PREVENTION OF TRANSMISSION OF HIV AMONG DRUG USERS IN SAARC COUNTRIES
TD/RAS/03/H13

LOW COST COMMUNITY-BASED CARE FOR DRUG USERS

INTERVENTION TOOL-KIT UNDER TESTING
Intervention Tool-kit
(A set of six modules)

An UNODC-ROSA undertaking
For the AusAID supported project 'Prevention of transmission of HIV amongst Drug Users in SAARC Countries' (Project code- TD/RAS/03/H13)

Module 6
'Low Cost Community-based Care for Drug Users'

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Module-6
'Low Cost Community-based Care for Drug Users'
EXTRACT FROM THE OPENING STATEMENT OF ANTONIO MARIA COSTA, UNODC EXECUTIVE DIRECTOR AT THE 48TH SESSION OF THE COMMISSION ON NARCOTIC DRUGS, VIENNA, MARCH 7-14, 2005

"In many countries, the current dramatic spread of blood-borne infections, from HIV/AIDS to Hepatitis C, is aggravating the suffering that comes from the chronic abuse of drugs. As a result, people at risk of HIV, or already infected by AIDS need tangible, targeted and immediate help before this pandemic evolves into the biggest killer in history ... My office is mandated, via the UN Drugs Conventions, not just to reduce the prevalence of drug abuse, but also to reduce the harm caused by drugs.

The best form of dealing with the problem is, of course, abstinence and at UNODC, we've invested substantial resources in prevention and treatment. We are increasing the assistance to populations at high HIV/AIDS risk, and we work with governments so that they can reach people before they join the ranks of the HIV-positive. This is where we can make a significant difference. This is where resources are well spent, as it is always easier to attack a problem before it materialises, or spins out of control.

My office believes that greater attention and more resources should be invested in drug control programmes aimed at checking the spread of blood-borne diseases. These initiatives must not stand alone, but be part of comprehensive efforts aimed at reducing drug use. We unequivocally reject any initiative, well-intended as it may be, that could lead to a perpetuation of drug abuse... Governments can, and must ensure both drug control and HIV prevention.

As stated by the INCB in its 2003 report: '... governments need to adopt measures to reduce the demand for illicit drugs taking into account... the drug-related spread of HIV infection. At the same time... prophylactic measures should not promote and/or facilitate drug abuse'."

UNODC’S COMPREHENSIVE PACKAGE APPROACH

HIV/AIDS prevention and care programmes for injecting drug users typically include a wide variety of measures (the 'package' approach), ranging from drug dependence treatment, including drug substitution treatment, outreach providing injecting drug users with information on risk reduction and referral to services, clean needles and syringes, and condoms, voluntary counselling and testing, treatment of sexually transmitted infections, antiretroviral therapy, and interventions for especially at-risk populations such as prisoners and sex workers who inject drugs. Such a comprehensive package of measures also usually includes treatment instead of punishment for persons convicted of minor offences, since drug treatment not only constitutes humane, cost effective alternative, but also incarceration usually increases the risk of HIV transmission.
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1. **INTRODUCTION**

Some 200 million people, or 5 per cent of the world’s population aged 15-64, have used drugs at least once in the last 12 months. The main problem drugs at the global level continue to be the opiates (notably heroin) followed by cocaine. In Europe and Asia, opiates accounted for 62 per cent of all treatment demand in 2003 (UNODC, 2005).

Worldwide, more than 55 million people use opiates, cocaine and amphetamine-type stimulants, and an estimated 13.2 million people inject these drugs. Most (78 per cent) injecting drug users live in developing and transitional countries (Aceijas et al, 2004, as cited in UNODC, 2005).

Globally, it is estimated that 5-10 per cent of all HIV infections are attributable to injecting drug use, mostly via the use of contaminated injection equipment (UNODC, 2005).

While most HIV transmission among injectors worldwide is related to the sharing of injection equipment, in some areas, sexual behaviour is primarily responsible for HIV transmission among injecting drug users. Interventions aimed at reducing risky injecting practices may not be as effective at reducing risky sexual behaviour (Booth et al, 1994; Welp et al, 2002; as cited in UNODC, 2005).

There is also increasing evidence of the link between HIV epidemics among IDUs and other drug users and of the spread of HIV epidemics in the general population through sexual networks (Lowndes et al, 2003, as cited in UNODC, 2005).

The learned behaviour of associating drugs with sex makes it difficult to reduce high-risk sexual behaviour (Paul et al, 1993, as cited in UNODC, 2005).

Though no reliable data exists, it is estimated by policy planners and service providers that there are approximately four million drug users in the SAARC region. Chasing (inhaling the vaporised form) of heroin is popular in the region, though transition to injecting has occurred and is rapidly diffusing. It is again estimated that SAARC countries have about 400,000 IDUs. It needs to be stressed that at present, apart from India, no survey or size estimation of either drug use or injecting drug use has been carried out in the region. Of concern is the escalation in the abuse of pharmaceutical drugs, including synthetic opiates (like injectable buprenorphine), tranquillisers (diazepam), antihistamines and drug cocktails. The sharing of injecting equipment is common in India, Nepal and Bangladesh and many IDUs in the region also practise unsafe sexual behaviours.
Opioid dependence, a complex health condition that often requires long-term treatment and care, is associated with a high risk of HIV infection when opioids are injected using contaminated injection equipment. Drug dependence treatment is an important strategy to improve well-being and social functioning of people with opioid dependence and to reduce its health and social consequences, including HIV infection. As no single treatment is effective for all individuals with opioid dependence, sufficiently diverse treatment options should be available. The treatment and rehabilitation process should begin with the early detection of drug abuse (Box 1).

1.1 Low Cost Community-based Care and Support (LCCS):
Low Cost Community-Based Care and Support, is one of the important approaches in addressing the adverse social, economic and health consequences of psychoactive substance use including vulnerabilities to STI/HIV, targeting population groups in resource-poor settings.

LCCS, thus, attempts to reach out to those drug users (including IDUs), who:
- are opioid and alcohol users and are at risk of transmission of STI/HIV through unsafe injecting as well as unsafe sexual practices, under the influence of psychoactive drugs.
- are far away from any institution-based addiction treatment (staying in remote areas).
- cannot afford to spare time to access the treatment (vulnerable women, daily wage earning drug users, etc.).

Box 1: Treatment and rehabilitation process

People with drug abuse problems come from all walks of life and have different needs. Treatment services thus must offer a range of approaches and should be tailored to each patient.

The treatment and rehabilitation process should begin with the early detection of drug abuse. The process includes all stages leading to eventual reintegration into society. The following steps are regarded as essential:

- **Early detection** and access to services needs to be facilitated for high-risk individuals. This is best accomplished through primary health-care settings.
- **Outreach** programmes are necessary to reach the many drug users who are not in contact with any medical or drug abuse treatment institutions. Flexible, unconventional approaches developed outside formal health and social environments and aimed at accessing, motivating and supporting drug abusers can reach out-of-treatment drug users, increase drug treatment referrals and reduce illicit drug-use behaviour.
- **Detoxification** should be seen in the context of broader social and treatment interventions. Community-based (i.e. non-residential) detoxification can be a particularly cost-effective approach, provided that there is a basic medical and social support infrastructure. Inpatient detoxification is essential for a small minority who are likely to experience severe withdrawal and associated medical complications.
cannot afford the cost of 
addiction treatment. 

✦ due to several relapses, do not 
have confidence on institution-
based addiction treatment. 

✦ have undergone successful 
addiction treatment but continue 
to undergo repeated relapse 
episodes due to negative 
community influences. 

✦ are HIV positive, are clinically 
indicated to start anti-retroviral 
therapy and have been advised to 
start anti retroviral therapy (ART). 

LCCS is also recommended in a 
situation where there is no in-patient 
adiction treatment facility or where, if 
a facility exists, it is inadequate to cater 
to the demand of addiction treatment 
in a particular geographical area.

1.2 Advantages of community 
involve

✦ The community's feeling of 
oneness is constructively 
utilised. 

✦ Responsibility is shared, leading to 
'doing with' rather than 'doing for'. 

✦ The community, when sensitised 
to the problem, prevents further 
spread of HIV, by way of 
decriminalising drug use and 
addressing dual stigma 
associated with drug use and 
HIV/AIDS. 

✦ The community is empowered to 
support clients in recovery.

1.3 What is Community-based 
Treatment Intervention?

A community-based response 
involving local agencies and 
organisations, including outreach

Box 1 Cont’d...

✦ Psychosocial interventions are a 
vital part of drug abuse treatment. 
Drug abuse affects other psychosocial, 
economic and behavioural 
dimensions. It is useful to have a 
multi-disciplinary team composed of 
medical, social and counselling 
providers. 

✦ Counselling is a very important 
component of treatment. It is also 
the first step towards rehabilitation 
and eventual social reintegration. 
Involvement of the family and 
mobilisation of the community 
contribute significantly to long-
term treatment and rehabilitation 
efforts. 

✦ Prescription of Substitutes can be 
an important aspect of treatment for 
many patients. The prescription of 
methadone, buprenorphine or LAAM to 
people dependent on opiates can help 
them stabilise their lives and reduce 
illicit drug use. 

✦ Social reintegration requires work 
with individuals, their families and 
communities. Marketable skills 
training and facilitating the re-entry of 
former abusers into the workforce are 
necessary components of 
rehabilitation programmes. 

✦ Integration of treatment and 
rehabilitation services within 
existing health services or systems 
should take place wherever possible, 
without creating a separate drug 
treatment system. 

('Access to treatment & rehabilitation', from 
services, is a necessary component of a strategy that seeks to reach drug users who are not in contact with services. A community-based response aims at:

✦ encouraging behaviour changes directly in the community;
✦ actively involving local organisations, community members and target populations;
✦ establishing an integrated network of community-based services.

It is also important to mention the term 'community empowerment', which implies something more than just community participation.

Being 'community-based' in the context of drug treatment is often perceived as involving little more than placing a residential treatment centre in a community with a few limited aftercare facilities provided in the community. Many services are still based on an approach focused on an in-patient treatment centre.

The community-based approach that tries to establish an integrated model of drug abuse treatment by actively engaging the community, in planning and implementation of addiction treatment and ensure a community-based rehabilitation.

Thus, while both types of approaches are necessary, and ideally should be complementary, it is important to keep in mind what 'community-based' actually means. An example of a response that specifically targeted a community in need is given in Box 2.

**Box 2: Community-based treatment in an Afghan refugee camp in Pakistan**

A community-based drug treatment, rehabilitation and prevention programme was initiated by the United Nations International Drug Control Programme (UNDCP), in the Akora Kattak refugee camp outside Peshawar with an estimated adult population of 9,000 Afghan refugees. The programme provided home-based detoxification and coordinated aftercare and social reintegration activities through a network of local non-governmental organisations, other UN agencies, volunteers and community groups. During the year 2000, the programme made contact with 800 (male and female) drug users in the refugee camp. Over 300 drug users were provided with pre treatment motivational counselling, and 128 males and 102 females were provided with home detoxification. In addition, 150 recovering addicts were provided with work experience, job training or start-up funding for income-generating activities. Six self-help groups, three for male addicts and three for female addicts, were also established in the camp, as well as both male and female community volunteer groups.

The experiences from the programme suggest that a well-resourced community-based treatment programme with fully trained and supported staff can provide a viable and cost-effective home detoxification and treatment scheme for both male and female drug abusers in Afghan communities. Such a scheme, however, requires the full back-up and support of a wide range of community-based aftercare and social reintegration services and facilities, including
As seen in Box 2, the key to the success of the programme was a radical change in the way staff understood drug abuse treatment services. The new concept relied heavily on the effective coordination of a wide range of non-specialist services, i.e., the professional delivery of addiction treatment by the treatment unit and the use of community resources.

1.4 Community approaches to addiction treatment – some examples:

In the area of addiction treatment, the community approach has been tried and successfully implemented.

Dr. Sell (1994) analysed community approach programmes that dealt with drug addiction in Northern Myanmar, India and Sri Lanka. According to him, a community approach involves the following steps.

✦ identifying all drug dependent persons living in one specific locality through multiple entry points.
✦ initiating a process of rehabilitation before detoxification. The basic issue in this step is to spread optimism, de-dramatise withdrawal and de-mystify drugs. It is a process of empowerment, not indoctrination.
✦ bringing together the parents and/or relatives/friends of the users to form a support group for self-help and mutual aid. Community leaders may have to be involved in this process.
✦ mobilising ex-users or other volunteers for assistance in the planning of a detoxification camp and for later work with the users for their transformation into an ex-users' activist group.
✦ organising needed physical facilities inside of the locality which can accommodate the users, parents, and volunteers during the camp.
✦ involving all or almost all users of a locality. If pushers are active in the locality, ways will have to be found to expel those pushers.
✦ maintaining contact with the community by having some of the medical staff stay in the locality to maintain the momentum. Assisting some of the ex-users to find employment or housing or helping them in any meaningful manner.

community networking, to be successful and effective and to prevent relapse.


Box 2 Cont’d...
The community approach, therefore, covers treatment, rehabilitation and prevention. It ideally lends itself to a ‘drug free zone’ in the best of its meanings.

Kaplan, Morival and Bieleman (1993) after observing three camp models viz., opium de-addiction camps at Rajasthan, free treatment for alcoholics conducted by TTK Hospital in Tamil Nadu and the ad hoc camps conducted by the National Dangerous Drug Control Board of Sri Lanka, listed a few salient features of these camps.

✦ All use a comprehensive community approach involving prevention, treatment, rehabilitation and health promotion as well as activities that are integrated with social movements.
✦ All provide a highly structured and intensive therapy for a relatively short period. All restrict themselves to substance dependencies defining their client population fairly specifically.
✦ All initiate treatment with detoxification and expand the services with intensive rehabilitation and counselling.
✦ All employ multi-disciplinary teams involving physicians, psychologists, social workers and ex-addicts as well as multiple methods using medications or herbal remedies for symptomatic treatment instead of substitution drugs like methadone.
It is difficult to implement Low Cost Community-based Care for drug users without a community presence and rapport with the community leaders. In the absence of such community attachment, the implementing agency has to go through a process of identifying a 'host organisation' (which tend to be organisations based in the community and already have the credentials of being involved in social action) and implementing the programme through them. Examples of 'host organisations' are voluntary agencies, rural upliftment societies, churches, etc., mainly non-governmental agencies, (as were used by TTK, Chennai, for treatment of alcoholism through camp approach). Similarly in Sri Lanka, for the addiction treatment of heroin-dependent persons through the camp approach, community infrastructure like temples, school buildings, or community centres with basic residential facilities for 10-15 persons were used. In another instance, community members chose a 'gurudwara' (a religious centre of the Sikh community) for a drug addiction treatment camp.

The LCCS implementing agency must have some knowledge about the prevailing drug use scenario in the area. They should be able to identify, within which geographical area, they should carry out a quick assessment of:

+ The drug use and HIV/AIDS situation - Rapid Situation and Response Assessment (RSRA) of

**Box 3**

"When an inquiry is needed at the country or community level it should ascertain whether or not the perception that drug and alcohol abuse has become problematic is real or not before a formal programme of assessment is developed. To validate these perceptions those involved should examine information already being gathered by specialised agencies, e.g., law enforcement agencies, medical services, social and welfare institutions.

**The key questions to be addressed in an initial inquiry or situation assessment are:**

1. What is the extent of drug and alcohol abuse?
2. Who are the persons involved in such use (e.g., age and sex of users)?
3. What is the nature of the abuse problem (e.g., types of drugs being used; frequency of use; route of administration, etc.)?
4. Why has such drug abuse occurred? Are there changes in availability of drugs, lower prices, or socio-economic changes, e.g., increased urbanisation, unemployment?
5. What are the possible factors initiating and supporting this drug use?
6. What are the resulting social, psychological and health related problems? Are they acute or chronic? How are such consequences affecting family, work and community institutions?
7. What are the social and other factors associated with alcohol and other drug use?"

*WHO Guide to Drug Abuse Epidemiology, 2000.*
drug use can be carried out, if there is not enough data to suggest extent, pattern and current drug use problem. Data collection schedules, may include questions to drug users about their opinion about community-based addiction treatment.

✦ The response to the problem of drug use and HIV/AIDS - for example, an analysis can be made of the existing gap between demand, availability and utilisation of addiction treatment services as well as other community responses to social issues.

✦ Resources - community, external as well as organisational.

✦ Stakeholders - identification of who can be the possible agencies (government, private), individuals who are concerned, affected and may contribute technical resources, material resources, infrastructure including essential supplies or financial support (e.g., families and friends of drug user clients and self-help group of ex-drug users can be of help).

A 10-step process may be helpful in organising the needs assessment. It should be noted that some steps can be done concurrently and that the starting point and sequencing may vary according to the scale and emphasis of the assessment exercise.

Step 1. Allocate resources and establish an agreed plan and methods for the needs assessment.

Step 2. Estimate the number of people in need of treatment in the target population and identify and profile subgroups and priority groups.

Step 3. Prepare a resource map of the treatment services provided in the locality, together with the services that are provided by facilities that are located in other areas.

Step 4. Conduct an audit of the demand profile of treatment services (capacity; number of episodes; and estimated number in need).

Step 5. Hold personal interviews with key informants across different stakeholder and professional groups to discuss strengths and weaknesses of current services and the areas of unmet need.

Step 6. Hold focus groups or other types of open discussions with key stakeholders to explore what they want from services.

Step 7. Compile a report containing an analysis of gaps in the current and desired profile of service provision, including the gap between financial and human resources and services needed or required.

Step 8. Offer recommendations for increasing treatment coverage, purchasing efficiency and service effectiveness based on available evidence.

Step 9. Undertake an assessment of reactions to recommendations from strategists, commissioners, service providers and service users.

Step 10. Develop an implementation plan based on the identification of activities, resources and timetables

(Adapted from 'Drug Abuse Treatment & Rehabilitation: A Practical Planning & Implementation Guide' UNODC, 2003).
Implementation of Low Cost Community-based addiction treatment for drug users will be carried out by agencies that have some experience of drug work in the community. These agencies may have identified specific pockets of substance users, who are away from treatment for different reasons or agencies implementing focused STI/HIV intervention with IDUs, have identified clients, who are willing to go through home-based, community-based addiction treatment. This section will be discussed in seven sub-sections as listed in Box 4.

A. Identification of target population and the setting for LCCS for drug users:
The situation, response, stakeholder and resource assessment should be able to provide adequate information on:

✦ What are the substances being abused by different drug users in the specific community setting
✦ Problems associated with drug abuse affecting the users (biological, economic, social, occupational) families and community (including law and enforcement agencies e.g., arrests/ crime associated with drug use)
✦ The services available to drug users, the capacity and quality of these services, utilisation rates by local drug users

Box 4
Steps for implementation of LCCS for Drug Users:
A. Identification of target population and the community setting for Low Cost Community-based Care for drug users.
B. Staffing
C. Training
D. Preparing the community and the target population
E. Carrying out a Community-based Care and Support programme
F. Supervision and support
G. Follow-up activities

Box 5
The Modality and Its Progress- a community-based addiction treatment in Sri Lanka
This community-based camp method for helping heroin dependents consisted of five stages: (10-15 addicts treated in a camp of 10 days duration) - 
1. Preventive education in locality, combined with the motivation of potential clientele to seek help
2. Preparation of clients for detoxification, family counselling and organising community for conducting a camp
3. Detoxification
4. Development of a further treatment / rehabilitation plan by clients with the assistance of family members and community leaders
5. Follow-up.
**B. Staffing:**
There are primarily four sets of activities, for which staffing is required:

**Before the camp:**
- i) Situation and response assessment
- ii) Community mobilisation, motivating drug user clients, mobilising community resources

**The Camp:**
- iii) Organising the camp, provision of medical treatment and psychotherapy to drug users for addiction treatment. Active engagement of family and community members.

**After the camp:**
- iv) 'After Care' outreach support to the recovered drug users in the community to facilitate stabilisation and maintenance of recovery from addiction.

**LCCS Team:**
The NGO Team-leader with either an ex-drug-use or drug-work background can be identified, who would also lead the therapy staff during the camp. This person would be assisted by an 'Outreach Coordinator', who would also be part of the therapy staff in the camp (Figure 1).

The NGO Team Leader and the Outreach Coordinator would be assisted by a set of four male recovering persons as 'Field Workers'. The field team, with the help of the community organisation, will identify two female 'community workers' from the community. They can be members of that host/community organisation or relatives of a drug dependent person or members of a women's Self-Help Group (SHG). This would be essential, not only to reach the wives and family members of drug users but also to enhance the scope of identifying hidden female drug users and improving their access the camp-based addiction treatment. This team would be primarily responsible for implementation of the project.

The implementing agency would assist this team of people to identify a formal community/host organisation in the identified project area, where at least 200-300 opioid and alcohol dependents can be found. The geographical location can be in semi-urban or rural setting (to be decided based on situation assessment). The assumption here is that most drug users stay in far off rural/semi-urban settings and do not access expensive inpatient facilities.

- The situation assessment, community mobilisation, organising the camp and after care in the community will be carried out primarily by the outreach coordinator, four male field workers and two female community workers.
✦ The Team Leader, with overall responsibility, will be instrumental in organising resources, networking and being responsible for managing the addiction treatment camps.

✦ The Outreach Coordinator will be head of the field team for being primarily responsible for pre-camp outreach work and post-camp follow up. He/she will also be a part of therapy staff, along with NGO Team Leader.

✦ Agencies with minimal experience in addiction treatment may require assistance of following staffs, such as one trained counsellor, preferably with experience in psychotherapy of substance users during addiction treatment, one medical doctor, three nursing attendants (to work in three shifts).

✦ NGO Team Leader, Outreach Coordinator and a trained counsellor (engaged temporarily during the camp) forms a three-member team of therapy staff during the camp and each one should take charge of all inputs and record maintenance for 5 to 8 clients in the camp, including their family members.

✦ The ex-drug users recruited, as 'Field Workers' will be assisting in different activities of the camp.

✦ Each camp will try to treat 15 to 25 addicts (fulfilling recruitment criteria) for a duration of 10 to 15 days, based on the addiction history, type of drug used, mode of intake and associated illnesses.

![Figure 1](image-url)
C. Training:
Training must be completed before actual field implementation of the project. Training would be coordinated by the mentor/consultant and concerned faculties/trainers should be identified by him/her to impart essential qualities and skill of the intervention team. A tentative five-day training schedule is given in the Annex. Areas for training would include:

i) Basics on psychoactive drugs, drug dependence, harmful effects (including STI/HIV vulnerability), treatment models, drug work, concepts and approach of Low cost Community-based Care for drug users.

ii) Implementing camp-based addiction treatment - organising a camp, client assessment.

iii) Fieldwork in LCCS - basics of outreach, community mobilisation, motivational skills, after care outreach.

iv) Camp-based addiction treatment - psychotherapy skills for drug users and family, after care follow up.

v) Planning, documentation and reporting - instruments for assessments.

+ Training inputs would be based on a facilitator’s guide developed by trainer / consultants.

+ Participatory training methodologies and skills practice session coupled with practical orientation during a camp would be essential for building up the skills of trainees.

D. Preparing the community and the target population:
Preparing the community and the drug users to come forward and join hands in addressing the drug use problem requires the creation of a better understanding of the problem and making them realise their strength in addressing it. This calls for developing a carefully designed IEC (Information, Education and Communication) strategy, based on the situation and response assessment. Simultaneously, work can be started with current drug users, family members, opinion leaders and local service providers.

Field workers, with previous drug use history and now in recovery programmes, would work as peer influencers and motivate current drug users to access addiction treatment services but they also add value to community mobilisation campaigns, and act as role models to family members as well. After analysis of the situation and response assessment findings, the implementing agency will identify the geographical area of work and identify the host organisation and local leaders and try forming a 'local committee', which would be encouraged to take a lead role in the entire project implementation. In the meantime, the field worker with the help of and the outreach coordinator, would start working with current drug users and simultaneously female community workers would be assisted to work with their families on a one-on-one basis. The intention would be to gradually bring them together and elevate their motivation level.
towards opting out of drug use, cooperating in and benefiting from addiction treatment. The idea of community-based addiction treatment should be brought in as an option, not a compulsion.

During this campaign period, the drug users should be provided with messages for STI/HIV risk reduction and will be linked to risk reduction services, based on assessed need. Situation and response assessment would be able to gather information about various ongoing HIV/AIDS intervention with different vulnerable population groups and addiction treatment facilities. Collaboration with such programmes would help in identifying drug users in need of addiction treatment services, residing in specific geographical area.

### E. Carrying out a community-based care and support programme:
Following the basic principles of planning. The implementation of addiction treatment and after care plan should include:

i) Listing out current drug users and preparing them for addiction treatment, following an eligibility criteria.

ii) Facilitating identification of the community infrastructure to be used for addiction treatment camp by the 'local committee' and 'host organisation'.

iii) Scheduling the time and duration of the camp through active consultation with all stakeholders and making sure that space identified for the camp is available during that time.
iv) Making the host/community organisation responsible for organising and managing the camp through shared responsibilities

v) Identifying the resources required to carry out the addiction treatment for 15 to 25 drug users for a period of 10 to 15 days, including the service providers.

vi) After clear interaction, developing a simple plan, presenting it to the team which will be involved in the camp, so that everyone knows who will be doing what. This means writing down and handing over a list of specific task/s with a timeline, (procurement responsibility should mention source and quantity) to everyone responsible for the specific task before, during and after the camp.

vii) Preparing a master checklist of activities, timeline and the names of persons against each task.

viii) Arranging for safety and security in the premises, where the addiction treatment camp will be organised.

ix) Doing a 'procurement plan' meticulously for all the materials needed, including medicines and consumables, with the help of technical people, like psychotherapists, doctors and nursing attendants.

x) Keeping local health and law/enforcement agencies informed for help, if required and making prior arrangements for quick referral in case of medical emergencies.

xi) Making arrangements for recreation for addiction treatment seekers.

xii) Working with the families of current users and organising the scope of their contribution in the camp (e.g., bed rolls for addicts, food, water supply, cleaning) and also not forgetting to arrange resting facility for the service providers.

xiii) Preparing a code of conduct (including a camp schedule/routine) for everyone, including the treatment seekers and making sure that is finalised after consultation. A written 'code of conduct' (refer to Module 2 on Peer-Led Intervention) needs to be communicated and agreed upon and, if required, be displayed prominently as a reminder to all concerned.

F. Supervision and support:
The Team Leader is responsible for periodic supervision, based on the activity plan drawn up for 12 months. But day-to-day supervision will be the responsibility of the Outreach Coordinator.

1. The NGO Team Leader and Outreach Coordinator have the primary responsibility of supervision and support. They must remind themselves that flexibility along with transparency in decision-making and accountability with teamwork spirit is absolutely essential for the successful implementation of the project.
2. Each of the project staff must have access to written job responsibilities and training provided to carry out the job. The Team Leader and Outreach Coordinator along with field staff should be able to develop a 'code of practice' for all the team members. (Refer to Box 12 in Module 2 entitled 'Peer-led Community Outreach Intervention': An example of a 'Code of Practice' for Peer Outreach Workers/Peer Outreach Coordinators).

3. The Outreach Coordinator should provide regular supervision for all Field Workers – a minimum of once every two weeks. Supervision is vital and should not be put off or given a low priority.

4. Supervision is a two-way process and provides an opportunity for encouragement, for a review of activities, for the setting of new targets and priorities, and for addressing any issues relating to the job.

5. The NGO Team Leader should be aware that, in order to work effectively, the Outreach Coordinator will be the direct supervisor-in-charge of the outreach work and they, along with the Field Workers and Community Workers, may have contact with people engaged in illegal activities and therefore must sometimes operate at times and in places quite different from usual health service staff. The Team Leader should offer appropriate advice and guidance for workers in this situation, to ensure their safety and security.

6. The Team Leader should ensure that there is a time for team support from others working in the agency/organisation and that there are opportunities for Field Workers to contribute to the work of the team.

G. Follow-up activities:

- Follow-up would be important for each client to assist in the client's recovery and stabilisation in the family and community setting, after he/she receives camp-based addiction treatment.

- A planned follow up would also help in understanding the effect of inputs provided by the intervention as it may help in identifying gaps and making the necessary changes in service delivery.

a) *Follow-up services to client* – After the addiction treatment camp, each client would receive follow-up services for at least one year following the camp. Services would be provided at home and community through Field Workers and Outreach Coordinator. It would be important to also provide facilities for clients and their families to access professional services of the organisation, whenever needed.

Client follow-up should be discussed and agreed upon jointly by the client, their family members and the organisation implementing Low Cost Community-based Addiction Treatment, as a part of the terms and conditions on Day 1 of the camp.
LCCS is intended to create a suitable addiction treatment option, which is affordable and easily accessible. It also creates a congenial community environment for after care through participation of family and community. Finally, it attempts to bring down the extent of stigma and discrimination associated with drug use and sometime added stigma of HIV/AIDS for injecting drug users.

b) Planned Follow-up – Follow-up activities help in assessing and evaluating the effectiveness of camp-based addiction treatment. Simple questions need to be prepared and information needs to be collected through one-to-one interaction, focus group discussion and observations. After the completion of each camp, it is mandatory to call community meetings immediately and members of the general community and the drug users need to be appreciated for their participation and contribution.
Monitoring is essential to ensure that the intended project objective can be achieved within the given time frame following the activities as planned to be carried out by project personnel. It is also essential to have some mechanisms in place so that LCCS for Drug Users, during its implementation, accomplishes its intended objective.

Any intervention effort should attempt to document the process of implementing (process indicators) as well as measuring change (outcome indicators) that might have taken place due to such intervention in a population group. Both process and outcome indicators can and should be measured by quantitative as well as qualitative data.

**Qualitative Monitoring**

For qualitative monitoring, 'field notes' (recording exact verbatim, exact description of a situation happening on the ground) play a great role.

**Qualitative indicators – Process:**

- What the target population does not find okay with the existing IEC materials and what changes they suggested and finally brought in through intervention programme?
- Has the target population taken part in further modification of IEC materials as felt appropriate?
- What does the qualitative record-keeping (filed notes) reflect with regard to the target population groups' opinion on the quality of services (timing, attitude of different categories of workers, efficacy) of intervention programme?
- What does the qualitative record-keeping reflect in terms of the opinion of target group on 'whether the communication mode and message was changing according to the community needs?'
- Perceived changes in the quality of lives by the target group members (indirect indicator of empowerment of target group which in turn helps in positive behaviour change).
- Number of the members of target group and general community members involvement in different stages of intervention programme development (indicator of how participatory has been the program)
- How many times community people have contributed in programme implementation in terms of time and materials.
Decision making positions held by the members of the target group (indirect indicator of empowerment).

**Qualitative indicators – Outcome:**
- Documenting changes in risk perception and practices through focus group discussions.
- Documenting the adherence to addiction treatment in each camp through camp records, field observations documented by Field Workers and Outreach Coordinators in their personal diaries.

(A few more indicators would be essential to measure the impact of 'camp-based addiction treatment' and community-based rehabilitation of drug users through continued follow-up)

**Quantitative Indicators:**
For quantitative monitoring, one can use either already available secondary data (also called historical data) or baseline data can be generated during initiation of the programme. Compiled data available from research agencies can be a good starter, if they can define the situation both in quantitative and qualitative terms. A new study for generating baseline data may unnecessarily delay the whole process of implementing or quick scaling up of the intervention.

- What proportion IDUs contacted through outreach, has accessed camp-based addiction treatment?
- Among total number of IDUs registered for the camp, how many could complete the addiction treatment in the camp?
- How many IDUs among total attending the camp, needed emergency referral from the camp?
- How many IDUs among total attending the camp, needed additional in-patient based psychotherapy following the camp?
- How many IDUs, among the total number attending the camp could maintain sobriety for one year or more?
- How many IDUs living with HIV/AIDS, indicated to start ART, could maintain sobriety to initiate ART, after attending the camp?
- What proportion of the population group had myths about drug addiction and HIV/AIDS before the programme and what is the status after one year of execution of the intervention programme?
- How many injecting episodes are safe - before and after intervention?
- What was the treatment seeking status before and which way has it changed after programme implementation (includes addiction treatment)?
- How many IDUs are seeking STI treatment?
What proportion of reduction of STI cases among drug users/IDUs has been achieved?

What proportion of drug users/IDUs are 'consistently/always using' condoms with commercial sex workers and unknown sexual partners, before and after one year of the intervention programme?

What proportion of commercial sex acts were 'protected', particularly in the case female/male IDUs (who are engaged in commercial sex), before and after one year of the intervention programme?

What proportion of IDUs (both male and female) are capable of 'negotiating safe sex/using condom' with their regular partners?

**Some Important Reminders**

- Personal details of the members of the target group along with identifiers do not serve as any monitoring indicator of public health importance. NGOs should avoid recording them, as this is unethical.

- Collecting huge amount of information just for information's sake, the utility of which is not clear either to the implementing or external monitoring agency, not only wastes time but also compromises the quality of intervention. Lessons learnt from many such programmes is 'only collect information that has practical applications in measuring the progress towards objectives and helps in appropriating improving the intervention further'.
5. CHECKLIST FOR MENTOR/S

A monitoring system based on checklists helps in improving the quality of work. In addition, a mentor/consultant should pay attention to the following issues (would include primarily training and implementation progress during three phases of the project, namely preparatory phase, conduction of camp and follow-up):

✦ Have members who could play an important role in fostering intervention support once the situation and response assessment comes to its completion been included in the local committee?
✦ Has the participation of drug users, in every stage of the assessment, been ensured?
✦ Has the participation of all sections of the community been ensured before and after the camps?
✦ Whether the community organisation has been identified for arranging the community events, including the addiction treatment camp?
✦ Are the trainees getting enough opportunity to raise their concerns, ask questions and clarifying their doubts during training?
✦ Has the safety of the field workers in the field been adequately ensured? It should also be ensured that the respondents are not endangered because of being involved in the assessment.
✦ Are the field workers introducing themselves and the work, ensuring confidentiality and voluntary participation and obtaining informed consent before undertaking any primary data collection from a participant or a group of participants?
✦ Are the rules of 'not buying articles or accepting gifts from respondents' and 'not raising false hopes in the community' being followed during fieldwork?
✦ Have linkages been forged with health care outlets (including STI/HIV risk reduction services) and addiction treatment centres where respondents can be referred in case necessity arise?
✦ Do field workers, based on their personal diaries and work plan, submit their report?
✦ Is positive feedback as well as suggestions to address the gap in their intervention being provided to the field workers by their supervisors?
✦ Is there a reporting mechanism from the field to the central coordinating office?
A suggested checklist for monitoring addiction treatment camp:

✦ Whether the staff is trained to conduct the camp?
✦ Whether the operational plan for conducting the camp is available to all concern staffers, before the camp?
✦ Whether concerned personnel have been informed and consulted on implementing the camp as planned?
✦ Do all staffers and concerned experts know their roles and responsibilities clearly?
✦ Whether required materials have been procured before the camp, based on a procurement plan?
✦ Is the written 'code of conduct' displayed at the campsite and known to all concerned staffers and clients?
✦ Whether the 'camp routine' is discussed, agreed upon with the client and displayed at the campsite?
### 6. COSTING IN TERMS OF MANPOWER, MATERIALS AND TRAINING

A suggested sample of costing heads is given below:

<table>
<thead>
<tr>
<th>Human resource (all full time except the camp staffs)</th>
<th>Material</th>
<th>Training</th>
<th>Subtotal</th>
<th>5% contingency</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Team Leader</td>
<td>Desktop PC with printer</td>
<td>7 days training for all staffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Outreach Coordinator (Male)</td>
<td>IEC materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four Field Workers (males)</td>
<td>Movement &amp; support in the field for Field work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Community Workers (Female)</td>
<td>Addiction treatment - 8 camps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Trained Counselor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three Nurses/Nursing Attendants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. REFERENCES


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Tentative Training schedule on "Low Cost Community-based Care for Drug Users"

(Practical field-based training will be more useful, rather than a classroom approach for developing capacity on Low Cost Community-based Care for Drug Users)

A 5 days training during the onset of the intervention and a 2 days follow up training after 6 months, is suggested for LCCS, with an assumption that the trainees have already undergone a training on RSRA and PLI.

0 day - Spending a full day with identified co trainers, prior to the 5 day training will be essential to include hands-on TOT process along with ongoing training during an addiction treatment camp. The meeting would discuss roles and responsibilities, training process and methodologies, simultaneously ensuring availability of training materials, finalizing fieldwork logistics as a part of training.

Day 1 - session schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 am – 9.30 am</td>
<td>Registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.30 am – 10 am</td>
<td>Session - 1 Welcome to participants and training programme overview</td>
<td>To develop clarity among the trainees about the intervention program and purpose of LCCS training.</td>
<td>Power point presentation</td>
</tr>
<tr>
<td>10 am – 10.30 am</td>
<td>Introduction of participants through ice-breaking game; ground Rules, Selecting 2 candidates for recap of pre and post lunch session of day 1.</td>
<td>To know each other To set out ground rules to be followed by all. To identify volunteers for recap of first day training process to be done on the morning of day 2.</td>
<td>Ice-breaking game.</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Objective</td>
<td>Method</td>
</tr>
<tr>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Session - 3</strong></td>
<td>10.30 am – 11.30 am</td>
<td>Problem analysis on country scenario on drug use and HIV</td>
<td>Brainstorming and free listing, followed by short power point presentation.</td>
</tr>
<tr>
<td>11.30 am – 11.45 am</td>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 4</strong></td>
<td>11.45 am – 12.45 pm</td>
<td>Effects of commonly abused drugs on human body and link of substance abuse with HIV, HCV</td>
<td>Mind mapping followed by Power point presentation</td>
</tr>
<tr>
<td><strong>Session - 5</strong></td>
<td>12.45 pm – 1.30 pm</td>
<td>Ongoing interventions for drug use in the country and strengths and gaps in different responses. - why LCCS</td>
<td>Brainstorming followed by discussion and short power point presentation on LCCS.</td>
</tr>
<tr>
<td>1.30 pm – 2.30 pm</td>
<td><strong>LUNCH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 6</strong></td>
<td>2.30 pm – 3.30 pm</td>
<td>Understanding drug addiction</td>
<td>Small Group work – case study analysis. Plenary discussion</td>
</tr>
<tr>
<td><strong>Session - 7</strong></td>
<td>3.30 pm – 4.30 pm</td>
<td>Pros and cons of different Addiction Treatment Models</td>
<td>Brainstorming and free listing followed by power point presentation.</td>
</tr>
<tr>
<td>4.30 pm – 4.45 pm</td>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Day 2 - session schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session - 1</strong>&lt;br&gt;9.30 am – 10 am</td>
<td>Recap of the first day and selection of the participants for recap on the next day</td>
<td>To make participant understand the importance of actively engaging the family and community in initiating, stabilizing and maintenance of recovery from drug dependence by the addict</td>
<td>Oral presentation (may be helped by power point slides)</td>
</tr>
<tr>
<td><strong>Session - 2</strong>&lt;br&gt;10 am – 11 am</td>
<td>Drug, family and society – role of family and community in addiction treatment process</td>
<td>To bring in clarity on 'Networking with community stakeholders' through planned advocacy strategy – the usefulness of RSRA</td>
<td>Role-play and plenary discussion.</td>
</tr>
<tr>
<td><strong>Session - 3</strong>&lt;br&gt;11 am – 11.30 am</td>
<td>Community engagement process – Stakeholders analysis and establishing linkages with various services</td>
<td>-</td>
<td>Case study analysis in plenary.</td>
</tr>
<tr>
<td></td>
<td>11.30 am – 11.45 am</td>
<td><strong>Tea</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Day 3 - Session Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session - 4</strong>&lt;br&gt;11.45 am – 12.30 pm</td>
<td>IEC in Community mobilization</td>
<td>To bring in clarity on the importance of an IEC strategy for effective community mobilisation</td>
<td>Small group work followed by power point presentation on IEC</td>
</tr>
<tr>
<td><strong>Session - 5</strong>&lt;br&gt;12.30 pm – 1.30 pm</td>
<td>Community drug work skills</td>
<td>To enhance basic communication skills</td>
<td>Skills practice session on interpersonal and group communication</td>
</tr>
<tr>
<td>1.30 pm – 2.30 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 6</strong>&lt;br&gt;2.30 pm – 3.30 pm</td>
<td>Who is more important – a drug user, family member or community</td>
<td>To reinforce the need of ethical principle to be followed in community drug work</td>
<td>Exercise - 'Agreement' &amp; 'Disagreement'</td>
</tr>
<tr>
<td><strong>Session - 7</strong>&lt;br&gt;3.30 pm – 4.30 pm</td>
<td>Assessing IEC needs</td>
<td>To develop skills in assessing IEC needs</td>
<td>Small group work and role play</td>
</tr>
<tr>
<td>4.30 pm – 4.45 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 8</strong>&lt;br&gt;4.45 pm – 5 pm</td>
<td>Resource Mapping</td>
<td>To develop skills in resource mapping</td>
<td>Skills practice</td>
</tr>
<tr>
<td><strong>Session - 9</strong>&lt;br&gt;5 pm – 5.15 pm</td>
<td>Feedback from participants</td>
<td>-</td>
<td>Mind mapping</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
<td>Objective</td>
<td>Method</td>
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<tr>
<td>-----------------</td>
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</tr>
<tr>
<td>11.30 am – 11.45 am</td>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 3</strong></td>
<td>11.45 am – 12.30 pm</td>
<td>Entry points – networking with different agencies working in drug use and HIV/AIDS</td>
<td>Brainstorming and free listing, followed by power point presentation</td>
</tr>
<tr>
<td><strong>Session - 4</strong></td>
<td>12.30 pm – 1.30 pm</td>
<td>Motivational skills</td>
<td>Role play</td>
</tr>
<tr>
<td>1.30 pm – 2.30 pm</td>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 5</strong></td>
<td>2.30 pm – 3 pm</td>
<td>Home detoxification before camp.</td>
<td>Power point presentation Mind mapping followed by power point presentation</td>
</tr>
<tr>
<td><strong>Session - 6</strong></td>
<td>3 pm – 3.30 pm</td>
<td>Intake assessment</td>
<td></td>
</tr>
<tr>
<td><strong>Session - 7</strong></td>
<td>3.30 pm – 4.30 pm</td>
<td>Managing of withdrawal and dependence – opiate / opioid users</td>
<td>Brainstorming and free listing, followed by short power point presentation.</td>
</tr>
<tr>
<td>4.30 pm – 4.45 pm</td>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 8</strong></td>
<td>4.45 pm – 5 pm</td>
<td>Relapse prevention</td>
<td>Brainstorming and free listing</td>
</tr>
<tr>
<td><strong>Session - 9</strong></td>
<td>5 pm – 5.15 pm</td>
<td>Feedback from participants</td>
<td>Mind mapping</td>
</tr>
</tbody>
</table>
# Day 4 - session schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session - 2</strong></td>
<td>Introduction to structured psychological therapy</td>
<td>To reinforce clarity on importance of structured psychological therapy in addiction treatment</td>
<td>Small group work, followed by power point presentation</td>
</tr>
<tr>
<td>10 am – 11 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 3</strong></td>
<td>Group therapy</td>
<td>To introduce participants on 'group therapy in addiction treatment'</td>
<td>Brainstorming and free listing followed by short power point presentation</td>
</tr>
<tr>
<td>11 am – 11.30 am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.30 am – 11.45 am</td>
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<td></td>
</tr>
<tr>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 4</strong></td>
<td>Mock session on group therapy skills</td>
<td>To help participants in fine tuning their group therapy skills</td>
<td>Role play for skills practice</td>
</tr>
<tr>
<td>11.45 am – 12.45 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 5</strong></td>
<td>Counselling skills</td>
<td>To reinforce counseling skills</td>
<td>Role play followed by short power point presentation</td>
</tr>
<tr>
<td>12.45 pm – 1.30 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.30 pm – 2.30 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 6</strong></td>
<td>Family Therapy</td>
<td>To reinforce on family therapy skills</td>
<td>Skills practice through role play, followed by short presentation.</td>
</tr>
<tr>
<td>2.30 pm – 3.30 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 7</strong></td>
<td>Basics on Organising an addiction treatment camp</td>
<td>To impart knowledge on basic steps in organizing an addiction treatment camp</td>
<td>Brainstorming and free listing, followed by power point presentation</td>
</tr>
<tr>
<td>3.30 pm – 4.30 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.30 pm – 4.45 pm</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Tea</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Session - 8</strong></td>
<td>Developing a daily camp routine / schedule</td>
<td>To reinforce need of structured programme for achieving intended treatment outcome</td>
<td>Brainstorming and mind mapping</td>
</tr>
<tr>
<td>4.45 pm – 5 pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 pm – 5.15 pm</td>
<td>Day's feedback</td>
<td></td>
<td>Mind mapping</td>
</tr>
</tbody>
</table>
Day 5

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Objective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session - 1</td>
<td>9.30 am – 10 am</td>
<td>Recap of the 4th day - and selection of the participants for recap on the next day</td>
<td>Oral presentation (may be helped by power point slides)</td>
</tr>
<tr>
<td>Session - 2</td>
<td>10 am – 1.30 pm</td>
<td>Practical orientation at addiction treatment camp site</td>
<td>Camp visit</td>
</tr>
<tr>
<td></td>
<td>1.30 pm – 2.30 pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Session - 3</td>
<td>Follow up services</td>
<td>Brainstorming and free listing followed by power point presentation</td>
</tr>
<tr>
<td>Session - 4</td>
<td>2.30 pm – 3.30 pm</td>
<td>Developing operational plan for LCCS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.30 pm – 4.30 pm</td>
<td>To ensure development of clarity on the implementation steps of LCCS intervention</td>
<td>3 small group exercises, followed by power point presentation</td>
</tr>
<tr>
<td>4.30 pm – 4.45 pm</td>
<td>Tea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.45 pm – 5 pm</td>
<td>Written feedback from trainees and co trainers</td>
<td></td>
<td>Feedback form</td>
</tr>
</tbody>
</table>

2 days Follow Up training – content of the training should be based on training need assessment after at least implementation of one addiction treatment camp.
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’.

*From a report prepared by V.Thirumagal (Consultant)*

**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.

<table>
<thead>
<tr>
<th>Phase 1 - Preparatory phase</th>
<th>Phase 2 - Camp programme</th>
<th>Phase 3- Follow up</th>
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<td>Awareness programs in community</td>
<td>Identify, Motivate &amp; Select clients</td>
<td>Home detox.</td>
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**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 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 outreach 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 provide 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, inpatient 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:**

- 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.
- At DIC or treatment unit of the organizing agency - can be accessed whenever the client wants support.
- 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.
LOW COST COMMUNITY-BASED CARE FOR DRUG USERS

INTERVENTION TOOL-KIT
UNDER TESTING