

Drug De-Addiction Programme (DDAP)
Ministry of Health and Family Welfare (MOH&FW),
Government of India

STRATEGY AND ACTION PLAN:
Enhancing the functioning of Drug De-Addiction Centres
under DDAP

National Drug Dependence Treatment Centre (NDDTC),
All India Institute of Medical Sciences, New Delhi

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A. BACKGROUND

Substance use is a significant problem in the country and a matter of concern. Even though there have been no recent nationwide surveys in India, data from existing surveys (National Survey on Extent, Pattern and Trends of Drug Abuse, 2004; National Family Health Survey, 2006) can be extrapolated to estimate that there are about 1 crore people in India who are near daily alcohol users and would need treatment for alcohol abuse/dependence. Similar figures for cannabis are about 11 lacs and for opioids about 5 lacs. Clearly that is a huge treatment need in the country but a miniscule of them has received treatment and the existing services are not able to cater to this need.

In India, the demand reduction for alcohol and drug use is the mandate of primarily two ministries of the union government, (a) Ministry of Social Justice and Empowerment (MSJE) and (b) Ministry of Health and Family Welfare – through its Drug De-Addiction Program (DDAP). While the MSJE program is implemented by NGOs, the DDAP has provided one-time grant to establish about 122 De-addiction centres (DACs) associated with various district hospitals and psychiatry departments of medical colleges with the understanding that the states (department of Health) will provide the required additional support to keep them functional. However, very little support has been received in most of the states as alcohol and drug abuse has not been identified as a priority health issue in spite of the large number of people affected. Some of these DACs (those in North-eastern region of the country, N=40) also get a recurring grant of Rs 2 lakhs/year for certain expenditure such as medicines. The centre at AIIMS has been designated as the National Drug Dependence Treatment Centre (NDDTC) and functions as a resource centre of the DDAP of the Ministry of Health and Family Welfare, Government of India.

Current Status of the DACs

1. Evaluation of the functioning of the DAC

It has been a challenge to know the current status of functioning of these established treatment centres (DACs) as most of them do not report their status on a regular basis to the MOH. In the past twice, evaluation exercises were conducted by the NDDTC regarding functioning of these DACs once in the year 2002 through a collaborative project of the WHO(I) and DDAP-MOH and again in the year 2006-07 for the report of a parliamentary committee. Both these efforts involved on-site visits and postal questionnaires. Besides these, zonal meetings have been conducted in 2008 and officials from the DDAP-MOH joined many of these meetings.

The study in 2002 noted that of the 104 centre studied, only 43 (41%) were functional and the remaining 61 (59%) was non-functional. However, 34 out of the 61 “non-functional centres” did provide De addiction Services in a limited way as a part of psychiatric/general medical services. The patient load in most centres was low and most did not provide any medicines to these patients. The staff present in most of the centres was grossly inadequate. Only a few had received grants from the state health departments and the programme had received very low priority by the state government.

In 2006-07, another effort was made to evaluate the functioning of the government De-Addiction Centres through site visits and interactions with the key functionaries of the state health departments. Evaluation of the centres was carried out on the following parameters - patient load, treatment being provided, availability and utilization of equipment, availability of staff and review of records. A total of 44 centres were visited by the staff from NDDTC (N=30) and NIMHANS (N=14). It was noted that approximately 50% had a separate facility for de-addiction. In some, the infrastructure originally made for the de-addiction centre was being used for other purposes – administrative offices, ICTC/ ART, school health, store etc. Approximately half did not have separate bed allocation for De-addiction and except the two nodal centres (NDDTC and NIMHANS), none had dedicated staff to treat these patients. In the majority of the Centres there were no earmarking days for a clinic offering these services and patients were being seen in the routine Psychiatry OPD. Treatment services were chiefly pharmacological and limited to detoxification. Record keeping was unsatisfactory and were generally a part of Psychiatry record keeping so it was difficult to get separate data on these patients. Linkage with NGOs for rehabilitation was the exception rather than the rule.

These evaluations revealed that almost one third DAC remain existing only on papers (i.e. only the building in place, which is being used for some other purpose), another third remain functional but only partially, while the remaining third can be categorised as functioning adequately.

2. Patient load

Another indication of functioning comes from the Drug Abuse Monitoring System (DAMS), whereby all the DACs are expected to provide data for all the *consecutive* new patients seeking treatment from them, to NDDTC, annually. The DAMS data from the year 2007 to 2012 shows that overall 68 centres have provided data for at least one year during this period. Of these, 42 centres (30%) have provided data for at least one year in the last 3 years. Even among the centres, which provide the DAMS data it is clear that the patient load is very low. For instance in the year 2012, only about 32

centres contributed to the DAMS. Except for the three outliers – NDDTC, AIIMS; PGI Chandigarh and NIMHANS, Bangalore with 3134, 1429 and 1154 patients (2011) respectively – remaining centres provided services to less than 400 new patients per centre in the entire year. **This is less than 2 patients per day in a typical centre!**

So, overall the **challenges** are:

1. No regular funding (except for centres in the North-East where the funding is available, though inadequate).
2. Low priority given to de-addiction services by the state health departments/district/civil hospital authorities
3. No dedicated staff available
4. Lack of support staff – Nurse, social worker, counsellor.
5. Poor patient load and treatment non-seeking
6. Irregular supply of medicines. No medicines available for long term use.
7. Lack of community based activities and linkage with NGOs
8. Inadequate record keeping or data management
9. No services available for women and adolescent substance users

The existing myths and facts that may have contributed to this are given below:

Myths	Facts
<i>Substance use disorders are a bad habit or a social problem.</i>	People start substance use voluntarily but usually continue as dependence sets in. Drug dependence is a medical disorder associated with neurobiological changes in the brain.
<i>People afflicted or affected by substance abuse or dependence are few in number and it affects only certain sections of society.</i>	The numbers affected are very large (with alcohol dependence affecting 1 crore people approximately) and this condition affects people from all sections of society.
<i>Substance users do not want to give up drug use.</i>	Many users want to give up drug use provided treatment is available in a patient-friendly environment to take care of their discomfort/withdrawals.
<i>Treatment of substance use must take place in an inpatient restrictive setting.</i>	Treatment can mainly be provided through outpatient setting and only some patients need to be managed in an inpatient setting.
<i>Treatment does not help.</i>	There is adequate data that has shown without doubt that treatment of substance abuse or dependence improves outcome for the individual, reduces burden on the family and cost for society.

B. PROPOSED STRATEGY FOR ENHANCING THE FUNCTIONING OF DACS – RUNNING DRUG TREATMENT CLINICS (DTCS)

It is proposed to enhance the functioning of DACs functioning under DDAP through entities called as 'Drug Treatment Clinics' (DTCS). This programme will be implemented by NDDTC, AIIMS under support and supervision of DDAP, MOH&FW. Through this initiative, NDDTC, AIIMS will identify health facilities which will provide drug treatment services for all types of drug users in keeping with the established standards of care and treatment. Those de addiction centres which already have infrastructure to run drug treatment centres would be identified. These centres would be provided

staff and consumables, including medicines to run drug treatment centres. The staff would be trained and employed exclusively to run these services. In this process, NDDTC will also enhance the capacities of two other centres as 'Regional centres' which will be capacitated to mentor and supervise other drug treatment clinics in their region. Broadly, the roles and responsibilities of each entity would be as follows:

a) National Centre – NDDTC, AIIMS

Besides managing a DTC of its own, NDDTC, AIIMS will act as the national coordination centre for the entire programme. The responsibilities of National centre, under this programme can be summarised as follows:

- The chief / head of the department / centre shall identify and nominate faculty members / staff who would be entrusted with the specific tasks of carrying out various activities under the programme.
- With support from the DDAP, MOH&FW close coordination and implementation of the entire activity and to identify the regional centres and sites for Drug Treatment Centres (DTC). The regional centres will be identified based on their strengths (participation as training resource institutions in previous training programmes)
- Development, distribution and sharing the resource material to ensure Minimum Standards of Care
- Developing training curriculum, developing formats for evaluation and monitoring
- Training of Service providers at DTCs
- Training of Trainers for the regional centres,
- Overall financial management and co-ordination of the programme implementation

NDDTC as the National Centre: Attributes/strengths
<ul style="list-style-type: none"> • National resource centre under the DDAP, MOH&FW • WHO collaborating centre for Substance Abuse • Coordinating centre for training program for GDMOs under the NFCD (Dept of Revenue, Ministry of Finance) funded scheme • National Technical Training Centre under the project Hifazat (funded by GFATM round 9 grant) for training of staff working under National AIDS Control Programme (entrusted with mentoring other RTTCs with additional responsibility for North India)

b) Regional Centres

The regional centres, besides managing their own DTCs, will also be responsible for the following activities:

- The chief / head of the department / centre shall identify and nominate faculty members / staff who would be entrusted with the specific tasks of carrying out various activities under the programme.
- Coordinate and work closely with the national centre (NDDTC, AIIMS) and act as a resource centre for the DTCs in their geographical region
- Training of the staff of the Drug Treatment Centres (DTC) and mentorship
- Evaluation, monitoring and Reporting

c) Drug Treatment Centres (DTC)

It is proposed that under this programme, the DTC should be made functional in Government Health care facilities (i.e. medical colleges and civil hospitals / district hospitals).

The features of these DTC would be:

- Part of the general hospital
- Dedicated outpatient clinic to provide services for patients with substance use problems
- Managed by dedicated staff (staff from the hospital and two contractual staff – one doctor + one counsellor engaged on a contractual basis exclusively for this purpose *(or placement of existing staff in NACO OST services where available)*)
- Available services would include provision of treatment services including psychosocial interventions as well as pharmacological treatment largely on outpatient basis.
- Those requiring in-patient care (a minority) will be admitted
- Services would be available for a range of substance use problems
- All the necessary medicines (including those for long term treatment) would be dispensed free of cost
- Referral and Linkage services would be made available to the patients – from other departments of the hospital
- Apart from patients, support and counselling services would be available for the family /care-giver.
- Community based activities in the form of awareness generation using IEC material will also be included
- Provision of services for special groups such as women and adolescents will be ensured in select centres

C. ACTION PLAN

The operational aspects of the entire programme have been described below. The programme will be managed, implemented and coordinated by the National centre, (NDDTC, AIIMS), through specific, earmarked grant provided by the DDAP, MOH&FW.

Operationalizing the entire exercise would involve the following steps:

1. **Communication from the DDAP to all the stakeholders identifying NDDTC, AIIMS as the National centre, and requesting them to extend cooperation for this plan.**

Through a communication from the DDAP to the state departments of Health, NDDTC AIIMS has been approved as the National centre to implement this programme and request has been made to various stakeholders to extend their cooperation.

2. **Identification of the regional centres (proposed below)**

Rationale for regional centres: All the staff from DTCs would require training programs. Additionally, all the DTCs will have to be monitored with respect to certain indicators of functioning and mentored with the purpose of ‘hand-holding’ for solving day-to-day problems. Thus it is being proposed that a network of Resource Centre – ‘regional centres’ be established in the country,

which will be located in the academic institutions of repute. At present, it is proposed to designate the following two institutions as regional centres since they are functional as training / resource centres under various national activities.

Regional Centres:

Centres	Attributes/strengths
1. KEM Hospital, Mumbai – Department of Psychiatry	<ul style="list-style-type: none"> • A reputed medial institution • Already running a De-addiction centre established by DDAP • Functioning as a resource centre For the <u>West zone</u> for training program for GDMOs under the NFCDA (Ministry of Finance) funded project • Regional Technical Training Centre – <u>West</u>, under the project Hifazat (funded by GFATM round 9 grant) for training of staff working under National AIDS Control Programme
2. RIMS, Imphal– Department of Psychiatry	<ul style="list-style-type: none"> • A reputed medial institution • Already running a De-addiction centre established by DDAP • For <u>Northeast</u> zone for training program for GDMOs under the NFCDA (Ministry of Finance) funded project • Regional Technical Training Centre – <u>Northeast</u>, under the project Hifazat (funded by GFATM round 9 grant) for training of staff working under National AIDS Control Programme

Thus these institutions have De Addiction Centres established by the DDAP – could become the regional centres and provide mentoring and monitoring to all the DTCs in their respective regions.

It must be noted that in the first year, the two regional centres proposed – KEM, Mumbai and RIMS, Imphal – shall function as DTCs, in collaboration of the National centre – NDDTC, AIIMS. From year two onwards, both these centres shall begin functioning as regional centres, besides managing their own DTCs.

Procedure for engagement of Regional centres: *The communication from the DDAP, MOH&FW along with the action plan document will be shared with the regional centres and a letter of agreement from the competent authority (addressed to chief NDDTC, AIIMS) shall be obtained. In the letter of agreement the competent authority from the regional centre, shall provide their agreement to conduct the activities as per the terms of reference provided in this action plan document.*

3. Meeting / workshop with the regional institutions to share the strategy and action plan and take suggestions/inputs

A workshop with the regional centres will be held, in which more details regarding operational issues will be discussed and finalized. Such workshops are being proposed to be held every six months.

4. Recruitment of the staff at the National and regional institutions

STAFF AT NATIONAL AND REGIONAL CENTRES: For effective functioning, the national and regional centres would need exclusive and dedicated staff, besides the regular staff and faculty already working. These would be employed on a contractual basis and would include:

- 1. DTC coordinator:** A Doctor, preferably a psychiatrist working or a corresponding non-medical degree holder but with suitable experience at the level of Research Officer (as per ICMR norms). Entrusted with the responsibility of coordinating all the functions of DTC under the supervision of faculty members. May have to undertake monitoring field visits.
- 2. Training and Field coordinator / Accountant-cum-Monitoring officer:** A Social work or Psychology Postgraduate, working at the level of Research Associate (as per ICMR norms). Entrusted with the task of organizing the training programs and communicating with the DTCs along with supervision of accounts and administrative issues.
- 3. Accounts cum administrative assistant:** A graduate in the accounts / commerce,, recruited as per the ICMR norms for UDC. Responsible for managing the accounts and administrative issues.

The staff at the national and regional centres would be chosen by the respective institution/s, in collaboration with NDDTC, AIIMS following norms/criteria and salary recommended by ICMR.

5. Selection of the sites for establishing DTCs

The “Drug Treatment Centres-DTC” would be located in civil hospitals / district hospitals/medical colleges. They will be providing (mainly) outpatient treatment services and some patients who need admission will be hospitalized in the established DAC ward or in the psychiatry ward (or in the medicine ward if DAC/psychiatry ward is not available). Subsequently, DTC would have a 10 bedded ward where such wards are not available.

Ideally, the selection of sites for deciding the location of DTCs should be guided by an assessment of the need of such clinics. However, as it is well known that no area of the country is untouched by the problem of substance use, it would be advisable to be guided with assessment of feasibility; i.e. to begin with, DTCs may be established in the places where they are likely to successful. Such locations may include:

- Hospitals with De-addiction centres established by the DDAP, which are functioning well (but are not a part of medical colleges). Centres which are already availing the recurring grant may be the other criteria for prioritization.
- Hospitals which already have a functioning Opioid Substitution Therapy (OST) centre, which may have been established under the National AIDS Control Program. In these cases, some infrastructure as well as human resources could be shared by both the programs – NACP and the DDAP.

It is proposed that for the first year, NDDTC AIIMS would assist in establishing the DTCs at the following hospitals / institutions / places:

1. **Community Clinic of NDDTC, AIIMS, New Delhi**
2. **KEM Hospital, Mumbai**
3. **RIMS, Imphal**
4. **Civil Hospital, Kapurthala**
5. **Civil Hospital, Bathinda**

These five places are being proposed for the following reasons:

- All the five are DACs, established by the DDAP. Two of these (KEM, Mumbai and RIMS, Imphal) are resource institutions which have been collaborating with NDDTC, AIIMS in various activities in the field of drug dependence treatment. These two institutions are also being proposed to be upgraded as Regional Centres from the year two onwards.
- All the five are currently implementing a pilot project in which treatment is being provided to Opioid Dependent patients through provision of Methadone Maintenance Therapy (first time ever in India). This project is being supported by the funds from UNODC and is likely to continue till October 2014. Afterwards, it was anyway expected that Government of India would take over these centres and would continue the services through government support.

While the ultimate goal may be to establish at least one Drug Treatment Clinic in all the districts of the country, it is being proposed that as a pilot programme, about 20 – 22 such DTCs would be established by 2017, so as to develop and demonstrate an alternative model of providing services for people with substance use disorders. The year-wise establishment of DTCs would be as follows:

1. First Year (2014-15) 05
2. Second Year (2015-16) 09 (new) and 05 (carried over from previous year)
3. Third Year (2015-16) 08 (new) and 14 (carried over from previous year)

Thus at the end of 3 years there will be 22 DTCs in the country with enhanced functioning.

The *feasibility assessment* for choosing the DTCs will be conducted by regional centres in coordination with NDDTC using performa designed by NDDTC for the purpose. The feasibility assessment will help in assessing the readiness of the hospital in opening a DTC, including willingness and support of the hospital authorities, willingness of the nodal officer in providing oversight to the DTCs, infrastructure available and refurbishment required, stock keeping, etc. The feasibility report will be submitted to NDDTC, AIIMS and due approval will be provided to make the DTC functional, after examining the feasibility report.

Procedure for engagement of DTCs: *The communication from the DDAP, MOH&FW along with the action plan document will be shared with the hospitals / institutes where DTCs are proposed to be set up and a letter of agreement from the competent authority (addressed to chief NDDTC, AIIMS) shall be obtained. In the letter of agreement the competent authority from the hospital, shall provide their agreement to conduct the activities as per the terms of reference provided in the action plan document.*

6. Establishing DTCs : Requirements of resources for optimum functioning

The resources required have been described under the following heads.

6.1 INFRASTRUCTURE

6.2 STAFF

6.3 MEDICINES

6.1 INFRASTRUCTURE

The infrastructure requirement may not need new constructions. If the hospital already has a functional De-Addiction Centre or OST centre (run under the National AIDS Control Programme), the DTC may be established in the same premises. If the hospital already has a building constructed with the funds meant for running a De-Addiction Centre the building may be re-claimed for running a DTC.

At the most, the centre may need some support for refurbishment of the infrastructure.

- Adequate space with the provision for
 - Doctors' chamber
 - Counsellor's chamber
 - Nursing / dispensing room (may be clubbed with the dispensary of the hospital)
 - Registration / record room
- Equipment and Supplies
- Computer with internet connectivity
- Furniture, storage cupboards
- Medications

6.2 RECRUITMENT OF STAFF AT THE DTCs BY THE HOSPITALS

Staff of proposed Drug Treatment Centres (DTCs)

1. **NODAL OFFICER – A senior medical officer attached to the hospital; in-charge of the clinic; largely administrative and supervisory role**
2. **A dedicated general duty MEDICAL OFFICER – trained in the management of substance use disorders (recruited as a contractual staff as per NRHM norms). At certain places the doctor from NACO OST programme could perform both responsibilities**
3. **A dedicated COUNSELLOR - trained in the management of substance use disorders (recruited as a contractual staff as per NRHM norms). At certain places the counsellor from NACO OST programme could perform both responsibilities**
4. **A dedicated NURSE – Trained in the management of substance use disorder (recruited as contractual staff as per NRHM norms)**

Staff: Qualifications and roles/responsibilities

- **Medical officer:** Minimum MBBS Qualification, with Medical council registration. Recruited as per NRHM norms of the state with salaries as per the same norms.

Roles/responsibilities

- Undergoing training provided by the National centre / regional centres
 - Working under the overall supervision of the nodal officer of the DTC
 - Providing assessment and diagnostic services to the patients
 - Providing initial short term treatment as well as long term pharmacotherapy to the patients
 - Providing referral services to the patients – including referral for other health conditions, other social needs, as well as referral to the higher centre for management of complex cases of substance use disorders
 - Providing orientation to other departments / staff of the hospital (to enhance referrals to the clinic)
 - Maintaining adequate medical records
 - Day-do-day supervision of the functioning of the DTC
- **Nurse:** minimum recognised ANM Qualification. Recruited as per NRHM norms of the state with salaries as per the same norms.

Roles/responsibilities

- Undergoing training provided by the National centre / regional centres
- Working under the overall supervision of the nodal officer and Medical Officer of the DTC
- Dispensing medications as prescribed by the doctor
- Maintain records related to dispensing as applicable
- Provide first-aid in case of absence of the medical doctor
- Maintain records related to stock management

- **Counsellor:** Minimum Qualification - Masters in social work/ humanities/sociology/psychology. Those who have undergone certificate training in counselling would be preferred. Recruited as per NRHM norms of the state with salaries as per the same norms.

- Undergoing training provided by the National centre / regional centres
- Working under the overall supervision of the nodal officer and Medical Officer of the DTC
- Providing assessment and diagnostic services to the patients
- Providing initial counselling and Motivation Enhancement to the patients
- Providing referral services to the patients – including referral for other health conditions, other social needs, as well as referral to the higher centre for management of complex cases of substance use disorders
- Liaise with other departments of the hospital to enhance referrals to the DTC
- Conducting awareness activities in the community (to enhance help-seeking)
- Establishing linkages with the NGOs working in the community (to enhance help-seeking)

- Conducting field visits / home visits to the patients, as and when required
- Maintaining records of all the activities and services; periodic reporting to the authorities

All the staff of the DTC will be recruited by the nodal officer as per norms and TOR laid down here as well as following financial norms laid down by NRHM for the state.

6.3 MEDICINES

List of medicines required at the DTC and their indications

Looking at the trend in various parts of the country, the most common substance use problem presenting to treatment centres is alcohol dependence followed by Opioid dependence. Some cases of cannabis, benzodiazepine and inhalant dependence also come forward for treatment. Based on this, the list of medications required at DTCs is as follows:

- **Tab. Diazepam** 5 / 10 mg (for managing acute alcohol withdrawal symptoms; as a sedative in the treatment of opioid dependence)
- **Tab. Lorazepam** 1 / 2 mg (for managing acute alcohol withdrawal symptoms in cases with suspected liver dysfunction)
- **Injection B-complex** (such as Inj. Trineurosol – H®) 5 ml ampoules (during the management of acute withdrawal of alcohol)
- **Tab. B-complex**
- **Tab. Naltrexone** 50 mg (for the long term treatment of opioid dependence and as an anti-craving agent for alcohol dependence)
- **Tab. Disulfiram** 250 mg (for the management of alcohol dependence – long term pharmacotherapy)
- **Tab. Buprenorphine** 2 / 0.4 mg (for the management of opioid dependence – withdrawal as well as long term agonist maintenance for IDU and non-IDU)
- **Syrup Methadone** 5mg/ml in select centres (for the management of opioid dependence – withdrawal as well as long term agonist maintenance for IDU and non-IDU)
- **Injection Naloxone** 0.4 mg ampoules (for management of acute opioid intoxication/overdose)

Some of the medicines such as diazepam, lorazepam, disulfiram and B-complex can be procured at the local level by the nodal officer, while others such as buprenorphine, methadone, naloxone, and naltrexone will be procured centrally by NDDTC, AIIMS and distributed to individual centres. The central procurement of the medicines mentioned above will ensure the lowest procurement prices. Standard operating procedures and financial guidelines will be followed for the procurement.

7. Capacity building

All the staff appointed under the DTCs as well as in regional centres would be trained by NDDTC, AIIMS. The training would include an initial induction training as well as annual refresher training. Periodic training programmes will be conducted to ensure that their knowledge and skills are updated on regular basis. To ensure uniformity of training, existing modules will be adapted, and if necessary, new modules would be developed by NDDTC, AIIMS.

From year-two onwards, the regional centres would take the responsibility of training the DTCs under their area of operation, with support from NDDTC, AIIMS. Once the capacity of regional centres is adequately built, the onus of training DTC staff will rest upon the regional centres. The onus of building capacity of regional centres will rest upon NDDTC, AIIMS.

The induction training programme is expected to be of 1 week duration.

8. Monitoring and supervision

To ensure that the DTCs are functioning optimally, an elaborate monitoring and supervision mechanism is proposed to be built in this initiative.

A. Monthly reporting

Every DTC will submit a **monthly report** on a performa developed by NDDTC for the purpose. The monthly report will be submitted to the regional centres. Every regional centre in turn will compile all the DTC reports within its area of operation and submit the compiled report to NDDTC, AIIMS. NDDTC, AIIMS will compile the monthly reports sent by regional centres and submit a monthly report to DDAP on the functioning of the DTCs. Submission of the monthly report (along with the attendance) would form the basis for payment of continued salaries to the staff.

The monthly report will be analysed by regional centres and NDDTC, AIIMS to assess the functioning of the DTCs, and suggestions/feedback as required will be provided to the DTC. Additionally, any specific area of concern will be flagged for action to the higher authorities by the regional centre/NDDTC.

During the course of the programme, an **online monitoring and reporting tool** will be developed by NDDTC, in which the individual DTCs can submit their reports online. This will enable DDAP to monitor the programme online on regular basis.

B. Quality Assurance visit to the DTCs

Every DTC will be visited **once in six months** by the regional centre. The **Quality Assurance visit** will be for a period of 1-2 days, and will be conducted by a specialist (such as a faculty member) from the area of drug de-addiction, based in the national / regional centre and trained / experienced in quality assurance. The standard norms will be followed for the expenditure towards such visits. The visit will be conducted with a dual purpose – (a) evaluating the functioning of the DAC as well as (b) to provide hands-on supportive supervision to the DTC staff in difficult areas. A report of such visits will be prepared, and submitted to NDDTC, which in turn, will compile and submit it to DDAP for information and action, if necessary.

C. National workshops

A two-day workshop will be organised by NDDTC every six months after the Quality assurance visits have been conducted. The workshop, attended by the regional centres, will enable the partners to discuss the programme implementation and take corrective measures, as required.

9. Gathering evidence and documentation

A baseline assessment will be conducted through the DTCs and the regional centres and followed up by a mid-line and an end-line assessment which will help in understanding the utility of the DTCs. Additionally, the feasibility assessment, monthly reports, and workshop minutes will be made use of,

and a document on the feasibility and utility of the DTCs in providing services to those affected by substance misuse in the country. The document will also provide a basis for expansion of such services to other centres by the end of the programme period (2017).

10. Year-wise action plan

YEAR ONE

- Establish optimum functioning of 5 DTCs by NDDTC, AIIMS
- Preparing two centres for assuming the role of 'regional centres' by NDDTC, AIIMS.
- Training and supervision of 5 DTCs

YEAR TWO

- NDDTC, AIIMS to establish 3 new DTCs and continue support to 5 DTCs established in previous year
- Each regional centre to establish 3 DTCs
- Training and supervision of the new and old DTCs
- Supervision of regional centres and DTCs in its area of operation by NDDTC, AIIMS

YEAR THREE

- NDDTC, AIIMS to establish 2 DTCs and continue support to 8 DTCs established in previous years
- Each regional centre to establish 3 DTCs and continue support to 3 DTCs established in previous year
- Training and supervision of the new and old DTCs
- Supervision of regional centres and DTCs in its area of operation by NDDTC, AIIMS

Periodic assessments, including baseline and end-line assessment will be conducted to monitor and record the progress and impact of the programme in enhancing the functions of the DTCs.

D. BUDGETS PROPOSED

The Annual budget for running one DTC (<i>Described in annexure item 'A'</i>):	12,24,000/-
The Annual budget for each regional centre for its mentoring and supportive supervision activities(<i>Described in annexure item 'B'</i>):	16,16,000/-
The Annual budget for National Centre (NDDTC, AIIMS) for its mentoring and supportive supervision activities(<i>Described in annexure item 'C'</i>):	25, 81,000/-

The total budget for the programme is **INR 6,43,91,000/-** for the three year period. The detailed budget with expenditure sub-heads can be found in Annexure.

Mechanism of implementation:

- As the National Centre, NDDTC, AIIMS will manage the activity and receive the ear-marked grant for this purpose from the DDAP. NDDTC, AIIMS will transfer the budgets to regional centres and DTCs under its area of operation on semi-annual basis.
- Every regional centre will open a separate bank account for the DTC programme, which will be operated by the nodal officer-in-charge of the programme. In case there is no separate bank account, the accounts pertaining to this activity shall be separately maintained and the statement of accounts would be made available for audit purpose.
- The salaries to the staff at DTCs will be paid by the national / regional centres directly through online bank transfer / Account payee cheque.
- Every DTC will open a separate bank account under the charge of the nodal officer, where the funds for refurbishment and monthly contingency expenses will be deposited. In case there is no separate bank account, the accounts pertaining to this activity shall be separately maintained and the statement of accounts would be made available for audit purpose.
- Appropriate accounting procedures will be followed for operating and monitoring / auditing the expenditure incurred.
- Every next tranche of funds from National centre to regional centres / DTC will be dependent upon the performance (and management of funds from the previous tranche)
- All the accounts will be audited independently, annually.

Annexure: Activity-wise budgets

STRENGTHENING THE DDAP - FUNCTIONING OF DRUG TREATMENT CLINICS						
Sl. No.	Activity	Description	Unit cost (INR)	No. of Units	Duration (in months)	Total (INR)
A	RUNNING OF A DTC*					
A1	Salary of Medical Officer (as per NRHM norms)*	A medical Officer contracted exclusively to run services at DTC	45000	1	12	540,000
A2	Salary counsellor	A counsellor contracted exclusively to run services at DTC	15000	1	12	180,000
A3	Salary of Nurse	One Nurse contracted exclusively to run services at DTCs	15000	1	12	180,000
A3	Refurbishment*	A one-time cost for refurbishment of existing DTC; applicable ONLY for the first Year of functioning of DTC	100000			100,000
A4	Medicines	for providing medical care to the patients, medicines to be dispensed free-of-cost from the DAC	200000			200,000
A5	Other expenses (local travel, correspondence, etc.)	expenditure towards local travel, correspondences, meeting, stationaries, etc.	24000			24,000
A6	TOTAL BUDGET FOR RUNNING OF ONE DTC					1,224,000
<p><i>*The funds allotted for refurbishment will be used for salary increments from year two onwards. A 5% increment will be provided to the DTC staff from year two, in keeping with NRHM norms. For sundry expenses shifting of budgets across budget lines shall be permissible on case to case bases.</i></p>						

STRENGTHENING THE DDAP - FUNCTIONING OF DRUG TREATMENT CLINICS							
Sl. No.	Activity	Description	Unit cost (INR)	No. of Units	Duration (in months)	Total (INR)	
B	TRAINING AND COORDINATION BY REGIONAL CENTRES						
B1	Salary of coordinator	A coordinator for day-to-day management of coordination activities		47000	1	12	564,000
B2	Salary of Training and field coordinator / Accountant-cum-Monitoring officer	for managing accounts as well as assistance in coordination and training activities		22000	1	12	264,000
B3	Salary of Accounts cum administrative assistant	For managing accounts as well as assistance in administrative functions		14000	1	12	1,68,000
B4	Other expenses (travel to DTC, correspondence, etc.)	expenditure towards local travel, correspondences, meeting, stationaries, etc.		100000			100,000
B5	Equipment and stationary			100000			100,000
	Sub-total						1,028,000
B6	training related expenses	one training per year for the medical officer, counsellor and nodal officer of the DAC					
B6.1	travel of participants			5000	20		100,000
B6.2	Accommodation			1200	20	5	120,000
B6.3	venue, refreshment and stationary			1000	20	5	100,000
B6.4	Honorarium travel and stay for resource persons						100,000
	Sub-total for training						420,000
B7	TOTAL ANNUAL BUDGET FOR ONE REGIONAL CENTRE (besides its role as a DTC)						1616000

STRENGTHENING THE DDAP - FUNCTIONING OF DRUG TREATMENT CLINICS						
Sl. No.	Activity	Description	Unit cost (INR)	No. of Units	Duration (in months)	Total (INR)
C	TRAINING AND COORDINATION BY NDDTC (NATIONAL CENTRE)					
C1	TOTAL ANNUAL BUDGET FOR ACTIVITIES TO BE CONDUCTED AS OTHER REGIONAL CENTRE	Activities pertaining to operationalise and training of DTCs				1616000
C2	Other activities as National coordinating centre					
C2.1	Workshop/Meetings	Three two-day workshops: first at the beginning of the programme to arrive at consensus and operationalise the programme, and then at 6 and 12 months for taking stock of progress and mid-course corrections if any				
	Travel	two persons from each regional centre	10000	6		60,000
	Stay of participants	two persons from each regional centre	5000	6	2	60,000
	venue, refreshments,	calculated @ Rs.1000 per person per DAY	1000	15	2	30,000
	Stationaries and other expenses		5000			5,000
	Subtotal for one workshop					155,000
	SUBTOTAL FOR THREE WORKSHOPS					465,000
C2.2	Monitoring and supervision					
	Development of tools for monitoring and reporting	Development of online tools for monitoring and reporting	500000			500,000
	SUBTOTAL OF OTHER ACTIVITIES					965,000
C3	TOTAL ANNUAL BUDGET FOR ACTIVITIES BY NDDTC AS NATIONAL CENTRE (Co-ordination, Training, Workshops and Monitoring) (besides its role as a DTC)					2581000

D. BUDGETS FOR SUPPORTING DTCs (as outlined in 'A' above)						
Centres	2014-15		2015-16		2016-17	
	No. of DTCs	Budgets	No. of DTCs	Budgets	No. of DTCs	Budgets
NDDTC - as the National Centre	5	61,20,000	8	9,792,000	10	12,240,000
RIMS - as the regional centre	0	0	3	3,672,000	6	7,344,000
KEM - as the regional centre	0	0	3	3,672,000	6	7,344,000
TOTAL	5	61,20,000	14	1,71,36,000	22	2,69,28,000

E. BUDGETS FOR MONITORING AND SUPERVISION (as outlined in 'B' and 'C' above)			
Centres	2014-15	2015-16	2016-17
NDDTC	2581000	2581000	2581000
RIMS	0	1616000	1616000
KEM	0	1616000	1616000

F. TOTAL FOR EVERY CENTRE (considering 'B', 'C' and 'D', above)	2014-15	2015-16	2016-17	TOTAL BUDGET FOR CENTRE (over three year period)
NDDTC	8701000	12373000	14821000	35895000
RIMS	0	5288000	8960000	14248000
KEM	0	5288000	8960000	14248000
GRAND TOTAL FOR THE PROGRAMME (INR)	8701000	22949000	32741000	6,43,91,000
GRAND TOTAL FOR THE PROGRAMME (INR)	Rupees Six Crores Forty Three Lakhs Ninety-one thousand only			