
- Conclude the session by conducting the interactive group quiz.

Presentation: Drug-related Harms

Contents of the presentation:

- Consequences / harms of druguse
- Inter-relationship between various drug relatedharms
- Hierarchy ofharms
- Prioritization amongharms
- Importance of drug relatedharms
- Interactiveexercise

DAY 1: Session 4

Local drug use scenario

Objectives

- The overt objective of this session is for thefacilitator and participants to understandthe local situation and nuances of drug use in order to contextualize 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 serviceproviders.

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 druguse):
   - *Common drugs used in theirarea*
   - *Estimates of number of drug users (ifany)*
   - *Problems / consequences of drug use, they know of*
   - *Available responses to the problem of drug use in theirarea*
   - 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 thepresentation.

If conducted as an unstructured discussion:

1. The facilitators should generate thediscussion on the above-mentionedissues.
2. It must be ensured that people from all sites talk about their opinion on drug situation and responsesintheirarea.Additionally,caremust be taken to bring out different perspectives from participants with variedbackgrounds.
3. Important issues must be noted by the facilitator onflip-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 people who use drugs) must be brought out and highlighted.

DAY 1: Session 5

Drug use disorder management strategies

Objectives

- To familiarize the participants with basicprinciples and issues surrounding drug supply reduction, demand reduction and harmreduction

- To bring about attitudinal changes among participants regarding drug treatment andharm reduction[2]

Materials and Method

This session will require about 30 - 45 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 drugtreatment.

3. Make the presentation about 'demand reduction' in 'Drug use disorder Management strategies'

4. Make the presentation about 'supply reduction' in 'Druguse disorder Management Strategies'

5. 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?

6. Link this to one of the earlier sessions on harms related to druguse.

7. Make the presentation on 'HarmReduction' in 'Drug use disorder Management Strategies'.

8. Discuss and address the common misconceptions people may have related to Harm reduction strategies

9. Conclude the session by conducting the interactive group quiz.

[2]Participants belonging to either of these two backgrounds drug treatment and harm reductionoften 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.

Presentation: Drug Use Disorder Management Strategies

Contents of the presentation:

- Drug use disorder management strategies(supply, demand and harmreduction)
- Why harmreduction?
- Harm reduction strategies (NSEP, outreach, education,OST)

DAY 1: Session 5

Principles of drug use disorder treatment

Objectives

- To familiarize the participants with basic principles of drug use disorder
- To make the participants understand the need for multimodal treatment and need for long term treatment in patients with drug use disorder

Materials and Method

This session will require about 30 - 45 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 the various models of addiction – Moral, Medical, Social and Biopsychosocial Models

2 Make the presentation on the models of drug addiction in 'Principles of Drug use disorder treatment'

3 Discuss about what should be the goals of treatment and whether same treatment goal is applicable for all.

4 Make the presentation -**'Principles of Drug use disorder treatment'**

5 During discussion on the presentation, address the common misconceptions related to drug use disorder treatment.

6

Address the common misconceptions people may have about drug treatment:

- *'Drug treatment inevitably means getting admitted to a restrictive setting for a longterm'*
- *'Detoxification is removal of toxins frombody'*
- *'Relapse means treatmentfailure'*
- *'A strong will-power is enough to quitdrugs'*
- *'Most medications for treating drug dependence are themselvesaddictive'*

Presentations: Principles of Drug Use Disorder Treatment

Contents of the presentation:

- Multimodal treatment approach
- Menu of options
- Different goals at different stages; continuous assessment and monitoring required
- Adequate duration of treatment
- Relapse is inherent part of recovery
- Clients must be made active partners in treatment
- Treatment should address other comorbidities

DAY 2: Session 1

Basics of Opioids - Overview of Opioids and Opioid dependence

Objectives

- To familiarize participants with the different types of opioids and their effects.

- To familiarize the participants about the features of opioid dependence and the various treatment options available in general

Materials 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. Make the presentation on '**Overview of Opioids**'

2. The discussion on types of opioids and the effects of opioids should move along with the slides

3. Conclude the first presentation with a short quiz

5. Again, the discussion should move along with the presentation of the slides.

4. Make the next presentation on **'Opioid dependence – Features and Management'**

Presentation: Overview of Opioids

Contents of the presentation:

- Types of Opioids
- General effects of Opioids on thebody

Opioid dependence: Features and Management

Contents of the presentation:

- Features of Opioid dependence
- Overview of Management of Opioid dependence

DAY 2: Session 2

Opioid substitution therapy – overview

Objectives

- To familiarize the participants with the concept behind OST
- To address the myths associated with OST

Materials 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

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

Presentation: OST - General Overview

Contents of the presentation:

- Philosophy of OST including benefits of OST
- Key Characteristics of OST
- Myths associated withOST
- Current status of OST

DAY 2: Session 3

Assessment and diagnosis

Objectives

- To familiarize participants with the steps involved in making assessment of an individual with an history of druguse

- To impart diagnostic interview skills among the participants

Materials and Methods

This session too will require about 60 - 90 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 move forward along with the slides.

Presentation: Assessment and Diagnosis

Contents of the presentation:

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

DAY 2: Session 4

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, XIIStandard 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 Phenergan. 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 an 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 drugscompletely.

Case vignette 2

RR is a 29-year-old male, who is a Class 8 pass laborer, 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–Phenergan, 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–Phenergan 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- Corexand 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 thisinjection. 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 5

Clinical pharmacology of buprenorphine and buprenorphine+naloxone

Objectives

- The purpose of this session is to familiarize participants to the basic pharmacology of buprenorphine and buprenorphine+naloxone sublingual tablets.

- Though primarily meant for doctors, all participants will benefit from this session, since this will help them understand the basic pharmacology of buprenorphine and buprenorphine+naloxone and equip them withthenecessary 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 move forward along with the slides.

Presentation: Pharmacology of Buprenorphine

Contents of the presentation:

- Buprenorphine, as amedication
- Pharmacokinetics and pharmacodynamics ofbuprenorphine
- Side-effects
- Precautions andcontraindications
- Role of buprenorphine+naloxone to prevent diversion and misuse

DAY 3: Session 1

OST with buprenorphine: Clinical Implementation

Objectives

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

Materials and Methods

This session will require about 90-120 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

1. Make the presentation on **'OST-Clinical implementation'**

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

Presentation: OST- Clinical Implementation

Contents of the presentation:

- Steps in implementing OST
  - Recruitment
  - Assessment
  - Psycho-education
  - Informedconsent
- Phases of treatment
  - Induction
  - Maintenance /stabilization - Follow-upassessments, Dispensing and Monitoring
  - Termination
  - Critical issues in OST programme

DAY 3: Session 2

Buprenorphine Dispensing

Objectives

- To familiarize all participants about supervised dosing and take-home dispensing of Buprenorphine.

- To familiarize participants with assessment of the client for suitability for take home dosing of buprenorphine + naloxone

Materials and Methods

This session will require about 30-45 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

1. Make the presentation: 'Buprenorphine Dispensing'

2. The discussion and presentation will move forward along with the slides

Presentation: Buprenorphine dispensing

Contents of the presentation:

- Supervised dispensing
- Take home dispensing
    - Essential requirements for Take-home dispensing
    - Assessment of client suitability for take-home dispensing
        - Eligibility criteria
        - Potential harms and benefits
        - Risk mitigation strategies
    - When to terminate take home dispensing

DAY 3: Session 3

Psychosocial Interventions

Objectives

- The objective of this session is to familiarize 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 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 move forward along with the slides.

Presentation: Psychosocial Interventions

Contents of the presentation:

- Psychosocial interventions: anintroduction
- MotivationEnhancement
  - oFeedback
  - o Decisionbalancing
  - o Developing discrepancy
  - o Supportingself-efficacy
- Psychoeducation
- Relapseprevention
  - o High-risksituations
  - o Copingstrategies
- Support / self-helpgroups
  - o Handlingdrop-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 themain task of the counsellors, ALL participants need to gain the required knowledge andskills.

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 andanotherfacilitator/ participantasthedoctor / service provider.

Steps

1. The facilitator, who is playing the role of a patient, must go through the suggested case vignettes[3] thoroughly and should present himself / herself as the fictional patient.However, there is ample scope for improvisation, taking cues from thesession.
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 thesession.
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 thesession.
5. Once the session is over, thank the volunteers and generate an open discussionon
   - 5.1. General observations about thesession
   - 5.2. The 'good' or remarkable things about the techniques in thesession
   - 5.3. Limitations / shortcomings, ifany
6. Sum-up the observations and provide recommendations for the nextsessions.
7. Repeat the steps with the remaining two case vignettes

[3] 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, classXIIpass, 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 Phenergan. 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 an 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 continue d 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–Phenergan, and he continued taking the same even after his treatment was over. Now he gradually stopped drinking and started injecting about 6-7 ampoules of Fortwin–Phenergan every day. He has now found a big circle of friends who inject together and sometimesshare 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 himselftested.

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

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 (continue d 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 alsorecentlyfound workasamotorcyclemechanic.However,hestillexperiencesoccasional 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 4: Session 1

Exposure to the OST clinic, including demonstration

Objectives

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

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, stabilization and termination), family members of clients and records that arebeing 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 exposurevisit.

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 otherrequirements as listed above. They should also select clients for case demonstrations (preferably of different drug use problems, in a different phase of OST treatment). 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 thevisit.

During thesession

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

3. This will be an interactive session and will require about onehour.

   3.1 Invite the project manager of the OSTclinic to give a brief background of the clinic and the facilitiesavailable.

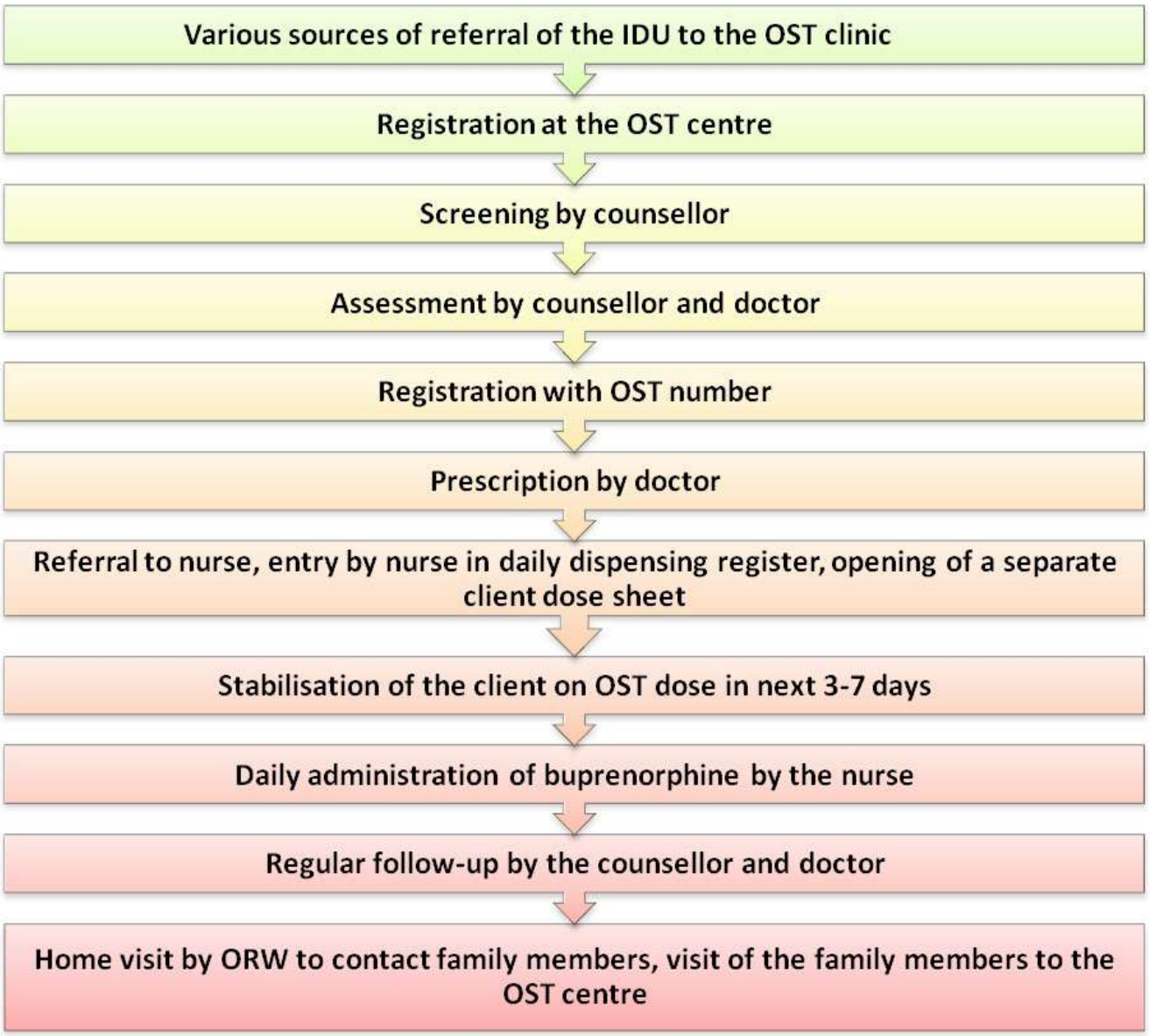
   3.2 Invite each of the staff in the OST clinictotalk about their duties, responsibilities andexperiences while providing OST to clients.Allow free flow of questions from theparticipants.

   3.3 This session should also provide participants with an understanding of the patient flow chart given on the next page - entry, assessment, induction, stabilization, continuation and termination of OST

   3.4 The process of assessing client suitability and clinical stability for the purpose of take-home dispensing of buprenorphine+naloxone tablets should also be discussed at length.

   3.5 The process of referral for other health problems or for detoxification at termination should also bediscussed.

   3.6 Also facilitate a discussion on termination of therapy and what is done in case ofdropout.



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

   a. Give them an opportunity to closely examine the records being maintained by each category of staff and allow a free flow of inter-action to clarify any doubts that they mayhave.
   b. Also allow them to note the caution exercised in keepingstocks.

   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 forOST

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

   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 theclient'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 druguse;

   5.2 Clients' understanding of OST, how it works, duration of treatment, their own roleintreatment 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 stabilize onmedication;

   5.6 Process of shifting a client from daily to take home medications and the assessment procedure followed

   5.7 Process of termination;and

   5.8 Involvement of the client in the process of treatment and the positive relationship that the client and the family members have with the OSTstaff.

DAY 4: Session 2

Debriefing and experience sharing

Objectives

- To recapitulate the highlights of theexposure, visit to the OSTclinic
- To allow participants to ruminate on new leanings and also dwell onpreparedness/steps that will be required by them to initiateOST

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 thevisit.
2. Provideallparticipantswithsmallslipsofpaper (about the size of a post card). Ask them to write down thefollowing:
   - At least one thing which was a new learning for them, especially in terms of their own roles in their OST centers
   - At least one thing which they feel can be improved upon (in the centre just visited, and which can apply to their centre aswell)
   - Any other remarkable aspect of thevisit
3. Ensure that all participants get a chance to speak and read out theirresponses.
4. Capture the responses on the flip-chartand note them down so that issues with similar content are put together for categorizing them theme-wise. Some of the themes can be:
   - Improvement in quality of life of the patient and familymember
   - Various sources of referral to OST services
   - Patient flow chart
   - Dose and duration ofOST
   - Compliance and efforts made to ensure compliance
   - Process of DOT, dispensing, counsellingand prescribing
   - Recordkeeping
   - Stock-keeping
   - Referral for health problems or detoxification
   - Roles and responsibilities of variouscategories ofstaff
   - What is done in case ofdropout
   - Termination oftreatment
   - Involvement of client intreatment
   - Client friendlyservices

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

OST with buprenorphine: Common clinical conditions

Objectives

- This session is intended to develop participants' knowledge about and skills to deal with common clinical conditions, likely to be routinely encountered while implementingOST.

Materials and Methods

This session will require about 30 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

3. 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 inOST.

4. Introduce the session. Emphasizethat there are certain commonclinical situations, the participants need to be familiarwith.

5. Make the presentation: special clinicalsituations

Presentation: Common Clinical Conditions

Contents of the presentation:

- Vomiting
- Constipation
- Sleep disturbance
- Sexual Problems
- Missed doses

DAY 4: Session 4

OST with buprenorphine: Special clinical situations

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 implementingOST.

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. Introduce the session. Emphasizethat there are certain specific clinical situations, the participants need to be familiarwith.

2. Make the presentation: special clinicalsituations

Presentation: Special Clinical Situations and Considerations

Contents of the presentation:

- HIV
- HCV
- Tuberculosis
- Psychiatricco-morbidities
- Women
- Children and adolescents
- Opioid overdose
- Pain management in people on OST
- Peri- operative issues
- Hospitalization
- Restriction of movements / Home isolation

DAY 4: Session 5

Programme Management–I

Operationalizing OST, Roles and Responsibilities of OST Staff

Objectives

- To familiarize the participants with operationalization of OST – Infrastructure and staff requirement
- To understand the roles and responsibilities of the various staff of OST

Material and Methods

This session will require about 15 to 30 minutes, to be conducted with the aid of flip-charts / white-board and markers, and PowerPoint presentation.

Steps

1. Make the presentation on 'Programme Management – I'.
2. In this session, the discussion and presentation move forward along with the slides

Presentation: Programme Management - I

Contents of the presentation:

- Operationalizing OST services
  - Infrastructure
  - Staff
- Roles and Responsibilities
  - Nodal Officer
  - Doctor
  - Nurse
  - Counsellor
  - Data Manager
  - TI – Programme Manager
  - TI- Outreach Worker

DAY 5: Session 1

Programme Management–II

Client Flow, Related Procures and Records

Objectives

To familiarize participants with the client flow in OST center

To familiarize participants with the records to bemaintained for OST services

Material and Methods

This session will take 60–90 minutes. A copy of the '**Standard Operating Proceduresfor Opioid Substitution therapyunder National AIDS Control Programme'** and '**Opioid substitution therapy under National AIDS Control Programme - Clinical Practice Guidelines for treatment with Buprenorphine – Third Edition'**prepared by NACO and NDDTC, AIIMSwill be required for each participant. Besides this, any other reporting formats that are to be filled up should be available as handouts.

Steps

1. Make the presentation on 'Programme Management – II' till Client Flow

2. After discussion on the client flow, divide the entire group breaking up into smaller groups based on their roles: nodal officers, doctors, nurses, counsellors, data managers and outreach workers.

3. Allowparticipantstodiscussamongthemselves and go through the record formats that will be maintained by them in the small groupsfor 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 – Clinical Practice Guidelines and Standard Operating Procedure) have been attached as an Annexure with this document.

4. 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.

Registers to be maintained (Hard Copy):

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 (fororganization)
	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 clientfile)	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. OST Take Home form (a part of client file)	Format for starting and monitoring the patients on take home dispensing	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 registers**	Details of dispensing carried out by the nurse every day (separate registers for clients on daily dispensing and take home) (Print out of dispensed medicines can be done from SOCH portal instead of manual entry if all dispenses are updated in SOCH portal)	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)

Forms to be filles in SOCH (Soft Copy):

S. No.	Forms	Description in brief	Staff responsible
1.	**New Client Registration Form**	Register of ALL NEW CLIENTS VISITING OST CENTRE containing names, age/ sex and address of clients along with client Id. no.	Data manager
2.	**Assessment form**	Details of assessment done by Physician, Details about eligibility of OST, Dosing of Buprenorphine / Buprenorphine + Naloxone if found eligible for OST	Data manager
3.	**Follow up form**	Details of assessment done by Physicians during follow up (Including substance use details, side effects, change in dosing of medications, etc.)	Data manager
4.	**Daily dispensation form**	Details of daily dispensation of medications done for each individual	Nurse
5.	**Take home dispensation form**	Details of take-home dispensation of medications done for each individual	Nurse
6.	**Recording details of transit to other OST facility**	Recordingtransfer details of client to another OST centre following assessment by doctor and counsellor, who is being transferred temporarily	Data manager
7.	**Recording details of transfer to other OST facility**	Recording transfer details of client to another OST centre following assessment by doctor and counsellor, who is being transferred permanently	Data manager
8.	**Referral form**	Details of referral to another service facility under NACO	Data manager
10	**Stock adjustment – Addition of stock**	Details of stock added	Nurse / Data Manager
11	**Stock Adjustment – Stock Consumption**	Details of stock consumed	Nurse / Data Manager
12	**Stock Adjustment – Stock Write Off**	Details of stock write off	Nurse/Data Manager

DAY 5: Session 2

Programme Management-III

Referral and networking, engaging civil society

Objectives

- This session has been designed to familiarize 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 PowerPointpresentation. The facilitator will require flip charts / whiteboard, marker pens and PowerPointpresentation.

Steps

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

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 organizations isrequired.

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

4. Generate a discussionon:

   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 theseservices?

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 networkingactivities.

Presentation: Referral and Networking

Contents of the presentation:

- What isnetworking?
- Whynetworking?
- Potential entities of networking
- Steps in referral andnetworking
- Referral analysis

DAY 5: Session 3

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 OSTimplementation

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 aflip-chart.

Doctor

1. Ensuring that each patient is being thoroughly assessed before recruitment. Recruitment to OST
2. is only after following the criteria. Patients not found suitable for OST are also provided appropriate available services
3. Ensuring that proper procedures for induction, maintenance and tapering of buprenorphine are being followed as per the clinical practice guidelines
4. Ensuringthatthedosageprescribedareadequateanddosemodificationsarebeingdoneincase ofrequirement
5. Ensuring that even in the stable phase, patients are being followed-up regularly.
6. Ensuring that stable clients are given take home dosing as per the clinical practice guidelines and are assessed regularly.
7. 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
8. Ensuring that patients who require other ancillary ser vices (Referrals, to ICTC, ART, DOTS for TB etc.) are able to access those services
9. Ensuring that patients off OST (after OST completion) are also able to access services required.
10. Ensuring adequate record keeping

Nurse

1. Ensuring continuous availability of medicines and keeping the nodal officer informed, well inadvance
2. Ensuring Safekeeping ofmedication
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 takingplace
4. Informing the doctor of any pertinent clinical issue noted by thenurse
5. Ensuring adequate recordkeeping

Counsellor

1. Ensuring that each patient is being thoroughly assessed before recruitment. Recruitment to OST and shift to take home is only after following thecriteria. Helping the doctor to assess psychosocial functioning of client in detail, especially before take home dosing is started.
2. Counsellingsessions
   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 followup
      i. Addressingadherence
      ii. Efforts atrehabilitation
      iii. RelapsePrevention
   c. Attempting involvement of familymembers
   d. Addressing substitution with other substances such as alcohol andbenzodiazepines
   e. Addressing high riskbehaviour
3. Making efforts to bring dropouts back in treatment (through maintaining close liaison with the outreachworker)
4. Ensuring adequate recordkeeping

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 forOST
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 OSTservices
4. Keeping contact with clients on OST and their family members in thefield
5. Reporting regularly to the staff in Government OST centre and serving as a link between the Government OST centre and the IDUTI

Additional Overarching Principles for Minimum Standards of Care

- Licensing /accreditation
- Compatibility with existing health services framework
- Sensitivity and adaptability to localculture
- Promoting serviceutilization
- A patient-friendlyatmosphere
- Ongoing efforts forimprovement
- Systems foraccountability

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 indicators listed in the adjoining table may be presented and discussed:

- Proportion of clients reporting improvement in psycho-social status
- Finally, the monthly report format must be discussed with the entire

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 (clients) is an essential component

group

	Indicator	Definition	Where to get data from
Service Uptake Indicators	Cumulative Service Uptake	Total number of clients registered at the OST centre till reporting month (Cumulative)	SOCH and/or Client Register (RF/1)
	New Clients enrolled during the reporting month	Number of clients started on OST by the centre during the reporting month	SOCH and/or Client Register – OST Clients (RF/2)
	Cumulative OST Uptake	Total number of clients started on OST by the centre till the reporting month (cumulative)	SOCH and/or Client Register – OST Clients (RF/2)
Service Uptake through IDU TI	Service Uptake through IDU TIs	Of the total clients registered till the reporting month, number referred by the linked IDU TIs (Cumulative)	SOCH and/or Client Register (RF/1)
	Cumulative OST uptake through IDU TIs	Of the total number of clients started on OST by the centre till the reporting month, number referred by IDU TIs (cumulative)	SOCH and/or Client Register – New Clients & OST Clients (RF/1 & RF/2)
Treatment completers / other outcomes	Monthly Treatment Completion	Number of clients who completed treatment and were taken off medications by treating team during the reporting month	SOCH and Client files & Dispensing Register
	Cumulative Treatment Completion	Total number of clients who completed treatment and were taken off medications by treating team till this month (cumulative)	SOCH and Client files & Dispensing Register
	Clients with Other Outcomes (Cumulative)	Out of the total number of clients enrolled in OST, number of clients not in treatment (did not receive even one dose during the reporting month) due to reasons like death, migration, imprisonment or transfer to other centers	Auto generated (Deaths + Imprisonment + Migration + Transfer to other OST centres)
	Deaths (Cumulative)	Out of the total registered OST clients, number of clients who have passed away (as reported by a family member / outreach staff of TI) (cumulative)	Client Files & Master Register of TI
	Migration (Cumulative)	Out of the total registered OST clients, number of clients are not in treatment due to migration outside the city / town where OST centre is located (cumulative)	Client Files & Master Register of TI

	Indicator	Definition	Where to get data from
	Imprisonment (Cumulative)	Out of the total registered OST clients, number of clients are not in treatment due to ongoing imprisonment	Client Files & Master Register of TI
	Transferred to other centers (Cumulative)	Out of the total registered OST clients, number of clients formally transferred to other OST centers (in same district or another district) for the remaining duration of treatment	SOCH and Client files & Dispensing Register
OST Client load	Expected OST Clients	Out of the total cumulative OST uptake, number of clients who should be on treatment during the reporting month	Autogenerated (Cumulative OST uptake + Transferred in Clients) – (Treatment completed + Clients with other outcomes)
	Active Client load **(Active OST Clients)**	Number of individual clients currently receiving OST from the centers in the reporting month (received medicines on at least one day during the reporting month)	Sum of Very Regular + Regular + Irregular Clients
	Very Regular Clients	Number of clients receiving medicines for 25 or more days in the reporting month	SOCH and Daily Dispensing Register (RF/8)
	Regular Clients	Number of clients receiving medicines for 15-24 days in the reporting month	SOCH and Daily Dispensing Register (RF/8)
	Irregular Clients	Number of clients receiving medicines for less than 15 days in the reporting month but received at least one dose	SOCH and Daily Dispensing Register (RF/8)
	Total Loss to Follow-up (LFU)	Out of the expected OST clients, total number of clients who did not receive OST on even one day during the reporting month	Autogenerated (Expected OST clients – Active OST clients)
	New Loss to Follow-up	Out of the expected OST clients, number of clients who were in treatment till preceding month but did not receive OST on even one day during the reporting month	SOCH and Daily Dispensing Register (RF/8)
	Re-entry into treatment	Out of the total active OST clients, number of clients who re-entered treatment (received at least one dose)	SOCH and Daily Dispensing Register (RF/8)

	Indicator	Definition	Where to get data from
		during the reporting months	
BPN dispensing	Total Dosage dispensed per month	Dosage Dispensed (Total number of times the OST clients visited the OST center and avail the service) in each month	SOCH and/or Daily Dispensing Register (RF/8)- Individual Tracking Sheet
	Total Quantity of Buprenorphine dispensed per month	Total quantity of Buprenorphine dispensed (monthly consumption in mg)	SOCH and Daily dispensing register and Stock Register
	Total Quantity of Buprenorphine Naloxone dispensed per month	Total quantity of Buprenorphine Naloxone dispensed (monthly consumption in mg)	SOCH and Daily dispensing register, Take Home Dispensing Register and Stock Register
	Number of clients on take home dispensing	Number of clients given take home dispensing in the reporting month	SOCH and Take-home dispensing Register
Follow up and Psychosocial Services	Number of follow ups by Doctor per month	Number of clients for whom clinical follow-up (follow-up with the doctor) was conducted at the clinic during the reporting month	Client Register - Follow-up Clients (RF/3)
	Number of follow ups by Counsellor per month	Number of clients for whom psychosocial follow-up (follow-up with the counsellor) was conducted at the clinic during the reporting month	Client Register - Follow-up Clients (RF/3)
	Number of individual counselling done per month	Number of individual (one-to-one) counselling sessions taken with the clients during the reporting month (excluding psychosocial follow-up visits)	Counselling Register (RF/4)
	Number of group counselling done per month	Number of group counselling sessions taken with the clients during the reporting month	Group Discussion Register (RF/5)
	Number of field visits done by counsellor per month	Number of field visits made by the counsellor during the reporting month	Counselling Register (RF/4)
	Number of clients counselled on ART per month	Number of clients counseled on ART (treatment preparedness, adherence and Positive living) during the reporting month	Counselling Register (RF/4)
	Number of clients counselled on reintegration	Number of OST clients counselled on reintegration during the month	Counselling Register (RF/4)

	Indicator	Definition	Where to get data from
Referral Services - HIV	Number of clients referred to ICTC	Number of individual OST clients referred to ICTC for HIV testing during the reporting month	Referral Register (RF/6)
	Number of clients tested for HIV	Number of individual OST clients tested for HIV during the reporting month	Other Services Register (RF/7)
	Number of clients tested positive for HIV	Number of individual OST clients detected positive for HIV during the reporting month	Other Services Register (RF/7)
	Cumulative number of clients tested positive for HIV	Cumulative number of OST clients detected HIV positive till this month	Other Services Register (RF/7)
	Cumulative number of HIV positive clients linked with ART	Cumulative number of HIV positive OST clients linked with ART centre till this month	Other Services Register (RF/7)
	Number of clients on ART currently	Total number of OST clients currently on ART medicines	Other Services Register (RF/7)
Prevention and Referral - STI	Condom distribution	Number of condoms distributed to OST clients during the reporting month	Other Services Register (RF/7)
	Clients referred to STI clinic	Number of individual OST clients referred to STI clinic during the reporting month	Referral Register (RF/6)
	Clients diagnosed and treated for STI	Of the total individual OST clients diagnosed and treated for STI during the reporting month	Other Services Register (RF/7)
	Clients treated tested for syphilis	Number of individual OST clients tested for syphilis during the month	Other Services Register (RF/7)
Referral – TB	Clients screened for TB	Number of individual OST clients clinically screened for TB in the reporting month	Referral Register (RF/6)
	Clients referred to TB services	Number of individual OST clients referred to TB treatment services in the reporting month	Referral Register (RF/6)
	Clients diagnosed with TB	Number of individual OST clients diagnosed with TB in the reporting month	Referral Register (RF/6)
	Clients currently on DOTS	Total number of individual OST clients currently on treatment for TB (DOTS)	Other Services Register (RF/7)
Referral – Other services	IDUs referred to Detoxification services - DTCs	Number of IDUs linked with Detoxification services at DTCs during the month	Referral Register (RF/6)
	IDUs referred to Detoxification - IRCAs	Number of IDUs linked with Detoxification services at IRCAs during the month	Referral Register (RF/6)

	Indicator	Definition	Where to get data from
	Clients referred to NMHP	Number of clients referred to NMHP during the month	Referral Register (RF/6)
	Clients referred to NVHCP	Number of clients referred to NVHCP during the month	Referral Register (RF/6)
	Clients diagnosed as Hep C positive	Number of clients referred to NVHCP diagnosed as Hepatitis C positive during the reporting month	Referral Register (RF/6)
	Clients diagnosed as Hep B positive	Number of clients referred to NVHCP diagnosed as Hepatitis B positive during the reporting month	Referral Register (RF/6)
	Clients started on Hep C treatment	Number of clients referred to NVHCP diagnosed as Hepatitis C positive and started on treatment during the reporting month	Referral Register (RF/6)
	IDUs linked with Rehab services	Number of individual IDUs linked with rehabilitation services during the month	Referral Register (RF/6)
	Clients linked with other welfare services	Number of clients linked with other welfare services (legal, aid, shelter, nutrition, etc.)	Referral Register (RF/6)
Referral – IDU/TI	Clients referred to IDU TI for registration	Number of OST clients referred to IDU TI for registration	Referral Register (RF/6)
	Coordination meetings linked with IDU TI	Number of coordination meetings held with the linked IDU TI(s) during the month	Meeting Minutes
Stock Management indicators	Closing Stock	Closing stock at the end of last month (OST centre + Central stock)	OST centre stock register and Central Stock register
	Stock received from SACS	Stock received from SACS during the reporting month	Central stock register
	Stock returned to SACS	Stock returned to SACS during the reporting month (mention only the unexpired stock returned, if any)	Central stock register
	Stock dispensed to clients	Stock dispensed to clients in the reporting month	Daily dispensing register, Take home dispensing register
	Stock expired	Stock expiring without use during the reporting month	OST centre stock register and Central Stock register
	Expected balance stock	Expected balance stock at the end of the reporting month	OST centre stock register and Central stock register
	Actual balance stock	Actual balance stock at the end of the reporting month (OST centres + Central stock)	OST centre stock register and Central stock register
	Difference between expected and actual balance stock	Difference between expected and actual balance stock	(Autogenerated)
	Stock projection	Stock projection as per last months consumption (in days)	OST centre stock register and Central stock register
	Reason for discrepancy in stock	Reasons for any discrepancy between expected and	

	Indicator	Definition	Where to get data from
	position, if any	actual stock position	

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: (Tick one)

1	Self -Referred		
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

2. PERSONAL DETAILS

Name:

Father / Husband's Name:

Age: **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	

3.2. Education

1	Illiterate
2	Literate (Read and Write)
3	Primary (5 years of schooling)
4	Middle (8 years of schooling)
5	Matriculation / Higher Secondary (10 years 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: Yes [1] No [2]

Frequency of Injecting in last 1month:

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 (usualrange):

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 ofParaphernalia: [1] Yes [2] No

Frequency of sharing of Paraphernalia:

[1]
[2] Never 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. SEXUALHISTORY

5.1. Age at sexual debut: (inyears)

5.2. **Historyof:**

Paid sex [1] Yes [2] No

Heterosexual intercourse [1] Yes [2] No

5.3. Recent SexualPractices Had sex in exchange of money / drugs [1] Yes [2] No

Currently sexually active (last1month)	1.Yes		2.No		
	Sex in last month with	Number of partners	Sexualfrequency - last onemonth	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 ANDAIDS

6.1. HIV / AIDSAwareness

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
[2] Sharing contaminated needles / syringes
[3] Through infected blood & blood products
[4] Infected Mother to Child
[5] All of the above
[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. HIVStatus

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 onART? [1] **Yes** [2] No

Last CD4 count(withdate)

Next CD4 count due (Month andYear)

7. COMPLICATIONS DUE TO DRUGUSE

7.1. Psychological [1] Yes [2] No
Details ifany

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 INR):

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

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. PSYCHOSOCIALSTATUS

8.1. Current LivingArrangement

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-socialSupport

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

8.3. Source of FinancialSupport

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

9. ABSTINENCEATTEMPTS

9.1. **Ever attempted to give updruguse** Yes /No

9.2. Details of previous abstinenceattempts

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

10. MOTIVATION

Reasons for wanting to abstain:

Recentsignificantabstinenceattempts	1.Yes	2.No	
Overall gradingofmotivation	1.Good	2.Fair	3.Poor

11. COUNSELLOR'SNOTES

11.1 Drugs UseIssues
11.2 Psycho-socialIssues
11.3 OccupationalIssues
11.4 Facilitating factors and Barriers to recovery
12. PLAN FOR TREATMENT AND PSYCHOSOCIALREHABILITATION

Signature of theInterviewer

2. INTAKE PROFORMA - DOCTOR

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

Nameofphysician: **Designation:**

ClientRegn.No: **Date of assessment:**

1. ASSESSMENT OF SUBSTANCE USEPATTERN

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 DRUGUSE

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 PHYSICALEXAMINATION:

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 indicatewhether 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. SYSTEMICEXAMINATION:

- **RespiratorySystem**
  - Breathsounds
  - Adventitioussounds
  - Any otherfinding
- **Cardio-vascularSystem**
  - HeartSounds
  - Murmurs
  - Any otherfinding
- **Abdomen**
  - Tenderness
  - Organomegaly
  - Any otherfinding
- **Neurologicalexamination**
  - Higher MentalFunctions
  - Cranial Nerves
  - Any otherfinding

5. MENTAL STATUS EXAMINATION (mention positivefindings):

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 TOOST

Essential:

Diagnosis of Opioid Dependence	1	Yes
	2	No
Current IDU (at least once in past three months)	1	Yes
	2	
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
Longhistoryofopioiduse(>3years) No	1	Yes
	2	No
Failed abstinence attemptsin thepast	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. Substitutiontreatment	1	Yes	Whether initiated on OST today?	1 Yes
	2	No		2 No
2. Other medicaltreatment	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 providedetails	
	2	No		

Signature of thePhysician

3. FOLLOW-UP FORM – PSYCHOSOCIAL

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

Date of OSTInitiation:

ISSUES IDENTIFIED (at treatment entry):

CURRENT STATUS:

- **Psycho-socialsupport**

- **Financial support**

- **Otherissues**

- **Living Arrangement**

RECENT SUBSTANCE USE (since last follow-up):

- Drugsused

- Injectingdruguse 1. Yes 2.No
- Last injectingact

RECENT SEXUAL PRACTICES:

Currently sexually active (since last follow-up)			1.Yes 2. No		
	Sex in last month with	Number of partners	Sexualfrequency - last onemonth	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):

Injectingfrequency	Before lastfollow-up	
	Since lastfollow-up	
SharingofSyringe/Needle	1. Yes	2.No
Frequency of sharingofSyringe/Needle	Before lastfollow-up	
	Since last follow-up	
Number of people shared with		
Sharing during lastinjectingact	1.Yes	2. No

HIVSTATUS:

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 ……

Signature of the counsellor

OST Format No. - FF / 3

4. FOLLOW-UP FORM –CLINICAL

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

Diagnosis: Currentdose:

Date ofOSTInitiation: Date ofFollow-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:

REPORTS / INFORMATION RELATED TO REFERRALS MADE IN THE LAST FOLLOW UP:

ANY OTHER MEDICAL COMPLAINTS:

ANY PSYCHIATRIC COMPLAINTS:

GENERAL PHYSICAL AND SYSTEMIC EXAMINATION (mention current findings):

MENTAL STATUS EXAMINATION (MENTION CURRENT FINDINGS, IF ANY)

TREATMENT PLAN (record any changes in the plan)

- **Substitution Treatment**
- **Other MedicalTreatment**
- **Investigations andReferrals**

Nextfollow-upafter…….Days/weeks **Signature of thePhysician**

5. CONSENT FORM

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

Regarding OST, I have been explained that:

- Buprenorphineisbeinginitiatedasapartofthecomprehensivepackageofharmreductionservices offered by National AIDS Control Organization to people who injectdrugs.
- 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 opioiddrugs.
- When combined with psychosocial interventions, it will minimize dysfunction, help me become productive and improve my self-esteem and personal dignity. My attendance to group sessions will improve the chances of successfuloutcome.

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 thesame.
- I will be required to come daily to receive the treatment under supervision and need to periodically follow-up with by the doctor and thecounsellor.
- Duringfollow-upvisitswiththe doctor /counsellor,Ishouldbehonestaboutmedicationsideeffects, 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-upvisits.
- 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 aspossible.
- The take home dosing of buprenorphine will only be provided if I adhere to treatment with buprenorphine, remain abstinent from opioids and other drugs and fulfill other necessary requirements for the same.
- I cannot claim take home dispensing of buprenorphine medication as a right if the doctor and other OST staff do not find my current clinical state suitable for the same.
- In case of relapse, incarceration, travel or any other reason leading to buprenorphine non-compliance, I will be shifted from take home to daily dispensing of medications for a period till I achieve the take home dosing requirements of the centre.
- Take home medication can be stopped at any time during the treatment process in case the OST staff feels that I have lost the suitability for take home dispensing.

In addition, I have been given to understand that

- The use of other drugs (such as alcohol, tranquillizers, 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 me and I should also inform other physicians about my treatment withOST.

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

- Violence, threatened violence, or verbal abuse towards other patients orstaff
- Failure to follow-up with the doctor for repeatprescription
- Unlawful entry onto the premises
- Presenting to the centre intoxicated with alcohol or otherdrugs
- Diversion of buprenorphinedoses
- Engaging in unlawful activity such as drug dealing around the clinic orpharmacy

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

6. PRESCRIPTIONSLIP

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

7. CHECKLIST FOR SIDEEFFECTS OFBUPRENORPHINE

S. No.	Symptom / Sign	Yes / No
1	Sedation	
2	Diplopia	
3	Giddiness	
4	Headaches	
5	Confusion	
6	Light headedness	
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 number:**
Date of OST Initiation:	**Current dose:**
Month of Dispensing:	**Number of dispensing days:**

Day	Date	Number of Buprenorphine tablets dispensed		Number of Buprenorphine+Naloxone tablets dispensed	Total dose consumed	Signature of the Nurse/ Pharmacist
		0.4 mg	2 mg	2 mg		
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
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23.						
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27.						
28.						
29.						
30.						
31.						

9. OST Take-Home Record

S No.	Date	OST registration no.

1. Eligibility of the client for take-home dosing – Essential Criteria

1.1 □ Three months of supervised buprenorphine dosing from a NACO-supported OST centre.

1.2 □ Clinical stability – All the following 5 criteria to be fulfilled

- ❒ Absence of recreational / illicit opioid drug use at least for the last three months
- ❒ No alcohol or benzodiazepines use in dependent pattern at least for the last three months
- ❒ No major changes in the buprenorphine dose during the last two months
- ❒ No or minimal missed doses during the last three months
- ❒ No opioid withdrawals and craving at the time of assessment

1.3 □ At least onefollow up every month in the last three months

1.4 □ Willing to follow the rules and regulations related to take-home dosing

2. Eligibility of the client for take-home dosing – Desirable criteria

- ❒ Has started / resumed his work or school
- ❒ Has a stable housing
- ❒ Improvement in social relationships

3. Contraindications for take home dosing – In past 3 months

- ❒ History of opioid overdose
- ❒ History of diversion of buprenorphine/ BPN-N
- ❒ Clients at risk of suicide or self-harm
- ❒ Any untoward behaviour in the OST centre either towards the staff or towards other clients

4. Special indications for providing OST

- ❒ Government imposed lockdown
- ❒ Client has confirmed / suspected COVID – 19 infection
- ❒ Clients with significant medical co-morbidities
- ❒ Others (Please specify reason for take-home dispensing)

5. Monitoring the clients on OST (Select all that apply)

5.1 □ Misses follow-up visits

5.2 □ Arrives OST centre in intoxicated state

5.3 □ Frequently requests for more/stronger medicine **or** medications for longer durations (without convincing circumstances) **or** replacement for 'stolen' or 'lost' medications **or** attempts to get medications out of turn

5.4 □ Increased OST dose without first obtaining permission from doctor **or** uses OST medication for problems other than pain, such as sleeplessness or low mood

5.5 □ Recent deterioration in overall psychosocial functioning (job status/social relations) of the client

5.6 □ Recent heroin use**or** diverted use of buprenorphine (e.g. IDU) **or** concomitant use of other substances

5.7 □ Complaints from family members/ friends/ significant others about misuse of OST medicine

5.8 □ Signs of recent Injecting drug use on clinical examination

5.9 □ Avoids taking the complete daily dose of medication in supervised manner **or** features of intoxication/overdose/precipitated withdrawal with supervised dosing

5.10 □ Involves in drug dealing, selling, giving or borrowing OST medicines

3. Take-home OST medication dispensed □ Yes □ No

4. OST medication dispensed to

□ Patient □ Family members

□ Community □ Doorstep Delivery

5. Dispensing Schedule

Buprenorphine ….....mg tablet x……tablet(s)/day x……day(s)

6. Agreed mechanism for follow up

□ Self visit at OST centre □ Visit by Family members

□ Home visit by OST/TI staff □ Through telephonic/mobile conversation

7. Next follow-up scheduled on (Please specify the date)

REMARKS

Instruction for Filling Desired Fields

- This sheet is required to be filled by the medical officers/OST team at the OST centres
  (1) at the time of initiating take home OST regimen
  (2) every 2-4 weeks among the clients receiving take home OST
  (3) whenever the medical officer/counsellor considers it appropriate to apply, in order to monitor the clients on OST
- Frequency of administering the sheet – at least once in a month

S.No.	Fields/ Indicators to be filled	Direction for Filling the sheet	Remark
1.	Eligibility of the client for take-home dosing	1.1 to 1.5: Select all the applicable choices 1.6: If the reason different from those already mentioned the reason for prescribing take-home to be specified	
2.	Monitoring the clients on OST (Select all that apply)	2.1 to 2.10: Select all the applicable choices	Clients positive for one or more options do not automatically disqualifies client from take home OST. Clinicians discretion is mandated. Reason to be put in remarks.
3.	Take-home OST medication dispensed	Select whether take-home OST was given or not	
4.	OST medication dispensed to	Select, who was handed over the medicine on behalf of the patient	
5.	Dispensing Schedule	Specify the strength of buprenorphine tablet used, number of tablet(s) to be used by the client per day, and the duration (in day(s)) for which the medicines are given	
6.	Agreed mechanism for follow up	Select the agreed method for the next follow up	
7.	Next follow-up scheduled on	Specify the scheduled date for next follow up	
8.	Remarks	Any additional remarks to be put here	

Annexure -2

OPIOID SUBSTITUTION THERAPY PROGRAMME

_____

(Name of the Register)

_____

(Name of the Centre)

National AIDS Control Organization
Ministry of Health and Family Welfare

1. CLIENT REGISTER: NEWCLIENTS

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: OSTCLIENTS

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

OST Format No. - RF / 2

3. CLIENT REGISTER: FOLLOW-UPCLIENTS

Date:

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

OST Format No. - RF / 3

4. COUNSELLINGREGISTER

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

OST Format No. - RF / 4

5. GROUP DISCUSSIONREGISTER

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

6. REFERRALREGISTER

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

OST Format No. - RF / 6

7. OTHER SERVICESREGISTER

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	NVHCP	NMHP	General OPD (Medicine, skin, surgery, etc.)	Drug Detoxification – IRCA	Drug Detoxification - DTC	Community Care Centre

8. DISPENSINGREGISTER

Month of Dispensing -													
S. No.	OST File No.	Name	Date				Date				Date		
			BPN 0.4 mg	BPN 2 mg	BPN- N 2/0.5 mg	Initials	BPN 0.4 mg	BPN 2 mg	BPN- N 2/0.5 mg	Initials	BPN 0.4 mg	BPN 2 mg	BPN- N 2/0.5 mg
1													
2													
3													
4													
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41													
42													
43													
44													
45													
46													
47													
48													
49													
50													
	TOTAL												

Signature of the Nurse

9. DAILY STOCKREGISTER

Date	Stock	Number of Buprenorphine Tablets		Numberof buprenorphine+naloxone tablets	Signature of Nurse / Pharmacist
		0.4 mg	2 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				

10. OST CENTRE STOCKREGISTER

Date	Medicine	Strength	Batch Details		A. Total Stock a t 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 s tock a t the OST Centre = A+B-C (at the time of entry)	Initials
			Batch No.	Expiry Date					
	Buprenorphine	**0.4 mg**							Signature of the Nurse
			Total Stock (0.4 mg)						
		2 mg							
			Total Stock (2 mg)						Signature of the Medical Officer
	Buprenorphine + Naloxone	**2 mg/ 0.5 mg**							
			Total Stock (2/0.5 mg)						

11. CENTRAL STOCKREGISTER

Date	Medicine	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					
	Buprenorphine	**0.4 mg**							Signature of the Store In-charge
			Total Stock (0.2 mg)						
		2 mg							
									Signature of the Nodal Officer - OST
			Total Stock (0.4 mg)						
	Buprenorphine + Naloxone	**2/0.5 mg**							
			Total Stock (2 mg)						

12. SACS STOCKREGISTER

DATE:							
Strength	Batch Details		A. Opening stock at the 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 s tore
	Ba tch No.	Expiry date					
Buprenorphine 0.4 mg							
	Total Stock (0.4 mg)						
Buprenorphine 2 mg							
	Total Stock (2 mg)						
Buprenorphine + Naloxone (2/ 0.5 mg)							
	Total stock (2 mg)						
Name of the OST Centre (which received / re turned 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		

ANNEXURE – 3
MONTHLY REPORTING FORMAT FOR OST CENTRE

DEPARTMENT OF AIDS CONTROL							
OPIOID SUBSTITUTION THERAPY PROGRAMME							
MONTHLY REPORTING FORMAT FOR OST CENTRE							
State:	**Sikkim**	**District:**	**East**	**Block:**		**City / Town:**	
Name of the Centre:				**OST Centre code:**			
Address:				**Phone No (Centre):**			
				E-mail ID (Centre):			
Type of OST Centre:	**Government**			**Type of Facility:**	**NGO/Medical College / District Hospital / CHC / PHC / Others**		
Month & Year of Roll-out:				**Month & Year of Reporting:**			
State:							
Name of the Nodal Officer/ Programme Manager:		**Phone No:**		**Email-ID:**			
Name of Reporting Officer:		**Designation:**		**Email-ID:**			
Number of the Linked IDU TIs :			**1**				
		(insert more rows if required)	**2**				
INDICATORS FOR REPORTING							
Section 1 : Service Uptake and Outcomes							
				Value			
S.No.	**Indicator**	**Description**	**Source**	**Male**	**Female**	**Total**	
1.1	**OST Target**	Target assigned to the OST centre by SACS					
1.2	**Cumulative Service Uptake**	Total number of clients registered at the OST centre till the reporting month (Cumulative)	SOCH and Client Register - New Clients (RF/1)				
1.3	**Service Uptake through IDU TIs**	Of the total clients registered till the reporting month, number referred by the linked IDU TIs (cumulative)	SOCH and Client Register - New Clients (RF/1)				
1.4	**Monthly OST Uptake**	Number of new clients started on OST by the centre during the reporting month	SOCH and Client Register - OST Clients (RF/2)				

1.5	**Cumulative OST Uptake**	Total number of clients started on OST by the centre till the reporting month (cumulative)	SOCH and Client Register - OST Clients (RF/2)			
1.6	**Cumulative OST uptake through IDU TIs**	Of the total number of clients started on OST by the centre till the reporting month, number referred by IDU TIs (cumulative)	SOCH and Client Register - New Clients & OST Clients (RF/1 & RF/2)			
1.7	**Monthly Treatment Completion**	Number of clients who completed treatment and were taken off medications by treating team during the reporting month	SOCH and Client files & Dispensing Register			
1.8	**Cumulative Treatment Completion**	Total number of clients who completed treatment and were taken off medications by treating team till this month (cumulative)	SOCH and Client files & Dispensing Register			
1.9	**Clients with other outcomes**	Out of the total registered OST clients, number of clients not in treatment (did not receive even one dose during the reporting month) due to reasons like death, migration, imprisonment or transfer to other centres	Sum of next 4 indicators			
1.9a	**Deaths**	Out of the total registered OST clients, number of clients who have passed away (as reported by a family member / outreach staff of TI) (cumulative)	Client Files & Master Register of TI			
1.9b	**Migration**	Out of the total registered OST clients, number of clients are not in treatment due to migration outside the city / town where OST centre is located (cumulative)	Client Files & Master Register of TI			
1.9c	**Imprisonment**	Out of the total registered OST clients, number of clients are not in treatment due ongoing imprisonment	Client Files & Master Register of TI			

1.9d	**Transferred to other centres**	Out of the total registered OST clients, number of clients formally transferred to other OST centres (in same district or another district) for the remaining duration of treatment	SOCH and Client files & Dispensing Register			
1.10	**Expected OST Clients**	Out of the total cumulative OST uptake, clients should be on treatment during the reporting month (i.e. who have not completed treatment and also not met other outcomes)	Autogenerated			
1.11	**Active Client Load**	Number of individual clients currently receiving OST from the centres in the reporting month (received medicines on at least one day during the reporting month)	Sum of next 3 indicators			
1.11a	**Very Regular Clients**	Number of clients receiving medicines for 25 or more days in the reporting month	SOCH and Daily Dispensing Register (RF/8)			
1.11b	**Regular Clients**	Number of clients receiving medicines for 15-24 days in the reporting month	SOCH and Daily Dispensing Register (RF/8)			
1.11c	**Irregular Clients**	Number of clients receiving medicines for less than 15 days in the reporting month but received at least one dose	SOCH and Daily Dispensing Register (RF/8)			
1.12	**Total Loss to Follow-up (LFU)**	Out of the expected OST clients, total number of clients who did not receive OST on even one day during the reporting month	Autogenerated			
1.13	**New LFU**	Out of the expected OST clients, number of clients who were in treatment till preceding month but did not receive OST on even one day during the reporting month	SOCH and Daily Dispensing Register (RF/8)			

1.14	**Re-entry into treatment**	Out of the total active OST clients, number of clients who re-entered treatment (received at least one dose) during the reporting month after LFU	SOCH and Daily Dispensing Register (RF/8)			
1.15	**Total Dosage Dispensed**	Total number of OST dosages dispensed to the clients during the reporting month (sum of dosages dispensed on each day of the reporting month)	SOCH and Daily Dispensing Register (RF/8)			
Section 2: Psychosocial interventions and Support Services						
				Value		
S.No.	**Indicator**		**Source**	**Male**	**Female**	**Total**
2.1	Number of clients for whom clinical follow-up (follow-up with the doctor) was conducted at the clinic during the reporting month		Client Register - Follow-up Clients (RF/3) and SOCH			
2.2	Number of clients for whom psychosocial follow-up (follow-up with the counsellor) was conducted at the clinic during the reporting month		Client Register - Follow-up Clients (RF/3)			
2.3	Number of individual (one-to-one) counselling sessions taken with the clients during the reporting month (excluding psychosocial follow-up visits)		Counselling Register (RF/4)			
2.4	Number of group counselling sessions taken with the clients during the reporting month		Group Discussion Register (RF/5)			
2.5	Number of field visits made by the counsellor during the reporting month		Counselling Register (RF/4)			
2.6	Number of clients counselled on ART (treatment preparedness, adherence and Positive living) during the reporting month		Counselling Register (RF/4)			
2.7	Number of OST clients counselled on reintegration during the month		Counselling Register (RF/4)			
Section 3: Referrals/Linkages and Other Services						
				Value		
S.No.	**Indicator**		**Source**	**Male**	**Female**	**Total**
3.a HIV testing and Treatment Services						
3.1	Number of individual OST clients referred to ICTC for HIV testing during the reporting month		Referral Register (RF/6)			
3.2	Number of individual OST clients tested for HIV during the reporting month		Other Services Register (RF/7)			

3.3	Number of individual OST clients detected positive for HIV during the reporting month	Other Services Register (RF/7)			
3.4	Cumulative number of OST clients detected HIV positive till this month	Other Services Register (RF/7)			
3.5	Cumulative number of HIV positive OST clients linked with ART centre till this month	Other Services Register (RF/7)			
3.6	Total number of OST clients currently on ART medicines	Other Services Register (RF/7)			
3.b Prevention, Early diagnosis and Treatment for STI					
3.7	Number of condoms distributed to OST clients during the reporting month	Other Services Register (RF/7)			
3.8	Number of individual OST clients referred to STI clinic during the reporting month	Referral Register (RF/6)			
3.9	Of the total individual OST clients diagnosed and treated for STI during the reporting month	Other Services Register (RF/7)			
3.10	Number of individual OST clients tested for syphilis during the month	Other Services Register (RF/7)			
3.b Early diagnosis and treatment for Tuberculosis					
3.11	Number of individual OST clients clinically screened for TB in the reporting month	Referral Register (RF/6)			
3.12	Number of individual OST clients referred to TB treatment services in the reporting month	Referral Register (RF/6)			

3.13	Number of individual OST clients diagnosed with TB in the reporting month	Referral Register (RF/6)			
3.14	Total number of individual OST clients currently on treatment for TB (DOTS)	Other Services Register (RF/7)			
3.b Drug Treatment and Rehabilitation Services					
3.15	Number of IDUs linked with Detoxification services during the month	Referral Register (RF/6)			
3.16	Number of individual IDUs linked with rehabilitation services during the month	Referral Register (RF/6)			
3.17	Number of clients linked with other welfare services (legal, aid, shelter, nutrition, etc.)	Referral Register (RF/6)			

Section 4: Linkage with TI Services

			Value		
S.No.	**Indicator**	**Source**	**Male**	**Female**	**Total**
4.1	Number of OST clients referred to IDU TI for registration	Referral Register (RF/6)			
4.2	Number of coordination meetings held with the linked IDU TI(s) during the month	Meeting Minutes			

Section 5. Status of Staff and Training

S. No.	**Staff Designation**	**Staff status**			**Training Status****		**Remarks**
		Number Sanctioned*	**Number In Place**	**Date of Joining**	**Induction Training**	**Refresher Training**	
5.1	**Doctor**						
5.2	**OST Nurse**						
5.3	**Counsellor**						
5.4	**Data Manager**						
5.6	**Any other staff (specify)**						
5.7	**New Recruitments during the month**						
5.8	**Total Staff positions vacant**						

***staff sanctioned by concerned SACS / DACS**

****whether received training on the NACO OST training module**

Section 6: Reporting of OST Stock Status				
A. Stock utilization and movement details				
S No	**Indicator**	**Number of Tablets**		
		BPN 0.4 mg	**BPN 2 mg**	**BPN-N (2/0.5 mg)**
6.1	Closing stock at the end of last month (OST centre + Central stock)			
6.2	Stock received from SACS during the reporting month			
6.3	Stock returned to SACS during the reporting month (mention only the unexpired stock returned, if any)			
6.4	Stock dispensed to clients in the reporting month			
6.5	Stock expiring without use during the reporting month			
6.6	Expected balance stock at the end of the reporting month			
6.7	Actual balance stock at the end of the reporting month (OST centres + Central stock)			
6.8	Difference between expected and actual balance stock			
6.9	Stock projection as per last month's consumption (in days)			
6.10	Reasons for any discrepancy between expected and actual stock position			
B. Balance Stock Details				
S No	**Indicator**	**Batch No**	**Expiry Date**	**Balance Stock**
6.11	BPN 0.4 mg			
		Total Stock BPN (0.4 mg)		
6.12	BPN 2 mg			
		Total Stock BPN (2 mg)		
6.13	BPN-N (2/0.5) mg			
		Total Stock BPN-N (2/0.5mg)		
C. Expired Stock Details				
S No	**Indicator**	**Batch No**	**Expiry Date**	**Balance Stock**
6.14	**Tablet Buprenorphine 0.4 mg**			
	Details of stock expiring in the reporting month			
	Expired stock returned to SACS during the reporting month			
	Total expired stock at the centre at the end of the reporting month			
6.15	**Tablet Buprenorphine 2 mg**			
	Details of stock expiring during the reporting month			
	Expired stock returned to SACS during the reporting month			
	Total expired stock at the centre at the end of the reporting month			
6.16	**Tablet Buprenorphine- Naloxone (2/0.5) mg**			
	Details of stock expiring during the reporting month			
	Expired stock returned to SACS during the reporting month			
	Total expired stock at the centre at the end of the reporting month			

Annexure -4
Evaluation and feedback sheets

The following set of questions can be used for pre and pos t 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 ofalcohol?
   - ❒ Beer
   - ❒ Wine
   - ❒ countryliquor
   - ❒ Gin
2. Which of the following is NOT a criterion for DrugDependence?
   - ❒ Using drugs in large amount over long duration oftime
   - ❒ Taking illegaldrugs
   - ❒ Desire or efforts to reduce druguse
   - ❒ 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 Stabilization 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 isfalse?

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

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

- ❒ Loss of job, heavy debt
- ❒ Involvement in illegalactivities
- ❒ Infections like HIV,HBV
- ❒ Frequentargumentswithfamilymembers

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

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

17. Which of the following is an example of harmreduction?

- ❒ Closing downwine-shops
- ❒ Arresting people who sell smack andganja
- ❒ Teaching injecting drug users to inject drugssafely
- ❒ Organising a campaign for school children in which they pledge not to takedrugs

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

- ❒ They reduce HIV risk but encourage drug users to use moredrugs
- ❒ They alone are enough to stop the drug problems in acity
- ❒ They encourage drug users to adopt safebehaviours
- ❒ They are illegal under thelaw

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

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

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

- ❒ Methadone maintenancetreatment
- ❒ Needle Syringe ExchangeProgramme
- ❒ Injection Room
- ❒ TherapeuticCommunity

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				
Basics of Drugs– Addictive substances and drug use disorder overview				1.
Drug related harms and problems				
Local drugabusescenario – Group Activity				
Drug Abuse Management Strategies				
Treatment Principles and Approaches				
Basics of Opioids – Overview of Opioids and Opioid dependence				
Opioid substitution therapy – overview				
Assessment and Diagnosis				
Assessment and diagnosis role-play and case demonstration/presentation				
Pharmacology of Buprenorphine and Buprenorphine + Naloxone				
Buprenorphine Dispensing				

Session	Useful	Can't Say	Not Useful	Any remarks?
Psychosocial interventions				
Role-play/Demonstration of psychosocial interventions				
Exposure to the OST clinic,includingdemonstration				
Debriefing andexperiencesharing				
Management of common clinical conditions				
Special Population / Special clinical considerations				
Programme management-I				
Programme management-II				
Programme management - III				
Programme management - IV				

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