8. ANNEXURE 2

A step by step of LCCS Treatment Camp Model implemented by TT Ranganathan Clinical Research Foundation (TTK Hospital), nominated Regional Resource Center for Low Cost Community Based Care for Drug users under the UNODC, H-13 project, 'Prevention of transmission of HIV among Drug users in SAARC countries'.

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LCCS TREATMENT CAMP MODEL FOR OPIATE, OPIOID AND OTHER INJECTING DRUG USERS

Objectives:

- To help client establish total abstinence from drugs
- To work towards whole person recovery
- To reduce HIV risk taking behavior
- To familiarize client with services available in the community
- To create a enabling environment for recovery in the family and community

The camp programme will be developed with **abstinence as the goal** of treatment even while acknowledging that all may not achieve this goal and many relapse before being able to establish abstinence.

The **shorter duration of treatment camp** while compared to institution-based approaches and that the programme is being **made available in the community** make it appealing to clients.

Clients will be treated on an **in-patient basis** and services provided free of cost including food to make services accessible to injection drug users who cannot afford to pay for institutionalized treatment programmes.

Both medical and psychological therapy will be made available. **Medications will be used** to make the withdrawal period comfortable for the client.

Responsibility of the NGO who is organizing the camp:

- Identifying and training of staff to participate in camp programme:
  - identifying doctor living in the community who is familiar with drug treatment issues and buprenorphine

- training staff in home detox, camp programme, issues that influence recovery, family involvement and skills of counseling, group therapy and other components of therapy
- employing ex- drug users as essential part of the treatment team

- Budgeting and ensuring availability of resources to facilitate smooth running of camp

Preparing list of materials needed and procuring the same - medicines, games, books, music, stationery, clinical records etc

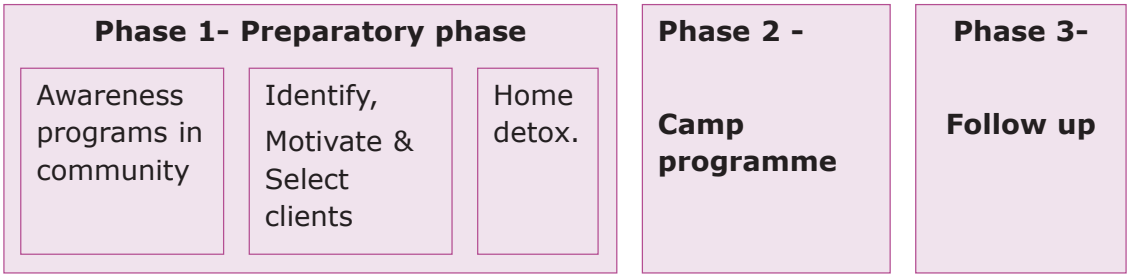
Duration: Minimum of 15 days of camp treatment, preceded by preparatory phase and follow up after the camp treatment is completed.

- 7-day home detoxification followed by 10-day camp programme would be suitable. The home detox. medications, largely buprenorphine would be withdrawn on day 2 of the camp.
- If clients approach for help on day 1 of the camp without the preparatory phase, the entry point into the camp setting would be different. In this case the counselor staff strength needs to be increased to 5, as both groups need to be handled in the same campsite but separately as two groups.

No. of clients in each camp:

25 (to ensure that quality care is provided and individual attention is possible)

LCCS camp model is described below as a three-stage process.



Venue: Camps are to be conducted in areas away from the in-patient treatment / rehabilitation units to reach out to the difficult to reach populations. Schools, churches or wedding halls are to be used as campsites. Campsites should have basic amenities like adequate ventilation, water and electricity and be accessible.

Staffing:

- Three therapy staff who will function as counselors, three to six peer volunteers who are ex-drug users, one doctor and one nurse or nurse aid. Other supportive staff like cook and driver may also be employed.

- A ratio of 1:8 will be maintained between staff offering psychological therapy and clients. Three staff will have adequate training in presenting input sessions, conducting group therapy and counseling and each will have a caseload of 8. Handling group therapy, counseling and family meetings and completing the records for the eight clients will be the responsibility of each of the three staff members.
- One of the counselors will be designated as team head and camp in-charge to provide overall supervision and coordinate activities. The counselors will stay in the campsite round the clock.
- The doctor will meet all clients on Day 1 and the penultimate day of discharge. In case of need, the doctor will visit the campsite or the client transferred to a medical care unit.
- Apart from cooking and peer volunteers, a health care worker or nurse will be available to administer medications and provide first aid if needed.

Figurative description of camp process

PHASE 1: PREPARATORY PHASE

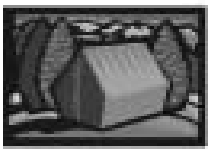
Create awareness in community about addiction treatment and forthcoming camp

Identify drug users through multiple sources

Motivate clients and family into treatment

Screen for medical problems and start detox.

Home detox. with tapered dosages

PHASE 2: CONDUCTING THE CAMP	PHASE 3: FOLLOW UP
	
Structured treatment programme with recovering drug users as part of treatment team	Offered in the community for one year

Phase 1: Preparatory phase

Preparation needed to:

- identify and motivate clients in community to access treatment
- heighten sense of optimism about recovery in client
- prevent drop out, thereby safeguarding client and staff morale
- ensure that the camp progresses smoothly

Main activities:

- Involving peer volunteers in identifying and preparing clients
- Mobilizing support of community to offer support in terms of
  - logistics : informing clients, food, stay and security arrangements
  - creating a sense of partnership with the camp effort

Issues to be kept in mind:

A. Preparing and mobilizing the community:

- at least three awareness programmes will be undertaken
- meeting held with key community members or leaders to solicit support
- publicizing information about forthcoming camp through notices in common places, cable TV networks, local newspapers and organized groups like NGOs, youth, church, teachers etc.
- efforts made to mobilize community resources in terms of materials, money or manpower

B. Identification of clients:

- by peer educator or peer volunteer
- ex-drug users only will be used. Current drug users may provide information about drug users in the community but will not participate in other camp activities as part of the treatment team.

C. Selection of clients to be based on certain criteria:
As the camp is conducted away from the well-established infrastructure of the institution treatment units and the short duration, it is recognized that all clients will not profit from the camp. Clients are screened to ensure a certain level of client- treatment matching to increase effectiveness and optimal use of resources.

Selection criterion:

i Clients living within a 10 to 20 km radius of camp site to ensure support of community, facilitate family participation and follow up.

ii Prior treatment exposure and failure to benefit from long term treatment may indicate poor chances of recovery from this short term treatment approach.

iii Motivation level of client reflected by cooperation showed.

iv Availability of family support and willingness of at least one family member to provide active support.

v Absence of serious medical problems like untreated abscesses, tuberculosis, uncontrolled hypertension, high diabetes etc.

vi Only injecting drug users. Users of ATS will be not be admitted as treatment issues may be complicated.

vii HIV positive clients will be admitted provided their health status is stable.

viii Aggressive clients, those with psychiatric problems as well as those with crime records may not fit in well with this camp approach.

ix Sex: Separate camps may be held for female clients only but both males and female clients will not be accepted at the same campsite as it may complicate issues.

D. Motivation and preparing client and family for camp treatment:
At least three meetings are held with client and family member

First meeting: Assessment, providing information about home detox and treatment process in camp and expectations of treatment centre from client and family

Second meeting: Re emphasizing issues explained previously and medical assessment by the doctor

Third meeting: Issuing buprenorphine for home detox., explaining mode of administration and effect of medications, emphasizing staying off from other drugs of abuse to both the client and family member. Medications are to be administered by the family member in close supervision.

E. Providing home detox. as first part of treatment intervention:

- Home detox medicines are issued for 2-3 days at a time
- Clients and their family members are expected to return on an agreed upon date, time and venue to meet treatment staff for collecting medications. The project coordinator and out reach worker will meet the client and family member to reinforce messages for change and ensure that they have not reverted to old pattern of drug use before issuing medications
- Family members take responsibility to administer buprenorphine as directed

F. Handling clients who join the camp without home detox.:

- In camp settings, a group of clients from a particular geographical area go through treatment together. The preparatory phase, actual treatment programme and follow up takes place in a visible way in the community. All this creates an environment that motivates other drug users to access help. Adequate publicizing of the programme during the preparatory phase will keep this number to the minimum.
- Even if admitted they would not form more than 25% of the total number.
- These clients will begin their detox. on day 1 while all the rest would have completed detox. by day 2. They will not be able to participate in the therapy programme along with the others and will be handled as a separate group. Extra staff will be assigned to provide the necessary services to this group.

From the public health perspective, it is essential to remember that limited resources are available for addiction treatment and has to be utilized efficiently. In today's situation, optimism about recovery is at a low level, so much so that a campaign, 'treatment works' was warranted. It is time that planning based on theoretical understanding and practical logical issues are brought into the treatment approaches and not be guided by good will alone.

Phase 2: Conducting camp:

The treatment camp will offer

- Structured treatment programme with a variety of activities for at least 15 days with emphasis on timing and regularity.
- Family participation will be mandatory.

Main activities:

- Combination of approaches - exercises, prayer, input sessions, group therapy, counseling, group activities based on participatory methodology, short films or presentations, group games and NA meetings / sharing

- Two family therapy sessions will be held on Day 1 and final day of camp at discharge.
- One support person will also attend a two hour session on day of discharge to provide additional support for client.

Issues to be kept in mind:

A. Structured psychological therapy:

- The last two days of the home detox. process will take place in the camp setting to ensure a supportive environment for client. Painkillers and medications for sleep disturbances will be kept to the minimum.
- A time table will be developed to provided planned inputs.
- Input sessions on addiction process, recovery, STI/ HIV, safe practices, resources for help will be provided by camp staff. Group therapy, activity sessions and counseling will form part of the therapy program.
- Narcotic Anonymous meetings or sharing of those with well established recovery will be held everyday.
- A meeting with the Hospital and Institution committee of the local Narcotics Anonymous chapter will be held once to forge linkages with the NA network.

B. Family sessions: Two 2-hour sessions will be held to help family understand:

- Addiction process and recovery.
- Relapse process and management.
- Provide right support to recovering client.

Attendance of at least one family member is mandatory. No visits from family or friends will be permitted during the camp period.

C. Guidelines to ensure drug free environment:

- All clients will be frisked and searched for presence of drugs on day 1 of admission.
- At least 3 peer volunteers who are ex- drug users will be available during night to provide support.

D. Documentation and record keeping:

- Medical sheets with buprenorphine dosage details, intake or individual case history records and follow up cards will be maintained for each client. The records will be structured and brief so that essential information can be recorded in a short period of time.
- Daily events record sheet will be maintained to record activities undertaken and issues that needed to be handled.

- In addition the following are essential:
- Indemnity bond in which client and family sign consenting for treatment and accept responsibility for unforeseen incidents and legally protect the treatment unit.
- Rules and regulations that state the do's and don'ts for clients. Smoking in campsite is to be permitted. But these are purchased and issued by treatment staff to ensure that it does not contain drugs and are rationed at 5 pieces twice a day. The client however will deposit money for the same. Phone calls, possession of money / other valuables, visitors or permission to leave campsite will not be permitted.
- The client and family signs a form acknowledging that free treatment was provided.

***Phase 3:* Follow up phase:**

- Considered as essential component.
- Provides support for client and family members and increases accountability of treatment unit.
- Referral network for treatment of tuberculosis, abscesses, in patient rehabilitation facilities, vocational guidance, NA networks and HIV related services will be made available.

Main activities:

- Offer follow up services free of cost in the community for a period of one year.

Issues to be kept in mind:

A. Follow up services will be made available at three levels:

i Community based services: Planned follow up sessions at pre set time, date and venue at the community in which the camp was held. These meetings will be held once in 2 weeks for the first three months and once a month for the rest of the seven months. Individual sessions as well as a group session will be held.

ii At DIC or treatment unit of the organizing agency - can be accessed whenever the client wants support.

iii Home visits made by the peer volunteer or out reach worker whenever possible.

A family member will accompany clients on all follow up visits.

B. Relapse management: Relapses will be handled by referring to the main treatment unit. Home detox will be considered to intervene quickly to prevent return to full-scale return to pre-treatment levels.

C. Recording: Individual follow up cards will be maintained. Follow up records reflecting progress of entire group will be maintained. Monthly meetings will be held with project coordinator, out reach worker and peer volunteer/ worker to review progress.

D. Self help groups: On going support of self-help groups must be made available. The treatment team will actively support initiation of self-help groups in the community and also encourage clients to attend meetings regularly.

TRAINING INPUTS SUGGESTED:

- Knowledge inputs about each treatment component, medical issues involved (STD/STI, HIV, Hepatitis B and C) and some skill building sessions are essential.
- Information about medical problems, handling withdrawal, recovery and relapse issues, role of the family and importance of follow up and self-help groups need to be part of the training.
- Skill orientation to group therapy, counseling sessions as well as facilitation skills with regard to handling lectures and group activities is essential.
- Guidelines for effective networking with community.
- Documentation and record keeping - the need and methodology involved
- Observation of the camp programme and observing camps would be an additional advantage.
- Setting monitoring and evaluating indicators can help.
- Ensuring on going support from the regional resource center for some amount of handholding needs to be considered.

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