2009

Minimum Standards of Care

For the Government De-Addiction Centres

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PREFACE

Substance use disorder is best conceptualized as a chronic, non-communicable disease. The disorder requires a comprehensive treatment, delivered by trained professionals, belonging to various disciplines, in a variety of settings. Consequently there is always scope for disagreement regarding what constitutes standard treatment for substance use disorder.

The Ministry of Health and Family Welfare, Government of India (Drug-De-addiction Programme-DDAP) has been involved in drug demand reduction activities by providing treatment services in the country. For the purpose, till date the ministry has supported 124 treatment centres (De-Addiction Centres, DACs) throughout the length and breadth of the country in various settings like Community Health Centre, District Hospital and departments of Psychiatry in Medical Colleges.

Field visits and assessment of these centres conducted by us have revealed lack of defined standards of care of at these government de-addiction centres. However, it is a challenge to arrive at the consensus upon what constitutes a standard approach or minimum level care.

For this purpose, The National Drug Dependence Treatment Centre (NDDTC), AIIMS, with the support of the DDAP has developed this document "Minimum Standards of Care for Government De-Addiction Centres." The development of this document has involved contributions from a number of experts in the area. Subsequently the draft guidelines presented here have also been discussed with experts from other sectors and their feed-back has been incorporated.

It is expected that the contents of this document may undergo revision, with the advancements in the fields and as new insights will emerge from experience. However, implementing the standards proposed in this documents and monitoring the extent to which these have been adhered to, will be the key issues for success of the Drug De-Addiction Programme of Ministry of Health and Family Welfare, Government of India.

I am sure that like the previous publications, this monograph too would be immensely useful tool for health professionals, programme managers, and policy makers alike.

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ACKNOWLEDGEMENTS

No work of any merit is possible without contributions from several ends. We wish to express our sincere gratitude to all those who made this work possible.

First and foremost, we would like to express our sincere thanks to the *World Health Organisation (India)* for the generous funding support to develop this monograph. We also acknowledge the *Drug De-Addiction Programme (DDAP)* at the Ministry of Health and Family Welfare, Government of India, for their support and encouragement. A special mention has to be made of Joint Secretary, *Mr. Debashish Panda* for his interest and involvement.

Acknowledgements are also due to the *Director* and the *Dean*, All India Institute of Medical Sciences for permitting us to carry out this work.

We also wish to express our deep appreciation and gratitude to *Professor Rajat Ray*, *Chief, National Drug Dependence Treatment Centre (NDDTC)* for being the guide and the source of encouragement.

We must also acknowledge all the experts and reviewers who participated in the meeting on Minimum Standards of Care and provided their valuable feedback.

We are grateful to all the *contributors* who undertook the mission of bringing this manual out on a war footing. Special thanks are due to each and every one of them.

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CONTENTS

INTRODUCTION

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BACKGROUND

Substance use disorders usually entail a comprehensive treatment, delivered by trained professionals, belonging to various disciplines. Consequently there is always scope for disagreement regarding what constitutes standard treatment for substance use disorder.

In India, The drug dependence treatment sector is still developing and undergoing refinement. The treatment services for substance use disorder in India are delivered by three major players[1]. The first major player is the Non-Governmental Organisation (NGO) sector. There are around 430 drug dependence treatment centres throughout the country, which are being run by NGOs, supported by the Ministry of Social Justice and Empowerment, Government of India (MSJE, 2008). Another major group is the private sector; many doctors including a large number of psychiatrists are providing services to people for substance use related problems. The third major group is the government de-addiction centres[2] ('DACs'). The Ministry of Health and Family Welfare (MOH&FW), Government of India, has established about 122 drug dependence treatment centres (or 'DACs' as they are called) throughout the length and breadth of the country(Panda, 2007). Most of these government centres are associated with either general hospitals at the district levels or with departments of Psychiatry at certain medical colleges.

With so many service providers in the country trying to tackle the problem of substance use disorders, it becomes important to look at the services provided to the substance users and their quality. To ensure quality, it becomes imperative to set up certain minimum-standards of care provided by various treatment agencies. While, it is well accepted that certain standards need to be in place while delivering substance use treatment services, it is a challenge to arrive at the consensus upon what constitutes a standard approach? There are no satisfactory, widely-accepted answers to the questions like, what should be the bed-strength for a district level in-patient treatment unit? How many doctors and nurses are required to run such a unit? How should the staff members be trained? What should be done to ensure that the facilities are running as per the accepted standards?

In order to find answers to such questions, the National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS) was asked to develop certain guidelines with regard to Minimum Standards of care for Government De-Addiction Centres. The first initiative was publication of the newsletter Drug Abuse: News-n-Views (April 2007), on the theme of Minimum Standards of care. As the next step, the current document – a multi-authored monograph – has been produced. Though the monograph is intended primarily for the de-addiction centres in the

[1] It must be noted that the three major groups of service providers mentioned here include only those who usually adopt a 'medical model' for the treatment of substance use disorders. There are other kinds of organizations which provide services for substance users adopting other approaches such as a predominantly behavioural / social approach (e.g. Therapeutic Communities) or a spiritual / religious approach (e.g. those following a 12-step model such as Alcoholic Anonymous).

[2] The term 'de-addiction' is a non-specific and vague term, which does not fully capture the intended meaning. The preferred term, we propose, should be "substance use disorder treatment." However, the term 'de-addiction' remains in popular usage, particularly in the Indian health system. In this document terms 'de-addiction' and 'substance use treatment' have been used interchangeably.

government sector, other sectors may also find it useful. This chapter serves as a backdrop for the monograph.

Establishing Minimum Standards of Care: International and National Efforts

World over, attempts have been made to formulate standards for delivery of substance-use treatment services. The World Health Organisation in the year 2000 produced a document titled *International guidelines for the evaluation of treatment services and systems for psychoactive substance use disorders* (WHO, 2000). This document basically provides an overview of methods which should be employed to evaluate substance use treatment services. As a part of its Drug Abuse Treatment Toolkit series, the United Nations Office on Drugs and Crime also produced a document in the year 2003, titled *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* (UNODC, 2003). The document which, has been designed to be a practical resource for Governments, policy planners, service commissioners and treatment providers, promotes a systematic approach to thinking about drug use problems, as well as to planning and implementing services. It advocates a logical, step-by-step sequence that links policy to needs assessment and treatment planning and implementation to monitoring and evaluation. A reflection of the concept of minimum standards of care could also be found in the series of documents from Europe titled *Adequacy in Drug Abuse Treatment and Care in Europe* (WHO, 2003). This four-part series of documents came about as a result of a WHO project in which all aspects related to adequacy of drug abuse treatment – Ethical Aspects, Treatment and Support Needs of Drug Users, Professionalism, Effectiveness and Economics – have been examined and reported upon.

In the year 2007, National Quality Forum of USA – in response to the observed variations in the quality of substance use treatment services – produced the *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices* (NQF, 2007). These standards were developed with the understanding that consensus on effective treatment practices can focus the development of measures of quality. For each endorsed practice, the target outcomes were identified, and additional specifications were provided for what a practice entails, for whom it is indicated, who performs it, and the settings where it is provided (see table 1).

Many developed countries have also developed standards for not only for treatment services for substance use in general but for specific issues such as opioid treatment programs (*CSAT guidelines for the accreditation of opioid treatment programs* [SAMHSA, 2006]*)* and Co-occurring Psychiatric and Substance Use Disorders (*Principles for the care and treatment of persons with co-occurring psychiatric and substance disorders*[American Association of Community Psychiatrists, 2000]*)*.Not just the centres or services, but initiatives have been taken to provide standards for the human resources too, by providing certification or accreditation for staff after training (more details have been provided elsewhere in the monograph).

The Colombo Plan Secretariat (Drug Advisory Programme) has also developed a comprehensive document titled *Guidebook on Minimum Standards; Management of Drug Treatment and Rehabilitation Programmes in Asia*. The document addresses issues like organisation of the programmes, human resource development and systems and procedures (Colombo Plan, 2005).

Table 1: National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices
Screening and Case Finding
1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use.
2. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population.
Diagnosis and Assessment
3. Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centred treatment planning for substance use illness and any coexisting conditions.
Brief Intervention
4. All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive a brief motivational counselling intervention by a healthcare worker trained in this technique.
Promoting Engagement in Treatment for Substance Use Illness
5. Healthcare providers should systematically promote patient initiation of care and engagement in ongoing treatment for substance use illness. Patients with substance use illness should receive supportive services to facilitate their participation in ongoing treatment.
Withdrawal Management
6. Supportive pharmacotherapy should be available and provided to manage the symptoms and adverse consequences of withdrawal, based on a systematic assessment of the symptoms and risk of serious adverse consequences related to the withdrawal process. Withdrawal management alone does not constitute treatment for dependence and should be linked with ongoing treatment for substance use illness.
Psychosocial Interventions
7. Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses.
Pharmacotherapy
8. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
9. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.
10. Pharmacotherapy should be recommended and available to all adult patients diagnosed with nicotine dependence (including those with other substance use conditions) and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with brief motivational counselling.
11. Patients with substance use illness should be offered long-term, coordinated management of their care for substance use illness and any coexisting conditions, and this care management should be adapted based on ongoing monitoring of their progress.

National Quality Forum (2007)

In India too, efforts have been made to develop standards of health care. While experts opine that, in general, the standards of health care in India leave a lot to be desired (Satpathy 2005), some initiatives like the "Indian Public Health Standards" have been taken. Though the Bureau of Indian Standards

had proposed standards for various categories of health-care facilities, these had been commented upon as being too resource-intensive and hence not achievable. To address this, and in order to ensure quality of services, under the National Rural health Mission, the Indian Public Health Standards (IPHS) have been set up for various levels of health-care facilities like the Primary Health Centres, Sub-Centres, and Community Health Centres etc. so as to provide a yardstick to measure the services being provided (MOHFW, 2006). These standards have been organised under different heads like, Services, Infrastructure, Supplies, and Staff etc.

In the area of substance use disorders too, a manual on minimum standards of care has been developed by the Ministry of Social Justice and Empowerment, with support from the NGOs, implementing the ministry's scheme for Treatment and Rehabilitation of Addicts. It is noteworthy that this manual has been prepared in participatory manner, involving all the stakeholders (see box).

Minimum Standards of care in the NGO sector

For the NGOs running de-addiction centres under the Ministry of Social Justice and Empowerment, a Minimum standards of care document was produced. This was drafted initially by one of the leading NGOs in the country, in the area of substance use treatment - the TT Ranganathan Clinical and Research Foundation ('TTK Hospital'). Further refinement of the drafts took place through discussion with an increasing number of NGOs. Recently the Minimum standards of care manual has been revised and released in the year 2009. The manual addresses the following issues:

- The facilities or resources those are essential
- The variety of programmes and frequency with which these will be offered
- The specific roles and responsibilities of the staff
- The clients' rights and the code of ethics for the staff
- Frame work for networking and linkages between services and institution to ensure optimum utilization of resources

Another initiative worth mentioning is the development of *Standard Operating Procedures (SOP) for implementing Oral Substitution Therapy (OST) with Buprenorphine* (NACO, 2008). Under the National AIDS Control Organisation (NACO) of MOHFW, certain NGOs are implementing the OST programme for Injecting Drug Users. In order to standardize the programme and to facilitate the accreditation of the implementing centres, NACO has developed the SOPs. Additionally, for the purpose of evaluating these centres and providing accreditation services, an independent body (the National Accreditation Board for Hospitals, NABH) has been engaged.

The Government De-Addiction Centres: Functioning

As mentioned earlier, about 122 drug dependence treatment centres (or De-Addiction Centres 'DACs') have been established by The Ministry of Health and Family Welfare (MOH&FW), Government of India. While most of these government centres are associated with either general hospitals at the district levels (district hospitals or civil hospitals), some have also been attached with departments of Psychiatry at certain medical colleges. It is noteworthy that the Union Health Ministry's contribution has been largely limited to providing one-time grants for construction / refurbishment of the buildings. Only a few centres (about 42, mainly those in the north-eastern states of the country)

receive recurrent grants from the union health ministry. Most others have been dependent on the state governments for the recurring expenditure (on staff salaries, supplies etc.). It is understandable that the state Governments may have varying degrees of health priorities; consequently the funds provided by the state governments have also been variable in nature.

While so far, there is no regular system in place to evaluate the functioning of these centres, the Ministry of Health and Family Welfare has been taking steps to conduct evaluation exercises, mainly through NDDTC, AIIMS and through NIMHANS, Bangalore. In the year 2002 an evaluation exercise was undertaken with support from the World Health Organisation (India). Again in 2008 – in response to a parliamentary query – another evaluation exercise was undertaken. The findings of the evaluation exercise do not paint an encouraging picture. The findings (see box) have revealed that there is a large amount of variability in the functioning of Government de-addiction centres. Though, it must be understood that in light of the factors mentioned above, it should not come as a surprise.

Functioning of Government De-Addiction Centres

- Most centres depend on State Government for recurring expenditure
- Evaluation exercises have revealed
  - Variability in service provision
  - Poor record maintenance
  - Shortage of staff
  - Lack of capacity of existing staff (i.e. lack of training on substance use disorders)
- It has been difficult to trace most of these centres. UNESCO (2009) has recently highlighted the difficulty encountered in accessing information about many of the centres

With this document however, we propose that – notwithstanding the variability in the organization of health systems in various states and variability of the available resources – there should be some 'minimum standards' of services available at these de-addiction centres. It must be understood that 'Minimum' may not mean 'Optimum' and certainly does not mean 'Ideal'. Even after adoption of minimum standards there may be scope for expansion of scale and improvement in the quality of services. However, at the least, all centres must aspire to achieve and to provide minimum standards of care as suggested in the subsequent chapters of this monograph.

About this document

This monograph has been organised as the following chapters. The introductory chapter describes the scope of this monograph. The First, chapter on **Services,** outlines the Services, which should be available at the Government De-Addiction Centre. Obviously, these services can only be delivered if there is adequate infrastructure which is discussed in the next chapter on **Infrastructure** which should be in place for delivering these services. In addition to the infrastructure, adequate human resources are required to provide these services. This aspect has been described in the chapter on **Staff**. Clearly all the manpower involved in the delivery of care for substance use disorders has to be skilled; the chapter on **Training** provides an outline of proposal for a National Master Plan for India. The chapter on **Monitoring and Evaluation** proposes a plan for monitoring the degree of compliance with the standards and accreditation of the de-addiction centres. Thus, while each individual chapter could be seen as a standalone unit, the content of each unit is linked with that of the other units.

It must be noted that this monograph, while serves the purpose of highlighting important components of substance use treatment services as a stand-alone document, is NOT a substitute for practice guidelines. Thus, for treatment professionals, this document would be most useful when combined with other publications focused on delivery of treatment. A host of manuals have been published under the Ministry of Health and Family Welfare, Government of India namely: *Manual for Physicians, Manual for nursing professionals, Manual for paramedical staff*, (by NDDTC, AIIMS[3]) *Manual on Psychosocial Interventions* (by NIMHANS) etc. All of these have been designed to help the service providers engaged in delivery of care to patients suffering from substance use disorders.

This document should also not be seen as the final word as far as standards for de-addiction centres are concerned. The document has been prepared by the experts in the field as per the current state of knowledge. Additionally, existing realities in most de-addiction centres have also been considered while proposing these standards. It would be important that contents of this monograph be subjected to critical scrutiny and discussions. Once the standards suggested in this monograph are implemented, further feedback may emerge from the field, enlightening all of us. As of now, the document represents an attempt to propose certain standards which must be adhered to by the Government De-Addiction centres. Upon subsequent discussions, deliberations and implementation in the field, it is expected that these standards would undergo revisions.

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[3] These manuals are available at the NDDTC website and can be freely downloaded.

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Minimum standards of care at De-Addiction centres: *SERVICES*

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In this chapter, we propose a set of services which should be available at a minimum level in every Government De-Addiction Centre. It is important to remember that substance use disorders are chronic, relapsing disorders associated with significant morbidity, mortality and disability. Thus, they are best seen with a chronic Non-Communicable Disease (NCD) paradigm. Consequently the treatment services offered should also be geared to deal with issues unique to substance use disorders.

While it has been well recognised that the treatment for substance use disorders should be available in all the levels of health care, i.e. primary, secondary and tertiary, this chapter will focus upon services which should be available at a dedicated de-addiction centre, which is a part of a general hospital (associated with a civil/district hospital or a medical college, as most Government de-addiction centres are). We begin with the outline of all the important services. Finally we also propose certain overarching issues, which make the services patient-friendly and more accessible.

List of services which should be available at Government De-Addiction centres

- Registration
- Outpatient Treatment
- Inpatient Treatment
- Emergency services
- Dispensing of medications (pharmacotherapy)
- Psychosocial interventions
- Laboratory services
- Referral / Consultation / Linkages
- Record maintenance

SERVICES

Registration

At a minimum level all patients attending de-addiction treatment services should be registered in a dedicated register and should receive a unique registration number. This service is linked to record maintenance and thus patients' unique registration number should be reflected in all the records of the patient. While most hospitals (of which the de-addiction centres are a part) are expected to have a central registration system, the de-addiction registration number should be **separate** from the hospital registration as this would be important for monitoring and evaluation purpose.

Outpatient services

Given the dearth of the specialist medical human resources in the country, the de-addiction services would have to be provided by doctors who may be either General Duty Medical Officers (GDMOs) or medical specialists / physicians. While these doctors may encounter many patients with substance use disorders in their routine 'general' clinics, such patients should be referred to / encouraged to

attend, the exclusive and dedicated outpatient clinic for substance use disorders. Thus all hospitals with Government De-Addiction centres should offer an exclusive outpatient De-addiction clinic. The expected patient load would determine the frequency of this De-addiction outpatient clinic; it may vary from daily (i.e. on all working days) to once/twice/thrice a week. Following services should be available in a De-addiction centre at outpatient level:

- ***Assessment:*** All patients should undergo clinical assessment (i.e. history taking and examination) by a trained and competent doctor. The assessment should be geared at making a *clinical diagnosis* (as per the ICD-10 or DSM-IV guidelines) as well as formulating a *treatment / intervention plan*. For the purpose, adequate infrastructure should be available ensuring comfort and privacy for the patients.
- ***Counselling / psychosocial interventions / psycho-education***: All patients (and their attendants, if available and only if the patients agree to involve them) assessed by the trained doctor, should receive Counselling / psychosocial interventions / psycho-education, as per the clinical needs. For this purpose it would be necessary to involve a trained medical social worker / counsellor / psychologist.
- ***Treatment prescription***: Every patient should receive a prescription of the treatment advised to him. If the procedures for dispensing involves a dispensing slip, that may also be provided to the patient.

The outpatient services should have provisions for both – the new patients as well as for the old patients on follow-up.

In-patient treatment

Patients who require in-patient treatment should be admitted in a dedicated ward which is **exclusively** meant for this purpose. Thus, each hospital with a government de-addiction centre should have an exclusive, 10-bedded de-addiction ward. While the duration of the in-patient treatment may vary as per the individual needs of the patients, all efforts must be made to provide the in-patient treatment for an adequate length of time. During the in-patient stay, following services should be made available to the patient:

- Assessment by the doctor(s): At least once per day during the morning rounds.
- Availability of nursing care: round the clock
- Availability of emergency care (on call doctor): round the clock
- Psychosocial interventions
- Medicines
    - For treatment of withdrawal symptoms
    - For management of associated conditions / symptoms
- Food
- Facility to meet visitors during the specified visiting hours
- Access to facilities for recreation: newspapers, television (if available), indoor games

IMPORTANT

While there may be certain restrictions during the inpatient stay (i.e. restrictions on bringing certain items inside the ward / restrictions on movements outside the ward etc.), the whole treatment should be provided only with the explicit informed consent of the patient. The patient should have a right to leave treatment (against medical advice i.e. 'LAMA'), any time of the day.

Since most patients admitted in de-addiction ward would be suffering from withdrawal symptoms, all efforts must be made to make their hospital stay comfortable. The in-patient treatment period should be used to formulate the plans for long-term treatment and rehabilitation and the same must be discussed with the patient. All admitted patients should be provided with a discharge summary with a detailed plan for further treatment from the OPD.

Dispensing of medicines

Pharmacotherapy plays the central role in the treatment of substance use disorders. All the patients seeking treatment from de-addiction centres should have access to the following medications – free of cost – from the dispensary. In addition, the centre should strive to also make available medications listed as 'Other medications', though they have not been put on the essential list.

Table: List of medicines for a de-addiction centre

S. No.	Name of medicine	Formulation / strength	Remarks / Indications
1	Diazepam	Tab. 5 mg Inj. 5 mg	**Essential**. Indicated for treatment of withdrawal symptoms in Alcohol dependence Can be used as sedative / adjunct in treatment of withdrawal symptoms in opioid dependence
2	Lorazepam	Tab. 2 mg	**Essential.** Indicated for treatment of withdrawal symptoms in Alcohol dependence with liver damage
3	B-complex / Multivitamin	Capsules / Injections	**Essential.** Indicated for treatment of withdrawal symptoms in Alcohol dependence
4	Dextrpropxyphene / Tramadol	Tab. / cap.	**Essential (where patients with opioid dependence are seen).** Indicated for treatment of withdrawal symptoms in opioid dependence Dextrpropxyphene should be avoided in North-eastern states / where there is risk of diversion and injecting
5	Disulfiram	Tab. 250 mg	**Essential.** Indicated for long-term treatment of Alcohol dependence
6	Naloxone	Inj. 0.4 mg	**Essential.** Indicated for treatment of overdose of opioids
7	***Other medications (addiction treatment)***: *Naltrerxone, Buprenorphine (2 mg / 8 mg), Methadone, Acamproste*		Indicated specifically for long term treatment of Alcohol and Opioid dependence. Centre must strive to make them available to the patients, though they are costly. For selected centres, cost of Buprenorphine and Methadone may be borne by the NACO, if the centres are participating in the OST for IDUs programme of NACO. Separate guidelines / SOPs exist for the same.
8	***Other medications (supportive treatment)***: *Antacids, Antibiotics, NSAIDs, Antipsychotics, Antidepressants, Antiepileptics,*		Indicated for treatment of associated co-morbid symptoms / disorders.

If the general hospital, of which the de-addiction centre is a part, has a dispensary, the same may be used for de-addiction centre as well. Otherwise, for dispensing of medications from the De-addiction

OPD, a system should be put in place, which allows for monitoring and auditing the dispensing procedure. It must be remembered that some of the medications used for treatment possess abuse liability and risk of diversion. Only authorised persons (such as a nurse / pharmacist) must be allowed to handle / dispense medicines. In a single visit, dispensing of take-home medicines for a period longer than two weeks should be avoided. SOPs for ensuring regular procurement, storage, and dispensing of medications must be in place.

Emergency Services

In those de-addiction centres which are a part of the general hospital, the emergency de-addiction services may be provided by the emergency department of the hospital. While most such emergency set-ups have provision of doctors / nurses and necessary supplies, these should be geared towards providing emergency services related to substance use disorders. The emergency set-ups should be geared to handle emergency situations commonly encountered in the area of substance use disorders viz. acute intoxication / overdose, withdrawal syndromes, adverse drug reactions etc.

Laboratory services

All the de-addiction centres should have access to basic laboratory services. It is not necessary that these services be established exclusively for de-addiction patients but these services may be incorporated with laboratory services of the general hospital. Specifically, the facilities for the following investigations should be made available:

- Routine Heamogram i.e. Hb, TLC, DLC, ESR, Platelets
- Liver function tests i.e. Serum Bilirubin, AST, ALT, Serum Alkaline Phosphatase, γ-GT
- Routine biochemistry: Blood Sugar, Blood Urea, Serum Creatinine, Routine Urine chemistry
- HIV screening: *through linkages with associated ICTC*
- Chest X ray
- ECG
- Additional services (if possible): Ultrasound abdomen, Urine screening for drugs

Psychosocial interventions

All centres should be equipped with facilities to provide psychosocial interventions at both the levels of care: Outpatient and In-patient and in both the settings: in group settings and in individual settings. Family members must also be involved in psychosocial interventions as much as possible. While the specialized psychotherapies may be out-of-scope for most of the centres, trained manpower and other facilities must be available for the following psychosocial services:

- Basic psycho-education about the nature of illness, important of treatment adherence
- Motivation Enhancement
- Reduction of high-risk behaviour
- Brief Interventions
- Relapse Prevention
- Counselling for occupational rehabilitation

Referral / Consultation / Linkages

While a comprehensive treatment programme should address multiple needs of the patient, no single de-addiction centre alone can provide all the services a patient requires. Consequently, it is imperative for the centres to establish and maintain referral and consultation linkages with other facilities and services. The important ones are:

- **General and specialized medical services**: for associated co-morbidities. Since the de-addiction centres are a part of the general hospital, it is expected that many of the specialist medical services would be available. For any associated symptoms / medical condition, appropriate referral or consultation from the concerned speciality must be sought. This is especially important for conditions like HIV/AIDS (linkages with ART centre), Tuberculosis (linkage with DOTS centre) and psychiatric conditions (linkage with nearest psychiatric facility or District Mental Health Programme – DMHP).
- **Paramedical staff (such as ASHA, Health worker, ANMs, Anganwadi workers etc.)**: These are the paramedical staffs that are usually expected to be in close touch with the community. If these staff members come across out-of-treatment drug users in the community, they can motivate the drug users to seek treatment at the Government De-addiction centre and provide referral.
- **NGOs in the locality**: It is well known that most substance users are unable to access treatment services for a variety of reasons. If there are NGOs in the locality working with substance users the centre should strive for establishing linkages with them, so that NGOs could identify the out-of-treatment drug users in the community and encourage them to seek help at the Government De-addiction centre. Similarly after the early phase of treatment is over from the Government De-addiction centre, NGOs could help the patient in social / occupational rehabilitation

Record Maintenance

Maintenance of clinical records is a very important aspect of the functioning of the centre. It is not only necessary for adequate clinical care of a patient at the *individual* level, but it is also necessary for monitoring and evaluation purpose at the *programme* level. The following records should be maintained by a centre:

- ***Individual patients file***: This should be traceable by a unique registration number. A system should so develop that, once the patient is admitted and discharged, his/her in-patient treatment record is also incorporated in the out-patient file. Thus upon picking-up a patient's file, one should be able to assess the entire treatment history and progress of the patient in a chronological order. At each instance of patients' follow-up in OPD, the file should be retrieved, presented to the clinical staff (doctor / counsellor), in which necessary clinical notes should be entered. All the records related to the patient (Investigation reports etc.) should be attached to the file.
- ***Drug Abuse Monitoring System (DAMS) proforma***: At every instance of first registration in the de-addiction clinic, the doctor / counsellor should fill up this proforma. Periodically, these proformas would be collected by a designated central / regional centre, and would be used to analyse the profile of patients seeking treatment.
- ***Medication dispensing records***: These should be maintained very stringently since some of the medications used for treatment possess abuse liability and risk of diversion. A system should be developed which would make each unit of medicine entering into the stores accounted for. After dispensing, the patients should be asked to sign the receipt of the medications.

OVERARCHING ISSUES AND PRINCIPLES

There are certain overarching issues and principles which must be adhered to for providing the services. All the Government De-addiction centres should strive to achieve the following:

Overarching Issues and Principles

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

Licensing / Accreditation: Ideally a system should be in place which provides certification or accreditation to a Government De-Addiction centre as an authorised substance use treatment centre. This issue has been discussed elsewhere in the monograph. For this purpose, the senior management of the centre / hospital should take the necessary steps.

Compatibility with existing health services framework: While planning and implementing substance use treatment services, it is essential to ensure that these services are compatible with the existing health care delivery system. A situation is avoided wherein certain policies and procedures of the De-Addiction centre are at odds with the policies and procedures of the associated hospital.

Sensitivity and adaptability to local culture: It should also be noted that the policies and procedures at a Government De-Addiction centre are sensitive to the local cultural scenario. For this, it is important that patients and their care-givers are involved not only in the process of clinical decision making at an individual level, but their involvement should also be sought for making policies and procedures of the clinic.

Promoting service utilisation: All efforts must be made to ensure that the services on offer are adequately utilized by those in need. List of services and facilities available should be prominently displayed. Additionally, opportunities for increasing the visibility of the centre among the masses (through advertisements in local media, local events etc.) should also be explored.

A patient-friendly atmosphere: All the services on offer should be made available to all sections of the society without any discrimination. All efforts must be made to ensure privacy and confidentiality of the patients and their families. No procedure – however well-intended – should be carried out without the explicit consent of the patient. Safety and security of the patients, their attendants and staff should receive the topmost priority.

Ongoing efforts for improvement: While the standards listed in this chapter (and the subsequent ones) should be seen as 'minimum' standards, a centre need not stop after achieving them. There should always be an ongoing process at work to bring about improvement in services as per the growing experience, changing needs and developments in the field.

Systems for accountability: Internal monitoring systems should be developed which ensure accountability at each level. These internal systems should be linked with the national systems for monitoring and evaluation (described in another chapter).

Minimum standards of care at De-Addiction centres: *INFRASTRUCTURE*

S. K. Arya, Shantanu Dubey

Infrastructure is the basic requirement for any organization to have an existence. It is the building which houses the people working there and the furniture and furnishings which make it comfortable for them to perform their duties. As such it is of utmost importance to enlist the infrastructure requirements for the De-Addiction Centres, under the Ministry of Health and Family Welfare. This chapter outlines the basic infrastructure requirements for the centres in terms of space and building requirements and the furniture required. This list may be considered as indicative and not prescriptive.

These standards are being framed for De-Addiction Centres at District level. As envisaged, these centres would be mostly adjunct to already running district hospitals. Hence these standards are being drafted keeping in mind the possibility of sharing some essential services with the Hospitals.

Wherever such centres already exist as part of a hospital, we propose that the space requirements for the Outpatient area may be shared with the hospitals resources. However, care should be taken to meet to as great an extent as possible, the standards given herein. If a new building is to be created, then they should have at least the proportions outlined in this chapter.

CENTRE BUILDING

The Centre should have a building of its own. The surroundings should be clean.

Location: It should be easily accessible from the outside. This facility should be functionally integrated with district hospital for seamless sharing of facilities of district hospital. The building should have a prominent board displaying the name of the Centre in the local language. It should be well planned with the entire necessary infrastructure. It should be well lit and ventilated with as much use of natural light and ventilation as possible. Entrance should be well-lit and ventilated with space for Registration and record room, drug dispensing room, and waiting area for patients. The doorway leading to the entrance should also have a ramp facilitating easy access for disabled patients, individuals using wheel chairs, stretchers etc.

Outpatient Area

The outpatient department of the centre should be a functionally separate entity from the Outpatient department of the hospital. If the expected number of patients reporting to the centre daily is estimated to be

- New patients: Five to Seven
- Old patients: Twenty to Twenty five

All patients would be seen both by the doctor and the counsellor/social worker. Hence rooms need to be provided for both, ensuring adequate privacy during interviews of patients.

Doctor's chambers: There should be adequate lighting and ventilation to provide a comfortable environment to the doctor and the patient. The furniture should include one desk and doctor's chair, with one stool and two or three additional chairs.

- Recommended: 2 consultation chambers
- Space requirement: 9 m^2 per chamber, presuming examination couch is not required.

Total area for consultation chambers: 18 m^2

Counselling room: Area and furnishing may be same as Doctor's chambers.

- Recommended: 2 chambers
- Space requirement: 9 m^2 per chamber.

Total area for consultation chambers: 18 m^2

Waiting area: the waiting area can be calculated by the general thumb rule of 1 sq meters per patient. Taking the approximate number of patients to be 7 new and 25 old (total 32) with scope for further increase in work load, total waiting area is proposed to be 40 sq meters. In addition to the waiting area the centre should have provision for basic facilities such as drinking water and waiting time entertainment such as a TV with cable connection etc.

Waiting Area: 40 m^2

Toilets: There should be one male and one female toilet (WC + wash basin) for the staff. The toilets for the patients and attendants should be made as separate toilet complexes for males and females. Each of these toilet complexes should have one WC and one Indian style lavatory and one wash basin. Male toilet complexes will have two urinals in addition to the above. The total area requirement can be arrived at as follows:

Staff toilets @ 6 m^2 each = 12 m^2
Patient toilet complex (with janitor's closet) @ 18 m^2 each = 36 m^2

Pharmacy: If the general hospital, of which the de-addiction centre is a part, has a dispensary, the same may be used for de-addiction centre as well. Otherwise, for dispensing of medications from the De-addiction centre an exclusive pharmacy should be established. In either of the cases, there should be provision for at least three cupboards for storing medications out of which at least one should have double lock and key mechanism to facilitate storage of scheduled drugs like Buprenorphine etc.

Recommended area for pharmacy (if not existing): 24 m^2

Drug dispensing room: This should be a small room located adjoining the exclusive DAC pharmacy to administer drugs to those patients who require the drug to be given under supervision. The drugs and names of patients should be recorded in a separate register and the whole process should be under the supervision of a trained staff nurse or a pharmacist.

Recommended area: 12 m^2

Records and registration room: Since substance dependence is seen as a chronic non-communicable disease, the patients who report to a centre like this usually expected to have a prolonged outpatient follow-up along with a few inpatient treatment episodes. Thus, maintenance of records remains a very important activity. To provide for this, the type of numbering system proposed is the *Unit numbering system*, which covers all patient records in a single number and files records of subsequent visits to the hospital under the same number.

To facilitate this kind of record keeping it is advisable to have an infrastructure which can be upgraded to incorporate computerized data entry system, which lends to easy search-ability even if the patient has not brought his previous records with him. Hence there should be enough space to keep a computer and printer setup in the registration area. Since the expected number of daily admissions is low, hence a single window system wherein the same window handles inpatients as well as new and old outpatient records is recommended.

The record room should be adjacent or adjunct to the registration counters. There should be a cubicle for the Medical Record Officer to sit and stations for other workers. The storage of old records should be done either in the same complex or in close vicinity to the registration so that old patient's files can be readily retrieved as and when the patient reports to the centre.

Recommended space requirement:

- Outpatient registration: **12 m^2**
- Admission office: **12 m^2**
- Medical records office: **24 m^2**
- Storage room: **12 m^2**

Total area for record maintenance: 60 m^2

Administrative area and stores: There should be a place for the rooms of Administrative officer and accounts personnel, if these staff members are exclusively meant for the centre and are not shared with the district hospital. Two rooms may be provided for administrative usage, and one for accounts and finance department. The stores require a bigger area for storage of medical, general and linen stores. One separate cabin should be provided for the store officer.

Recommended Space requirements:

Room for Officer / Sister in charge: **12 m^2**
Room for accounts personnel: **12 m^2**
Store room: **36 m^2**

Total area for Administration area and stores (if not shared with hospital): 60 m^2

Others :

Urine sample collection room: Though the centre is expected to share the laboratory facilities with the district hospital, a separate room for collection of urine samples may be provided, only for those centres which are running urine screening facilities. Recommended area: **12 m^2**

Staff room: A room would be required for the staff to sit, discuss, have refreshments etc. Recommended areas: **24 m^2**

Total OPD area: 312 m^2

In- Patient Area

Wards: There will be a ten bedded ward in the hospital for the De Addiction Centre. These beds should preferably be in an area away from the general traffic to ensure privacy for such patients. At least two beds should have railings and/or provision for restraining violent patients. The ward should have provision for round the clock nursing. There should be a well stocked and equipped nursing station, with file racks, cupboard for storage, water supply, etc.

The following is a list of different inclusions in the ward:

- 10 Beds – two cubicles of 4 beds each and 2 bed room with restraints

- Nursing station
- Interview room
- Doctor's Duty room
- Nurses changing room
- Ward store
- Sluice room
- Visitor's room
- Toilet
    - Staff toilet male and female
    - Toilet complex for male and female patients separate
- Janitors closet
- Group D room
- Pantry

- There should be one nurses' changing room which should have adequate ventilation and should provide for a toilet with one WC and wash basin.
- Provision for a water cooler with filtration systems may be made. Separate toilets (with WC and wash basins) and bathrooms should be provided for male and female patients. A sluice room may be provided with janitor's closet.
- The ward should have an interview room which provides privacy during doctor-patient or counsellor-patient interactions. The interview room should have adequate lighting and ventilation, and sufficient furniture.
- All electrical connections in the ward should be planned such that the patients have minimal access to the electrical points. Electrical sockets should specially be avoided in secluded area like the toilets and bathrooms. The electrical connections for all such areas should be placed in a centrally decided location preferably near the nursing station.
- Likewise the ward windows may be designed to minimize chances of illegal traffic of substances through the spaces or of patients escaping through windows.
- Use of glass partitions or windows should be minimized in the ward as such items are liable to be broken or damaged and may be injurious to the patients.
- Light music can be played in the ward during waking hours to provide a soothing environment to patients to hasten recovery.

Space requirements for ward areas:

- Beds: 8 m^2 per bed X 10 beds: **80 m^2**
- Nursing station with toilet: **18 m^2**
- Interview / treatment room: **12 m^2**
- Doctor's Duty room with toilet : **18 m^2**
- Nurses Changing room: **12 m^2**
- Ward store: **24 m^2**
- Patients relatives waiting area with toilets: **18 m^2**
- Sluice room: **12 m^2**
- Group D room: **12 m^2**
- Ward pantry with drinking water facility: **18 m^2**
- Staff toilets @ 6 m^2 each: **12 m^2**
- Patient toilet complex (with janitor's closet) @ 18 m^2 each = **36 m^2**

Recreation/rehabilitation/activity room: This room may be used to provide facilities for light entertainment like Television with cable, light music and different activities like indoor games, reading newspapers and magazines and handicrafts. This room may also be used for group interactions / meetings.

Space requirement: roughly 2 m^2 per patient i.e. **24 m^2**

Total covered area for Indoor: 296 m^2

Table 1: Space calculation for the centre

Name of the area	Space (in m^2)
Out Patient Area	
Consultation chambers	18
Counselling room	18
Waiting area	40
Staff toilets	12
Patient toilet complex	36
Pharmacy	24
Drug dispensing room	12
Records and registration room	
Outpatient registration	12
Admission office	12
Medical records office	24
Storage room	12
Administrative area and stores (*only if not shared with the hospital)*	
Room for Officer / Sister in charge	12
Room for accounts personnel	12
Store room	36
Wards	
Beds (8 m^2 per bed X 10 beds)	80
Nursing station with toilet	18
Interview / treatment room	12
Doctor's Duty room	18
Nurses Changing room	12
Ward store	24
Patients relatives waiting area with toilet	18
Sluice room	12
Group D room	12
Ward pantry with drinking water facility	12
Staff toilets	12
Patient toilet complex	36
Recreation/rehabilitation/activity room	24
Sub total	606
Add 30% extra for circulation space	182
Sub total	788
Add 10% for walls	80
Total covered Area	**866**

Other special requirements of the centre

Water supply:
The centre should have provision for 24 hours water supply. The bathrooms, wherever provided should be fitted with geysers and/or other equipments as required to ensure supply of hot water during cold season.

Waste management:
All necessary steps should be taken to ensure proper segregation and disposal of bio medical waste in the centre. The disposal of Bio medical waste may be clubbed with Bio Medical Waste management in the rest of the hospital.

Security services:
Security must be adequately provided both in wards and in outpatient area. Some of such patients can turn violent at times and the security personnel need to be trained in handling such outbursts. The work of the security service should be augmented by intelligent facility design as had been suggested earlier to minimize chances of illegal substance trafficking, patients escaping from the ward or breakage of ward property by violent patients.

Signage and Publicity:
Prominent signage and publicity boards should be put up to make the public aware of such services in the hospital.

Shared services:
The following services are proposed to be shared with the main hospital:

- Emergency
- Laboratory and Radio diagnostic services
- Kitchen / dietary services
- Laundry services
- Housekeeping and other support services

Furniture:
The centre must be adequately furnished so that the minimum standards of services can be maintained. The table 2 provides a suggestive list of furniture. This list has been guided by the Indian Public Health Standards (IPHS) list of furniture.

Table 2: Suggested list of furniture required	
Writing tables with table sheets	12
Plastic chairs (for in-patients' attendants)	60
Armless chairs	36
Full size steel almirah	6
Almirah double lockable	2
Arm board for adult and child	4
Wheel chair	2
Stretcher on trolley	2
Instrument trolley	2

Wooden screen	6
Foot step	5
Coat rack	2
Bed side table	10
Bed stead iron (for in-patients)	10
Stool	10
Medicine chest	3
Locker chests	6
Fans	36
Tube light	36
Sundry Articles including Linen:	
Buckets	4
Mugs	4
LPG stove	1
LPG cylinder	2
Sauce pan with lid	2
Water receptacle	2
Rubber/plastic shutting	2 meters
Drum with tap for storing water	2
I/ V stands	4
Mattress for beds	10
Bed sheets	10 + 30
Pillows with covers	10 + 10
Blankets	10 + 10
Baby blankets	2
Towels	10
Curtains with rods	To be kept as appropriate

Conclusion

Adequate infrastructure is essential to provide minimum standards of services for treatment of substance use disorders. While planning the infrastructure it is very important to keep in mind the projections for the future increase in patient-load and needs of services.

Minimum standards of care at De-Addiction centres: *STAFF*

Rakesh Lal, Nirupam Madaan

Treatment goals for a patient of drug use disorders can be total abstinence, substitution, harm reduction and acceptance within the societal framework. Treatment services for the substance use disorders are provided by private practitioners, stand-alone specialty clinics, integrated health care systems, and Government and non-government organizations. Despite the existence of a multitude of services, due to societal ambivalence and consequent stigma, many of the patients do not access these services. Stand-alone centres, in particular, lose out on their patient load due to the problem of 'labelling'. The Government of India, is engaged in providing substance use treatment services through the Ministry of Health and Family Welfare (through De-Addiction centres associated with government hospitals) and through the Ministry of Social Justice and Empowerment (through stand-alone Drug Treatment Cum rehabilitation centres, run by NGOs). Additionally, plans to make treatment services available for substance users at all district hospitals are also on anvil for ease of access as well as utilization without stigmatization. Although many services are available at the Government De-Addiction Centres, the qualities of these services are not monitored and more often than not leave a lot to be desired.

Many countries have developed standards of health care delivery in all areas including drug dependence treatment. The WHO and the UNODC have developed specific guidelines for treatment services. The United State of America have detailed guidelines for substance use, use of specific drugs like opioids and for special populations like women and those with co morbid HIV infection.. Canada and Europe too have their own guidelines (see chapter on Introduction).

As mentioned earlier, The Ministry of Social Justice and Empowerment (MSJE), Government of India is also involved in the delivery of substance use treatment services through NGOs. The emphasis of the MSJE is on capacity building, upgrading of information and making a data base, linkage with local, national and international bodies, creating awareness, non-pharmacological interventions and rehabilitation. Under the MSJE's scheme, guidelines and specification for staffing various facilities are available.

The Ministry of Health and Family Welfare has established De-addiction centres in various district hospitals and medical colleges which have (at least) 10 beds earmarked for drug treatment services in addition to regular outpatient services. As of now, there is no document that gives guidelines for acceptable Minimum standards for such centres. In this chapter we propose the specification of the staff which should be in place at the government DACs.

Though these district hospitals are already providing general health care to the public, the addition of services for management of substance abuse would require some additional staff. While many services at the DACs can be shared by the general staff of the district hospital, there are some services for which exclusive staff at the DAC would be required. Apart from the basic infrastructure, availability

of adequate trained staff is essential to ensure these standards are adhered to. This can be achieved by appointing more staff specifically trained for such services.

Staffing pattern for any health-care organization or institution would largely be determined by

1. Services being planned
2. Physical location – stand alone or part of a larger hospital
3. Expected patient load

1. SERVICES BEING PLANNED

Though these have been described in another chapter of this monograph, briefly the services at a DAC can be broadly divided into:

a) Inpatient care : Services in the ward may include detoxification, management of physical and psychological co morbidity, individual and group therapy and day care facility
b) Outpatient care: Diagnostic, therapeutic and counselling services, along with supervised medication for maintenance therapy as well as psychosocial intervention
c) Emergency services
d) Laboratory services: Clinical chemistry and haematology and drug screening
e) Community outreach services including both service delivery, awareness generation and motivating patients

2. PHYSICAL LOCATION

A stand alone centre will essentially require a self contained unit, with all categories of staff available as per requirement. This will involve a policy decision as to whether some of the services can be utilized by from another organization i.e. affiliation with an adjoining hospital for allied medical care i.e. associated medical, surgical problems or emergencies. A stand alone centre could also have a panel of visiting specialists from allied medical fields. Additionally a policy decision has to be made on outsourcing of services and personnel.

Since most of the Government DACs are part of a larger hospital the need for medical specialists, administrative and support staff is minimized or obviated. No separate provision for emergency and laboratory services need to be catered for though some additional staff may be required specifically for de-addiction services. Support services like catering, laundry, transport and house-keeping can be accessed from the general pool.

Keeping these factors in mind one can plan for the basic staff. Staff would essentially include the medical and nursing personnel, laboratory staff, pharmacists, paramedical staff, administrative staff and other support staff including drivers, record maintenance personnel, catering staff, peons, safai karamcharis and security personnel.

3. EXPECTED PATIENT LOAD

It is envisaged that a district hospital would attract at least 3 to 5 new patients and 25 to 30 old patients in the outpatient clinic on a given day.,

Based on the above premise concerning the essential requirement for a basic substance abuse treatment centre providing outpatient care, a 10-bedded inpatient facility, minimum laboratory backup and referral system the following staff is recommended.

MOST ESSENTIAL staff for the De-Addiction Centre

A. General Physician / General Duty Medical Officer (GDMO).....1

Due to a dearth of psychiatrists in the prevailing circumstances, any qualified physician with specific training in substance abuse treatment can be a team leader. A Psychiatrist is more equipped to be a team leader for a de-addiction unit, because of the professional training he/she would have received. His/her job will be to diagnose and treat substance use disorders, coordinate the services, manage the team, liaison with other agencies including NGOs and provide care at the OPD and in-patient levels. If the leader happens to be psychiatrist he/she would be equipped to recognize and deal with psychiatric co-morbidity too.

However, due to the shortage of even GDMOs in the country, the doctor-in-charge of de-addiction services may also share some other duties and responsibilities of the hospital.

EXCLUSIVE staff for the De-Addiction Centre

B. Nursing personnel.....4

Indian Nursing Council norms require 1 staff nurse for every 5 beds in a non-teaching hospital. For a 10 bedded unit of a district hospital, this translates into 2 staff-nurses. However, at least 3 staff-nurses are required for round the clock patient cover in a dedicated unit, with 1 leave reserve. One of these could be nurse in-charge who is expected to look after administrative responsibilities like making duty rosters, keeping leave records, addressing grievances of patients and nurses and coordinating the treatment plan of the patients with the entire health delivery unit. The additional staff nurse for leave reserve will be present in the OPD for any procedures including dispensing medicines, doing dressings and giving injections when not in the ward. Thus, 24-hour coverage of the ward will be done in the ratio of 1:1:1 + 1 in-charge. In the ward the nurses are expected to carry out various functions including dispensing medicines, keeping a record of various patient parameters, ensuring cleanliness and provide basic counselling.

While the nurses from the general pool of nurses at the hospital can also be posted at the DAC, it would be advisable to post only those nurses who have received specific training on substance use disorders.

C. Social workers/counsellors.....2

Social workers and counsellors are the very important category of staff at the DAC. Their primary duties would include counselling and other psycho-social interventions at the outpatient and inpatient level. Additionally, they can also be involved in generating community awareness by holding public meetings and interacting with community leaders. They would form the mainstay of the psycho-social interventions and would also be responsible for the motivation of patients and their psychological rehabilitation. They could also be involved in making education material including posters and leaflets.

D. **Security staff.....4**

The above mentioned category of the staff would be required exclusively for the de-addiction centre. Additionally, some other staff members would also be required to help running the centre smoothly. However, all these additional staff can be shared with the district hospital and hence would not be performing exclusive duties at the de-addiction centre.

Record section Staff A de-addiction centre would require an exclusive record section of its own. For this, there must qualified staff in the form of Medical Records Technicians or attendants. These may be shared with the pool of such staff from the hospital. They will perform tasks like: maintaining records and filing, running the registration, accessing records and delivering them to the doctors.

SHARED Staff for the De-Addiction Centre (suggestive list)

E. Laboratory staff
F. Pharmacist
G. Nursing attendants
H. Store-keeper
I. Administrative staff
J. Safai karmachari
K. Security
L. Engineering
M. Catering
N. Laundry

When a patient approaches a treatment centre he should have access to services which will give him a reasonable chance of recovery. These include immediate and long term therapies – pharmacological as well as non-pharmacological. These are the suggested basic minimum staff for optimal functioning of a substance abuse treatment centre that provides outpatient and inpatient services. Community outreach programmes are also an essential part of treatment as are both pharmacological and non-pharmacological interventions for substance abuse and any co-morbidity. It is acknowledged that the Psychologist has an important role to play in substance abuse management, but the reality is that there is a severe shortage of trained Psychologists in the country. Indeed having one on the rolls is could be seen as a luxury and not the basic minimum requirement. Finally, it is emphasized that though the Psychiatrist (if available) is ideally equipped to be team leader, a lack of Psychiatrist is also a reality. This role can be very ably performed by the Physician with some basic training in substance abuse management. Physicians should be trained to manage psychiatric co-morbidity too. In fact it is strongly suggested that all members of the treating team – especially the exclusive staff – must be trained training to equip them with skills in management of substance use disorders. This would not only enhance skills and make them more confident but lead to an attitudinal change and remove any negative bias.

Synopsis of manpower requirement for a ten-bedded de addiction centre		
EXCLUSIVE STAFF		
Designation	**Minimum Qualification *(either as following or as per state government norms)***	**Requirement**
Staff-nurses	B.Sc Nursing	04
Social worker/counsellor	B.Sc SUPW / BSW / MSW / Psychologist	02
Security guards	10+2	04

SHARED STAFF *(Such staff may be shared from the common pool of the hospital)*		
Designation	**Minimum Qualification *(either as following or as per state government norms)***	**Requirement**
Physician in-charge[4]	**MBBS with training in substance use treatment or MD, Psychiatry**	**01**
Laboratory technician	B.Sc Medical Lab. technology	01
Laboratory attendant	10+2	01
ECG technician	Diploma in Electrocardiography/ 3 yrs. ECG experience	01
Pharmacist	B.Sc Pharmacy	01
Nursing attendant	10+2	04
Medical Record technician	Diploma in Medical Record Technology	01
Store keeper	Graduate	01
Store attendant	10+2	01
Safai karamchari	--	04
Cooks	10+2	02
Helpers/stewards	--	03
Washer man	--	01
Laundry attendant	--	01
Plumber	10+2 with 3 yrs. work experience	01
Electrician	10+2 with 3 yrs. work experience	01
Carpenter	10+2 with 3 yrs. work experience	01
Administrative officer	Graduate	01
Accounts officer	Graduate, in accountancy	01

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- Ministry of Social Justice and Empowerment (2009): http/social justice.nic.in/

[4] It is preferable to have an exclusive and dedicated physician-in-charge. However, due to the shortage of even GDMOs in the country, the doctor-in-charge of de-addiction services may also share some other duties and responsibilities of the hospital.

CAPACITY BUILDING: Proposal for a National Training Master Plan

Anju Dhawan, Anita Chopra

INTRODUCTION

Although a substantial numbers of persons are affected by drug and alcohol abuse and dependence, there are several gaps in service provision. These include inadequate number of services, inadequate treatment seeking by substance users and also lack of trained manpower in the country. This chapter discusses capacity building for staff working at the district hospitals to ensure adequate trained manpower for service provision for substance users. Although the dimensions of capacity building include health infrastructure, program maintenance and sustainability and increasing competence and capabilities, this chapter will focus on **training manpower** specifically.

According to the latest National Household Survey on drug use for the country (UNODC and MSJE, 2004) there are about 10.5 million alcohol users, 2.3 million cannabis users and about 0.5 million opiates users in the country who are dependent on these substances and are in need of treatment. **Treatment needs to be made available at the district level considering the large numbers affected by substance use disorders.**

Gaps in Service Provision

- Inadequate number of services,
- Inadequate treatment seeking
- Lack of trained manpower in the country

Treatment Provision

- Large number of persons affected by substance abuse/dependence
- Treatment needs to be made available and accessible
- Treatment provision required at district level
- Training of General Duty Medical Officers is required

In India there is a severe shortage of trained mental health professionals; there are just about 0.4 psychiatrists and 0.02 psychologists per 100,000 people. Clearly, they alone cannot cater to the huge number of substance users in the country. Therefore, by training of other health professionals like general duty medical officers (GDMO's) to adequate levels of competence one can hope to achieve bridge this gap. This will be necessary to infuse the health-care system with the kind of improved care that will raise the quality of life of substance using individuals. The need to train medical students and non-specialists has also been emphasized by policy making bodies, starting from the Health Survey and Planning – 'the Mudaliar Committee' (Government of India, 1962) to the National Health Policy (Ministry of Health and Family Welfare, 2002). The policy recognizes the need for more frequent in-service training of medical personnel at the level of medical officers as well as paramedics. Training of health-care professionals like nurses and paramedical professionals would be required to enable effective delivery of treatment through team effort.

DE-ADDICTION CENTRES – CURRENT STATUS

Under the Drug De-Addiction Programme of the MOH & FW, 122 government de-addiction centres in the country have been set up in medical colleges and district hospitals. Evaluation and monitoring

exercises have been conducted periodically to examine functioning of these centres as part of a WHO funded activity (in 2002) and as part of a Parliamentary committee query (in 2008). Both the exercises focussed on treatment centre as well as patient characteristics. Results showed that there were shortages in manpower and also in basic skills and expertise in substance use treatment. Capacity was found limited by the lack of a sufficient number of trained medical doctors and nurses in these centres.

The paucity of properly trained professionals is a barrier to the development and delivery of effective treatment services to drug users. The constraints are still more when dealing with special populations like substance using women and adolescents.

PROVISION OF SERVICES IN GENERALIST AND SPECIALIST SETTINGS

Internationally, drug use in primary care settings has been addressed and found acceptable to both the providers and patients. In the Indian context, the role of physicians in the prevention and treatment of addictive disorders is important as they are well positioned to play a significant role in the recognition and treatment of drug users. Findings of an ICMR-collaborated multi-site study showed that majority of patients with psychiatric disorders including alcohol-related problems sought advice from the general physicians (Ghosh, 2007).

However, physicians often miss the diagnosis as they do not screen patients for alcohol /drug use and do not treat substance use with the same frequency, accuracy, or effectiveness as other chronic medical diseases. This is partially due to inadequate attention towards identification, diagnosis and management of alcohol and other drug problems in basic medical training itself. In USA, the amount of formal training in substance use disorders determined in selected residency programs revealed that percentage of programs with required substance use disorders training ranged from 31.8% in paediatrics to 95.0% in psychiatry, with 56.3% for all programs combined. The median number of curricular hours devoted to substance use disorders ranged from 3 hours (emergency medicine and OB/GYN) to 12 hours (family medicine) (Issacson, 2000). In India, training in substance use disorders is minimal during undergraduate medical training. Even postgraduates in psychiatry have very little exposure to this field in most medical institutions in the country barring a few.

Most general practitioners report that given adequate training and support, they are willing to conduct interventions in patients with substance use disorders.

The care providers apart from physicians also include nurses, psychologists, social workers and health care workers. Involvement of nurses in provision of care to substance users has been inadequate. Basic knowledge on drug addictions is inadequate among the nurses as well. They experience difficulties in working with drug using population and are unable to take adequate measures or to plan effective intervention Building teams of physicians and nurses can enhance the treatment of alcohol and drug dependence.

TRAINING INITIATIVES/PROGRAMMES ON SUBSTANCE USE DISORDER: *International*

Training of general physicians in substance use disorder has received attention in several parts of the world. The Association for Medical Education and Research in Substance Abuse (AMERSA) in USA promotes substance use education among health professionals by developing curricula, promulgating relevant policy and training health professional faculty to become teachers in this field. The organization also publishes a peer-reviewed, quarterly journal, Substance Abuse, which emphasizes research on the education and training of health professionals (Samet et al, 2005). The Hazeldon

foundation in USA offers a residential programme for physicians at their home institutions where participants also receive CME credits. Project MAINSTREAM of the Hazeldon foundation (2009) aims to bring together and train substance use educators from different professions and has established a web site which provides access to resources. In Australia, the National Centre for Education and Training on Addiction (NCETA) is an internationally recognized research centre that is involved in the promotion of Workforce Development (WFD) principles, research and evaluation of effective practices. The European Addiction Training Institute (EATI) an initiative of the Amsterdam based Jellinek foundation specialized in addiction treatment and prevention in the Netherlands and was one of the leading centres in Europe involved in trainings (European Addiction Training Institute, 2009). Certification procedures are also available. Certification demonstrates that a doctor has met vigorous standards through intensive study, assessment, and evaluation. Certification is designed to assure the public that a medical specialist has successfully completed an approved educational program and an evaluation, including a secure examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality patient care. The details of certification by various International organisations have been appended to this chapter.

TRAINING INITIATIVES/PROGRAMMES ON SUBSTANCE USE DISORDER: *National*

Various Ministries and Nodal Government agencies are involved in training of personnel in substance use disorders. The Ministry of Health and Family Welfare considers training of the General Duty Medical Officers (GDMO's) (especially those working in the government de-addiction centres) as a priority area. The Ministry of Social Justice and Empowerment is involved in training of the staff from NGOs.

Training Initiative by the Ministry of Health and Family Welfare

i) Development of the Course Curriculum

Following a meeting of national experts in 1988 at the National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi a course curriculum was developed for the General Duty Medical Officers GDMOs). The group of experts recommended that the trainees should: get adequate theoretical and practical knowledge on drug dependence and be trained to develop laboratory services to screen drugs of abuse in urine, wherever possible. The training should comprise of didactic lectures, adequate clinical exposure and hands-on experience to provide various treatment modalities. A training course of 3 weeks should devote 35% of the total duration to theory and 65% to clinical exposure. Over the years, following observations and feedback, the duration of training course for new trainees has been condensed to 14 working days instead of the three weeks period. The curriculum developed has been in use by the NDDTC, AIIMS during the conduct of its training courses. In the year 2003, following the recommendations of a national workshop of experts the curriculum and methodology of training for GDMOs was reviewed, revised and updated.

ii) Course content

The content of the trainings developed by consensus in the national meeting covers comprehensive topics: national policies and programmes, legal aspects, epidemiological perspective, assessment and diagnosis, aetiology, acute effects, chronic effects, treatment principles, pharmacotherapy, maintenance treatment, psycho-social treatment (brief intervention, relapse prevention, family based intervention), community based treatment, monitoring of drug use, prevention, role of laboratory services and

psychological testing. The course includes training on treatment of alcohol and opioid dependence. There is also focus on special populations such as Injecting Drug Users, Drug use and HIV/AIDS, dual-diagnosis, women and adolescent drug users. The course also includes management of nicotine dependence and inhalant use. The course is modified based on the needs perceived by the trainees and sessions are added or removed based on their inputs.
Besides lectures / presentations, the methodology of the training includes case-demonstrations, case-discussions, group discussions, visit to NGOs and community clinic. The group discussions focus on developing linkages with NGOs, conducting community awareness programmes, conducting a training programme etc. A more detailed curriculum for a four month training as part of a WHO fellowship has also been developed. This includes conducting a research study (planning a research study, collection of data and report writing) and also includes hands-on training on searching internet for literature, lectures on research methodology and statistics.

iii) Training Courses: So Far

The National Drug Dependence Treatment Centre has coordinated and conducted several training programmes for medical doctors, with financial assistance from WHO (India), along with support from the Ministry of Health and Family Welfare. Between 1989 and Feb. 1999, 35 training courses were conducted and 455 medical / para-medical persons were trained. Majority of the trainees were general duty medical officers working at district hospital or primary health centre (PHC) while others were psychiatrists, nurses, social workers, pharmacists and jail warders. Highest number trained was from the states of Manipur-50 followed by Nagaland-47, Haryana-37, Assam-29, Gujarat-27, Punjab – 27, Himachal Pradesh-23, Maharashtra-22, Delhi-16 and several from other states in the country. In the year 2000, with the support of World Health Organisation (India), six training courses were conducted at Mumbai, Dibrugarh, Goa, Imphal, Shillong and Jodhpur and 105 doctors underwent training. The NDDTC conducted and coordinated, in the years 2004-2005, eight training courses and more than 100 doctors were trained and in years 2006-2007, six training courses were held and 62 doctors trained. Recently, training courses have been held for GDMOs at different places in the country. In the last two decades NDDTC has coordinated about 60 training programmes and about 900 doctors have been trained. The training programmes have also been conducted at the following institutions: AIIMS (New Delhi), Srinagar Medical College (Srinagar), National Institute of Mental Health and Neuro-Sciences (NIHMANS) (Bangalore), KEM hospital (Mumbai), Jodhpur Medical College (Jodhpur), Regional Institute of Medical Sciences (RIMS) (Imphal), Assam Medical College (Dibrugarh), Department of Health Services (DHS) (Kohima, Nagaland), DHS (Goa), Institute of Post-graduate Medical Education and Research (IPGMER) (Kolkata).

Training courses have also been conducted for nurses and para-professional workers at some select sites on a pilot basis. The training for nurses focuses on development of knowledge and skill to be able to screen, detect and provide care to substance users at the district-hospital level.

A National Workshop was held at NDDTC in 2009 to develop the curriculum for training of paramedical staff as a part of WHO (India) activity. The paramedical staff has been provided training to be able to contribute to the delivery of care by performing the task of early identification of problem substance users, facilitate the process of accessing services for substance users, thereby acting as a bridge between users and services, enhancing the motivation of users to seek treatment, deliver brief interventions in the health care setting or even in the community itself, assist the doctors and nurses in various steps of treatment like assessment, psycho-education, counselling etc., assist in the rehabilitation of the recovering substance users and help them in re-integration with the society.

Further, NIMHANS, Bangalore offers a one month orientation course in substance use disorder treatment for medical as well as non-medical professionals. It also conducts courses for State Government medical officers and training of trainers from the southern region, WHO fellows from Bangladesh, Myanmar, Iraq, Nepal [SEARO] and Iraq [EMRO] are also referred for training. It is involved in providing training to several non-governmental organisations involved in community developmental activities on skills to handle persons with drug and alcohol use disorders and their families (NIMHANS, 2009).

Post-Graduate Institute of Medical Education and Research (PGIMER), Chandigarh has organized six Training of Trainers courses under WHO or UNDCP covering six states (Punjab, Chandigarh UT, Haryana, HP, Rajasthan and Arunanchal) and has trained 80 doctors.

Training Initiative by Ministry of Social Justice and Empowerment

The National Institute of Social Defence (NISD) which functions as an advisory body for Ministry of Social Justice & Empowerment and Resource and Training Centre of Excellence conducts both long term and short term training and capacity building programmes for drug use prevention for staff from NGOs. It has a repertoire of a three Month Certificate Course on Deaddiction, Counselling and Rehabilitation, a one-month course on drug abuse prevention, and five day courses on various thematic issues of drug abuse prevention such as counselling – issues and process, preventive interventions for high risk groups, rehabilitation and relapse prevention – issues and modalities. Several manuals also exist to assist the training courses. The Regional Resource and Training Centres (RRTC's) are the designated NGOs to provide training to service providers of treatment and counselling centres for enhancing their capacity at the regional levels. These RRTCs are located at New Delhi, Pune, Chennai, Kolkata, Imphal, Kohima, and Aizawl. There were 36 courses conducted in 2004-05, 37 courses in 2005-06 and 64 courses in 2006-07 for the beneficiaries (NISD, 2009).

Training Courses on Agonist Maintenance

With the need for agonist maintenance treatment now being recognized in the country, it is important to discuss, the training on agonist maintenance.

International

Internationally, various training courses/modules are available on maintenance treatment. A few of them have been listed in the Appendix to this chapter.

National

A pilot study was initiated by UNODC (ROSA) to examine the feasibility and effectiveness of buprenorphine maintenance in India. Training programmes on buprenorphine maintenance were held during this multi-centre project that was coordinated by AIIMS in 2006. The training included training of five categories of Personnel-Team Leader/programme manager, doctor, social worker, and nurse/pharmacist and laboratory staff. Training was partly common and partly separate and was of 3 day duration. Trainings have also been conducted by Emmanuel Hospital Administration (EHA) before initiating agonist maintenance programme through NGOs. Training programmes on Agonist

Maintenance have also been conducted by certain State AIDS Control Organizations (SACS).

Based on inputs from various experts, the training curriculum on Agonist maintenance for a mixed group of participants was finalized through a national meeting of experts held at NDTC, AIIMS through WHO (India) funds in 2008. The need for this was particularly felt due to the plans to upscale agonist maintenance programme in the country. Some elements of the curriculum proposed in this meeting were:

a. The curriculum for training needs to address different categories of staff like Programme managers, Doctors, Nurses/Pharmacist, Counsellors, Laboratory staff. A sensitization of the Heads of institutions is also required as many of them do not have prior exposure to substance use training, specifically the agonist maintenance training.
b. There should be a common training of one day duration for all staff categories. There should also be a separate clinical/practical training-doctors (3 days), (counsellor (3 days), nurses/pharmacist (1 day), laboratory personnel (1/2 days), and programme manager (1 day).

It was also felt that refresher training needs to be carried out after 2-3 months and that it is important to make site visits and for the trainees to be able to make contact with trainers as and when required. The methods that need to be used for training should include Theoretical lectures, On-site visits, Case demonstrations, Case work-up, Group discussions, and Role plays. The resource material to support trainings should include Practice Guidelines, On-line material in the form of power point presentations, Trainer's manual, CD for demonstration and Patient information sheet.

Based on recommendations of the workshop, two training courses for a mixed group of participants have been held at NDDTC, AIIMS, New Delhi and at RIMS, Imphal in 2009. Based on this, it was proposed that the training course for doctors and counsellors needs to be of 5 days duration and the training to programme managers on management of the programme and to nurses on dispensing related issues can be adequately carried out in 2 days. Issues related to tapering, patients using alcohol on maintenance medication, co-morbid psychiatric illness were added. The psychosocial issues were included in the doctors training as well to facilitate team work and referral for intervention.

iv) Various Training Courses

Over the period, there has been a substantial expansion in both the nature and content of available training courses. This expansion has taken various forms. The course programme and contents have been developed as a module of four month, two weeks, six days and three days duration respectively. Over the period, training courses have undergone changes and new courses have been introduced (summarised in the table below).

Types of courses for doctors:

Training course type	Description	participants	Duration
In-country fellowship	Comprehensive training in identification & management of drug users	Medical doctors (GDMO's)/psychiatrists	**Four months**
Training of Trainers	Comprehensive training in identification & management of drug users	Medical doctors (GDMO's)/psychiatrists	**Two weeks**
Training by trainers	Conducted by regional medical colleges with a resource person from NDDTC, AIIMS joining the course for a short duration	Medical doctors (GDMO's)/psychiatrists	**One week**
Refresher training	Provides continuing education and updating of knowledge	Medical doctors (GDMO's)/psychiatrists	**Three days**

Training course type	Description	participants	Duration
Training for Nurses	Comprehensive training in identification & management of drug users	Nurses	**Two weeks**
Training for para-professional workers	Training in identification , motivation for treatment, assist medical team and aftercare of drug users	Pharmacist, Lab personnel	**Four days**
Training on Agonist maintenance	Comprehensive training in appropriate use with adjunct behavioural intervention	Psychiatrist / Medical doctors (GDMO's) Nurses, Pharmacist, Lab personnel	**Five days**

Feedback on training: Post course evaluation and feedback received from the trainees has shown:

- Individuals who undergo training are given opportunity to work in the field of substance use.
- About 60 percent report having outpatient, inpatient or both the facilities to treat patients with alcohol and drug dependence.
- Majority feel competent to diagnose drug dependence, treat withdrawal and associated medical illnesses.
- Majority feel comfortable to provide brief counselling
- Majority felt that the training was overall adequate.
- Most reported that the training was very useful.
- Most felt the need of additional training in the form of refresher course.

Subsequent training programs must carefully consider the cultural backdrop in which such endeavours will be undertaken. Therefore, the goals to which training efforts must aspire for is to take into account the unique cultural / regional training needs and issues as they differ across and within the states of our country.

The data from treatment seeking demographic profile of users suggest that more than 95% of the treatment seekers are adult males. There are concerns that females and adolescents are not receiving or seeking services. They are under-served by the existing treatment services. There are additional needs of these populations to access satisfactory treatment. These must also be addressed in the training programmes.

BARRIERS FACED IN TREATMENT PROVISION

Based on several interactions with trainees during site-visits or refresher trainings, it emerges that though the training courses have improved the knowledge, attitudes and skills of the trainees, there remain factors because of which physicians have not been able to adequately address substance use problems with their patients in their settings. Some of the barriers that prevent them from functioning optimally are:

- existing work load,
- lack of resources,
- lack of administrative or institutional support,
- disruption of clinical schedules,
- lack of motivation and incentive.

Each of these barriers (individual, professional and systemic) needs to be targeted.

A National Master plan for capacity building

In the proposed approach, the staff from the district hospitals would be provided the training pertaining to treatment of substance use disorders. It is felt that at a minimum level, the services provided at district hospitals should include both outpatient treatment and inpatient treatment (with variable length of stay based on the need and intensity of treatment required). Both, short- and long-term pharmacotherapy and psychosocial interventions (brief-intervention, motivation enhancement and relapse prevention) should be available at the district level. Referral of patients that need more intensive intervention and specialist skills (such as those with associated physical or psychiatric co morbidity and multiple drug use) can be made to the medical colleges.

The training would be conducted in **ten medical colleges or training institutions**. Initial meetings with these institutions will review the existing curriculum and also decide on a training framework. Then, these training institutions can provide training to doctors, nurses and paramedical staff at the district level. Certain central /regional institutions can provide technical support during these trainings. Additionally, training tools such as resource materials for trainers, handbooks and manuals for facilitators would also be prepared.

Subsequently refresher programmes should also be organized for trainers as well as trainees. Specialized training courses focusing on specific interventions that need implementation based on the local drug use scenario also need to be conducted. For example, provision of long term pharmacotherapy using agonist maintenance agents (buprenorphine/methadone). Such specialized training programmes would be useful in those districts where IDU is a problem. These hospitals can then be linked with the targeted intervention sites of NACO.

Expected skills to be developed after training	
Doctors	Assessment and diagnosis of substance use disorders, formulation of treatment plan, delivery of effective treatment services both pharmacological and psychosocial
Nurses	Supportive treatment for substance use disorders, some skills on psychosocial interventions
Paramedical staff	Identification of substance use conditions, skills on psychosocial interventions like motivation enhancement, referral relapse prevention, case management approach

Requirements of institution conducting training:

An institution conducting training needs to fulfil the following requirements-

- Availability of expertise within the institution and to be able to involve other experts from the field as resource persons. A minimum of five experts are required to conduct the training.
- Resource persons should able to devote the necessary time for training (taking lectures, group discussions, case demonstrations and case discussions). A total of about 38-40 man-hours are required for the training by trainers programme.
- Availability of adequate patient load to allow clinical demonstrations and case-work-ups.
- Ability to organize the logistics aspects of training such as a classroom, stay for trainees, meals etc.

The development of a National Master plan can have important implications for education and training of the health workforce. A master plan is needed to guide national capacity building,

development and to assist each state /centre in setting its own priorities based on local needs. The initiative needs to be supported by sustainable funding resources. This would establish and operationalise a national level framework that would facilitate continuous learning and prepare for a systematic and sustainable approach to providing medical and para-professional with equitable access to skills development. We discuss below relevant details.

The year of activity would be 2010-2013. It is proposed that about 10 medical colleges may be involved in the training and may become training institutions for general duty medical officers / psychiatrists and other staff in the field of substance use disorders at the regional level. The conduct of the training courses should be preceded by a meeting of the Head of department of the institutions who will be conducting the training or their nominees. It is also important to conduct sensitization workshops on substance use disorder for Medical Superintendent of district/civil hospitals so that the trainees are able to put their training into clinical practice and the area is identified as an important area by the hospital. This is because they may need structural support such as provision of medicines, support staff, allocation of time which they can devote to drug use related services.

Proposed National Master Plan for training

- Training of doctors, nurses and paramedical staff to be conducted in ten training institutions
- 2 courses/year for each: doctors, nurses and paramedical staff per year
- By the year 2013, 1000 doctors, 1000 nurses and 1000 paramedical staff from 500 district/civil hospitals can be trained

By end of year 2013, it is proposed to train 1000 doctors, 1000 nurses and 1000 paramedical staff from 500 district/civil hospitals through ten institutions. Therefore, 250 doctors, nurses and paramedical staff each needs to be trained in a year or 25 doctors to be trained by each institution in a year. If each course for doctors comprises of about 10-15 participants, then 2 courses need to be conducted for doctors by each institute in a year with a similar plan for nurses and paramedical staff.

The Ministry of Health and Family Welfare through its nodal institutions will be involved in

- Coordination of the activity
- Organizing meetings with the training institutions and working on a framework for conducting the trainings
- Providing technical materials that have been developed through meetings of national experts. This includes the curriculum for the trainings, the resource material –manuals, CDs and Power point presentations and also the assessment formats that have been used. These would also be available on the website.

Conclusion

Capacity building through training of staff is an important step in improving treatment seeking as well as quality of treatment that is provided to substance users. To meet the treatment need, treatment must be available at the district hospitals. Seeing the magnitude of the problem and the disability caused by it, it is important to invest national resources in training of staff working at the district level. Training can be conducted through certain identified medical colleges. Curriculum and resource material have been developed in the last few years through national meetings and with some additional inputs, it is feasible to train the staff from 500 district hospitals in about three years.

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Appendix 1: Certification: International efforts

Certification by the **American Society of Addiction Medicine (ASAM, 2009)** requires clearing an examination. Eligibility for appearing in the examination requires that a medical graduate complete one year's full-time involvement or one full-time equivalent in the field of alcoholism and other drug dependencies in addition to, and not concurrent with, residency training. One Full time equivalent is equal to at least 1920 hours over the last 10 years in teaching, research, administration, and clinical care of the prevention of as well as treatment of individuals who are at risk for or have a substance use disorder. At least 400 of these hours should have been spent in direct clinical care of patients. Certain credits are also required as eligibility.

Certification by International Society of Addiction Medicine: The field of Addiction Medicine requires knowledge of pharmacology, psychiatry, general medicine, and psychology, as well as an understanding of the interaction of these disciplines. In order to insure that the trainee is well-versed in these areas, training programs must include both hands-on experiences in clinical situations as well as classroom and seminar sessions.

1. Recognition of the signs and symptoms of the use of all of the major categories of drugs/psychoactive (mood-altering) substances, including sedatives (alcohol, benzodiazepines, barbiturates), stimulants (cocaine, amphetamine, tobacco), opioids, hallucinogens (marijuana, LSD, PCP) and inhalants (organic solvents, glue)
2. Recognition of the signs of abuse and dependence on these categories of drugs/substances
3. Recognition of the signs of withdrawal from these major categories of drugs and knowledge and experience with the range of options for treatment of the withdrawal syndrome and its complications
4. Recognition of the signs and symptoms of overdose and medical and psychiatric sequelae of these major categories of drugs and knowledge of the proper treatment of overdose.
5. Diagnosis of the medical sequelae of addiction, including hepatic, central nervous system, infectious, and HIV illness.
6. Recognition of the signs and symptoms of the psychological, social and spiritual problems accompanying the chronic use, abuse and dependence related to the major categories of drugs and knowledge of the range of management options.
7. Recognition and understanding of the special problems of drug/substance use, abuse and dependence during pregnancy and of the babies born to these mothers.
9. Recognition, education and appropriate treatment related to behavioural addictions like gambling, sex and love, internet, work, shopping etc.
10. Recognition, education and appropriate treatment of adjustment disorders and/or other concurrent illness in individuals and their family members

BASIC CLINICAL EXPOSURE

1. Exposure in the clinical context to:
   a) patients with substance-related disorders in a community, out-patient setting
   b) hospitalized medical and surgical patients with substance-induced disorders and substance use disorders
   c) psychiatric patients -- inpatient or outpatient -- with concurrent substance use disorders, specifically - Substance Abuse and Substance Dependence, including alcohol, tobacco and other drugs
   d) families of above patients suffering from adjustment disorders
2. Laboratory assessments

a) biochemical indicators of chronic alcohol/drug use and their complications
b) questionnaire assessments, such as the MAST, AUDIT and CAGE-AID
3. Knowledge of the evaluation and treatment of abuse of each of these categories of agents:
a) depressants like alcohol, benzodiazepines, barbiturates
b) opioids
c) cocaine and stimulants
d) marijuana and hallucinogens
e) inhalants like organic solvents, glue
4. Pharmacology of the aforementioned psychoactive/mood-altering substances
5. Types of treatment
a) detoxification
b) medical complications of substance use disorders (including intravenous drug use and its related transmission of infectious diseases like Hepatitis B, C and AIDS)
c) rehabilitation models based on 12-step programs and other psycho-social-spiritual, behavioral approaches
d) counseling, individual psychotherapy and group psychotherapy
6. Exposure in the clinical context to the diagnosis and treatment of behavioral addictions

Source: http://www.isamweb.com/pages/International_certificate.html

Certification programmes for nurses are also available. The World Health Organization and the International Nursing Council (WHO-ICN 1991) have recommended a model which proposes (a) a **basic training** of nurses in general care focussing on sensitization, awareness and understanding of the problem of drug use, (b) an **advanced training** for nurses from specialized services or outpatient clinics with specific needs and characteristics requiring technical skills and specific interventions and (c) a **specialized training** for nurses directly involved in the care of drug users so they can provide adequate care.

Appendix 2: Training Courses on Agonist Maintenance: International efforts

- A training course programme on Methadone maintenance has been developed by WHO (SEARO) for physicians (3 day training), counsellors/case managers (3 day training), clinic staff (2 day training) and pharmacists and dispensers (1 day training). The themes to be covered in the curriculum have also been listed (www.searo.who.int/).
- SAMHSA's Centre for Substance Abuse Treatment (CSAT) in USA involves a training of physicians of 8 hour duration for prescribing Buprenorphine (http://csat.samhsa.gov/). Combined online and face-to-face training provided in 8 hours is needed to obtain the waiver to use buprenorphine. Besides the curriculum sample slides and sample questions are available. The American Academy of Addiction Psychiatry (AAAP) and American Psychiatric Association (APA) also offer Web-based instruction.
- Through the Blending Initiative by NIDA's Clinical Trials Network and staff from SAMHSA / CSAT's ATTC Network, Training Package Contents are available for download which includes a 6-hour classroom training program providing an overview of Buprenorphine treatment, a Trainer's Manual, Annotated bibliography and research articles and a video about Buprenorphine (http://www.nida.nih.gov/Blending/buptreatment.html).
- The Drug and Alcohol Services South Australia (DASSA) suggests separate training programs for each medication methadone and buprenorphine. Training on Buprenorphine involves theoretical knowledge acquisition, practical problem solving and practical skills development. The training in metro area includes non-clinical teaching through a half-day workshop (on a weekend) and clinical

sessions of one day at one of the DASSA sites. In the rural and remote areas, training is on site, is of one day duration and is of workshop format with role plays for relevant skills. They also have Clinical Guidelines, ongoing education through a bi-monthly newsletter with practical clinical and administrative information, quarterly meetings for prescribers, rural and remote meetings and practice visits and audit undertaken by DASSA medical staff. The DASSA doctor sits in with the GP while seeing their patients, with opportunities for discussion and feedback and case note audit and feedback (http://www.dassa.sa.gov.au/site/page.cfm?u=370).

Minimum Standards of Care: *Monitoring and Evaluation*

Mukta Sharma[5]

INTRODUCTION

Drug treatment services can be delivered as part of a standalone service or be integrated into the wider health system. Services can be delivered by governmental agencies or non-governmental and community organizations either as outpatient or in patient services – in some cases, both. While all drug treatment centres should aspire towards good practice, this is often context specific and depends on a number of resource and capacity factors. Irrespective of the modality and nature of delivery of drug dependence treatment services, certain minimum standards of care need to be delivered in every treatment centre that aims to offer treatment and management of substance use problems. These have been discussed elsewhere in this monograph.

Once the minimum standard of care that a drug treatment centre (DTC) (or a De-Addiction Centre – DAC, as it is called in Indian health system) must provide has been defined, it must be followed by a clear and simple procedure to monitor implementation of those standards. When devising such procedures, certain basic principles must be kept in mind. *First*, monitoring and evaluation (M&E) must not be seen as an additional burden, but built into existing or routine systems where possible. This is only possible in situations where existing systems are functional. Where such systems do not exist, an additional investment in terms of time and resources is required. *Second*, the indicators used for monitoring should be simple, unequivocal and objective. Often too much information and data are collected, which is not useful or not analysed. This creates an unnecessary burden on staff who is tasked with collecting that information. *Third*, monitoring and evaluation are ongoing activities that should be repeated periodically. These should never take the form of inspections, rather they are opportunities to build capacity and make improvements. *Fourth*, as M&E is an ongoing activity, an adequate allotment of human and financial resources to this activity must be built into budgets and terms of reference of treatment centre staff. *Finally*, any assessment of the implementation of standards should include client[6] perspectives - as the entire aim of implementing a minimum set of standards of care is related to improving the experience and outcomes of patients who seek treatment for substance use disorder in these centres.

Monitoring and Evaluation: Basic Issues

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

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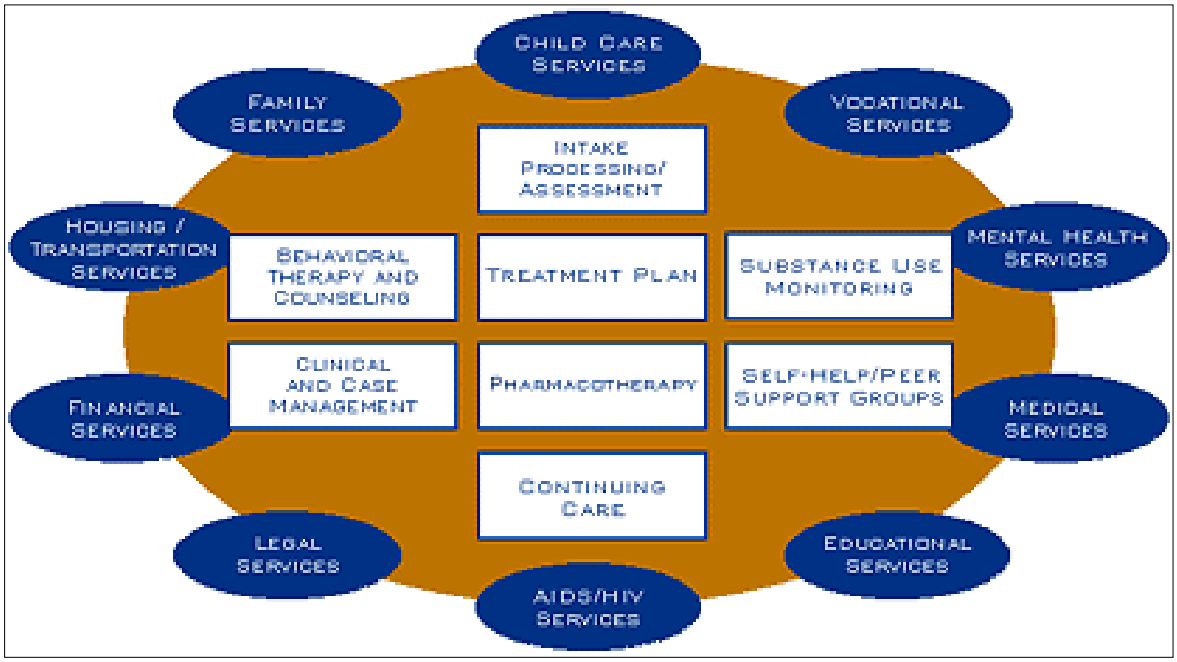
[6] In this chapter, terms 'client' and 'patient' have been used interchangeably.

Any M&E activities relating to the implementation of minimum standards must also be guided by the basic principles of drug dependence treatment. These are most clearly enunciated in the WHO and UNODC, (2008) guidelines and are paraphrased here:

- Drug dependence treatment must be available and accessible.
- Screening, assessment, diagnosis and treatment planning are essential components of drug dependence treatment.
- Drug dependence treatment must be evidence informed.
- Drug dependence treatment must be delivered in a way that upholds human rights and patient dignity.
- Drug dependence treatment must be tailored to adequately target specific sub populations (such as women, adolescents) and conditions (such as HIV positive individuals).
- Drug dependence treatment must be made available within the criminal justice system and options to divert drug users into treatment must exist
- Drug dependence treatment must happen with the participation of the patient and the community
- Patients must receive orientation to treatment services, including their roles, responsibilities and privileges
- Drug treatment services must have accountable, effective and efficient clinical governance and management systems
- Drug treatment services must be guided by appropriate treatment policy, strategic planning and effective coordination across different sectors including health, law enforcement, and civil society.

The components of "good" drug dependence treatment are shown in Figure 1. These are presented in white boxes and include: intake processing, assessment, treatment plan formulation, behavioural therapy and counselling, clinical case management, pharmacotherapy, substance use monitoring, peer support groups and ongoing follow up.

Figure 1: Components of "good" drug dependence treatment



Strong linkages and referral mechanisms with other support services (which are marked in blue ovals) are also required. In some cases, unless some supportive services are available, it will not be possible to deliver the minimum components of drug dependence treatment – for example, a female drug user may not be able to come into the treatment centre if no mechanism to take care of her children while she is accessing treatment is available to her. However, the provision of some or all of these support services may not be possible in many developing country settings – meaning that many drug treatment services may be constrained by the overall lack of supportive social services or infrastructure requirements. Therefore, in this chapter (as in other chapters of the monograph) we will discuss the implementation of standards that guarantee the delivery of a minimum set of services rather than attempting to reach "best" practice in service delivery.

IMPLEMENTING AND MONITORING MINIMUM STANDARDS

While defining a set of minimum standards of care is a relatively easy task, actual implementation – particularly in the overall context of poor health infrastructure and limited human resource capacity – is a significant challenge. For example, if a facility does not have running water, poor equipment, and inadequate nursing staff, then it is not possible to adhere to a minimum standard of care. Therefore, unless health system strengthening occurs side by side, the implementation of minimum standards of care tends to remain a theoretical concept in many settings.

Key to the implementation of minimum standards of care is the capacity building of the staff (both managerial and technical), and a clear written description of roles and responsibilities for each staff member. Each staff member must clearly know what their roles and responsibilities are in implementing and maintaining a set of minimum standards of care. Additionally, written materials to support implementation of established standards are important (in the form of standard operating procedures/ job aids) and adequate supervision is vital. **A simple and reader friendly copy of standard operating procedures must be available in every DAC.** Finally, compliance with minimum standards is helped if the agreed standards are visibly displayed in the DAC and staff is held accountable for the implementation of agreed standards of care, both by clients as well as service managers.

In order to monitor the implementation of minimum standard compliance, a combination approach of gathering and analyzing information/data from checklists, service records (includes intake forms, assessment sheets, client files, treatment plans etc) and staff/client interviews should be used.

- **CHECK-LISTS AND RECORD-REVIEWS**

For routine monitoring, a simple checklist can be administered by the medical officer in charge. This can be done on a three monthly basis and is best done by an initial review of randomly selected case files. This depends on a functioning system of making and storing individual client files - case files must be properly updated and organized. All case files should be traceable with a unique registration / code number. Each case file should have the following documentation as a minimum:

1) Consent form – client and family members
2) Medical case sheet, including a history of any referrals
3) Case history or assessment sheet
4) Summary of issues raised in counselling sessions
5) Summary of information about the client's participation in the programme and his/her progress

6) Individual treatment plan
7) Discharge counselling form
8) Follow up form

The checklist should be simple, easy to administer and should be designed in a tiered manner – in order to enable the flagging up of urgent issues. An example of a checklist is provided below. A red flag indicates a serious lapse in compliance with minimum standards and corrective action must be immediate.

Table 1: Example checklist for monitoring compliance with minimum standards in the intake/ processing and assessment stage

Indicator		Yes	No	Comments
a. All clients give informed consent as verified by client file and interviews with individual files.				
b. All clients wishing to receive drug treatment are assessed using standard assessment checklist by counsellor and doctor as reflected in client file				
c. Assessment clearly indicates if a diagnosis of dependence based on ICD- 10 or DSM IV has been made				
d. Assessment clearly identifies any physical and other harms associated with clients drug use (confirmed where required by lab reports) as seen in client file				
e. Written treatment plan is available in client file and has been signed by the client to indicate his agreement				
f. Clients, both inpatient and outpatient inducted into all DAC procedures and policies as verified in interviews with client and staff				

Note: In places where the red flag appears, it indicates that a 'no' answer is a serious lapse in maintenance of minimum standards of care and needs to be immediately addressed.

Table 2: Example checklist for monitoring minimum standards in post-diagnosis and treatment planning stage				
Indicator		**Yes**	**No**	**Comments**
g. All clients attending DAC receive counselling sessions – on motivational enhancement therapy, risk reduction, relapse prevention as verified through interviews with client and notes in client file				
h. Confidential HIV testing and counselling has been offered to the client and evidence of pre test counselling and /or referral to ICTC is present in case file				
i. Withdrawal services are in line with practice guidelines / manuals / protocols and client prescriptions reflect appropriate medication and dosage				
j. All clients generally report that staff were supportive during withdrawal and they received appropriate medication in interviews with them				
k. For DACs dispensing medications, all documentation under NDPS Act and other relevant laws are updated and available for inspection				
l. Controlled medication is kept under lock and key and stock registers are updated as confirmed through visual inspection				
m. Dispenser checks identity of patient before dispensing controlled medication and cross check amount with prescription as confirmed by visual inspection				
n. Patients on pharmacotherapy are monitored for other legal/illegal substance use and overdose potential (by patient interview, physical examination and/or urine testing) and verified in doctors notes in case file				
o. Dosing of patients is in line with practice guidelines / manuals / protocols and is reflected in prescriptions and visual inspection of dispensing practices				
p. Regularly scheduled group meetings / group sessions of patients are held in DAC or at another convenient venue				
q. All clients are given discharge				

	counselling and asked to attend day care or follow up				
r.	An emergency tray and a procedure for dealing with emergencies such as fires and earthquakes in established, visible and clear to staff as confirmed by visual inspection and staff interviews				

Additionally, service statistics and patient outcome data are useful in understanding the extent of the implementation of, and compliance to minimum standards of care. For example, if very few clients are recorded as having received discharge counselling, this may indicate problems with the implementation of standards relating to follow up. Similarly, if there is a high dropout rate indicated by clients leaving treatment before completion, this could also point to problems.

- **OBSERVATIONS AND PATIENT INTERVIEWS**

Observations are also an important tool when assessing the level of implementation of minimum standards of care. For example, if a patient shows significant Alcohol withdrawal on day 3 of his treatment and both the assessment sheet and treatment plan do not reflect Alcohol use in the last one month - then this may indicate lapses in the assessment process. A good starting point in observations is to approach the patients openly, observe them carefully and talk to them for a few minutes – asking them how they feel, what problems they are currently having and invite comment about their experience in the DAC so far. After this initial dialogue the case files of the patient should be reviewed for consistency between observations, patient reports and recorded information. It is important to note that when this method of monitoring is used, it requires a person who has significant experience in managing drug dependent patients. The observation tool is not suited for routine use, but can be used bi-annually or annually, depending on human capacity and resources.

Consulting with staff and patients in the form of brief interviews or informal discussions and observations will also be of great use to an assessor. Well developed and easily administered tools that assess client satisfaction exist. However, such tools are best administered by an outside independent assessor to prevent bias (or be given to the client to self administer) and should be interpreted in conjunction with other available data. Such a tool should not be administered to clients in withdrawal or who may be intoxicated. An example is provided in Table 3.

Table 3: Sample client satisfaction form	
1. About the treatment here I feel (tick one)	○ Unhappy ○ Just okay ○ Satisfied ○ Happy ○ Very happy
2.I would rate the admission procedure here as (tick one)	○ Very poor ○ Poor ○ Average ○ Good ○ Very good
3. I would rate the medical care here as (tick one)	○ Very poor ○ Poor ○ Average ○ Good

	○ Very good
4. I have been seen by a counsellor during my treatment here (tick one)	○ More than 3 times ○ 3 times ○ Between 1- 2 times ○ Never
5. I would rate the management of my withdrawals during treatment as (tick one)	○ Very poor ○ Poor ○ Average ○ Good ○ Very good
6. I would rate the overall nursing and therapeutic services here as (tick one)	○ Very poor ○ Poor ○ Average ○ Good ○ Very good
7. This centre is a drug free place (tick one)	○ All the time ○ Most of the time ○ Sometimes ○ Drugs can come into the centre easily
8. The centre staff treat patients well (tick one)	○ All the time ○ Most of the time ○ Sometimes ○ Rarely ○ Never
9. Would you recommend this treatment centre to other drug users (tick one)	○ Yes ○ No If your answer is No, please explain the reason……

ANALYZING, REPORTING AND DISSEMINATING M&E DATA

While it is essential that the data collection and monitoring tools suggested in the previous section should be appropriately used by staff at all levels, unless the information is actually analysed and reported, any M& E effort is likely to be wasted. Within each DAC, this responsibility must be given to a specific person. Standardized and easy to complete reporting formats must be developed and the mechanisms for reporting should be well understood by all staff in the DAC. Reports must be completed and submitted at least once every six months. Reports are also not just meant for government agencies, health administrators or policy makers. In order for the M&E to be effective, the results of M&E exercises must be shared with the staff. Good performance of staff in DACs must be commended and positive suggestions for improvements should be made in order to keep staff motivated.

MONITORING MINIMUM STANDARDS OF CARE IN DRUG DEPENDENCE TREATMENT AT THE NATIONAL LEVEL

While individual drug dependence treatment facilities are responsible for ensuring the delivery of standards of care, there needs to be some mechanism to monitor standards and outcomes at the national and state level (as health is a state subject in India). Given that more than one ministry is involved in India, it is important that parallel systems are not set up and one national integrated system is set up. For this purpose, a focal point for M&E and quality assurance in each ministry is a

pre-requisite. There must be regular meetings and coordination between the concerned ministries and agreement on the minimum standards of care. These focal points may consider undertaking the following activities:

1) Undertake annual reviews personally in a selection of DACs - both announced as well as unannounced visits.
2) Ensure that an adequate mechanism for reporting programme-data and patient outcomes is set up. This will require technical assistance and the allocation of funds from the concerned ministries.
3) Meet regularly with heads of institutions and DAC staff to advocate for the implementation of minimum standards in all facilities and understand the problems faced by staff in implementation
4) Commission regular surveys and evaluations (once every two/three years) that provide information on standards and outcomes in DACs.
5) Ensure the dissemination of survey and evaluation results to a wide range of partners including all DACs, civil society, NGO and private service providers and representatives of drug user groups.

Key Readings

- WHO and UNODC (2008) " Principles of Drug Dependence Treatment", Discussion Paper, available at http://www.unodc.org/docs/treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08%5B1%5D.pdf
- WHO (2008) "Operational Guidelines for the Management of Opioid Dependence in South East Asia, New Delhi, India
- WHO (2009) "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence", Geneva, Switzerland
- The Colombo Plan Drug Advisory Committee (2006) "A guidebook on minimum standards – Management of Drug Treatment and Rehabilitation Programmes in Asia"

ANNEXURE 1

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ANNEXURE 2

***Meeting on:*Minimum Standards of care for Government De-addiction centres**

27th July, 2009

Department of Psychiatry, AIIMS, New Delhi

BRIEF REPORT

A meeting was organized where all the draft write-ups were discussed among authors, invited resource persons and certain other stakeholders. A total of 14 participants were present (list attached).

Prof., R Ray, Chief, NDDTC, AIIMS welcomed the participants. He provided a brief account of genesis of the *Minimum standards of care* monograph. He also thanked WHO (India) for its support to this activity under the WHO Biennium activities (2008-09).

This was followed by the presentations by the authors on their respective chapters and discussion among the participants on the contents of each chapter. By and large consensus was achieved on the contents and organization of the monograph. Some specific remarks / suggestions / recommendations have been listed below:

- The successful initiative of the NGO sector (under MSJE) to develop and implement a manual on minimum standards should be highlighted. Though the group felt that a detailed description of or any comments on the MSJE manual or comparison with the proposed monograph should be avoided.
- The Monograph should recommend that the grant to the Govt. DACs should be linked to the implementation of minimum standards by the centres.
- All the facilities i.e. infrastructure, staff, services which a de-addiction centres shares with the attached hospital should be specifically mentioned. In other words, all the specifications proposed in the monograph should not be seen as exclusively for the de-addiction centres, since many of these may be shared with the hospital.
- The group strongly felt that at a minimum level a GDMO (as opposed to a psychiatrist) should be recommended for the government de-addiction centres.
- Expected skills for the various categories of trained staff should be specified in the chapter on 'training'
- At this stage, specification or projections of resources (funding) which would be required can be avoided.

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ANNEXURE 3

List of De-Addiction Centres established under the Ministry of Health and Family Welfare

As of now, a comprehensive list of De-Addiction Centres with full contact details is not available. UNESCO India has recently attempted to provide such a list as an annexure to one of the recent publication[7]. We take this work forward by adding some more contact details. However, this should be seen as a work in progress. In future this list will be hopefully updated so that contact details of all De-addiction centres are available.

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7 UNESCO (2009), *Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres in India*, UNESCO, New Delhi

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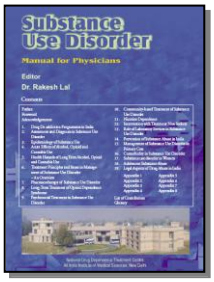
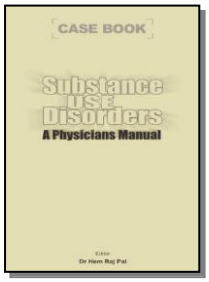
Other publications by NDDTC, AIIMS

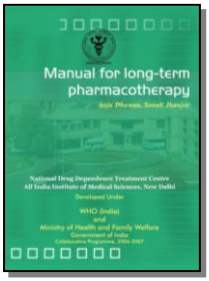
It has always been an endeavor of the centre to produce high-quality resource material on substance use disorders for various health professionals.



Substance Use Disorders: Manual for Physicians



Case Book - Substance Use Disorders: Manual for Physicians



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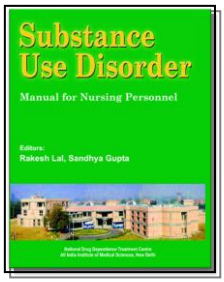

Substance Use Disorders: Manual for Nursing Professionals

Drug Abuse: *News-n-Views*

A newsletter published twice a year, focused on a specific theme related to substance abuse and its treatment

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These can also be downloaded free from our website

http://www.aiims.edu/aiims/departments/spcenter/nddtc/nddc_intro.htm