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Guidelines for Drug Treatment cum Rehabilitation Centres in Bhutan

Under Testing

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Project RAS/H13: Prevention of transmission of HIV among drug users in SAARC countries

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
AIDS	Acquired Immunodeficiency Syndrome
BHU	Bhutan
BNCA	Bhutan Narcotic Control Agency
BNCB	Bhutan Narcotic Control Board
CBT	Cognitive Behaviour Therapy
CSO	Civil Society Organization
DIC	Drop In Centre
HISC	Health Information Service Centres
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
NA	Narcotics Anonymous
NDPSS	Narcotic Drugs and Psychotropic Substances Act
OPD	Out Patient Department
RGB	Royal Government of Bhutan
RBP	Royal Bhutan Police
SHG	Self Help Group
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
TAP	Treatment Assessment Panel
TB	Tuberculosis
TRC	Treatment cum Rehabilitation Centre
TI	Targeted Intervention
HIV	Human Immunodeficiency Virus
NGOs	Non-Governmental Organisations
SAARC	South Asian Association for Regional Cooperation

1. BACKGROUND

1.1 Drug use and related problems

Drug dependence is considered a multi-factorial health disorder that often follows the course of relapsing and remitting chronic disease. Unfortunately in many societies drug dependence is still not recognized as a health problem and many people suffering from it are stigmatized and have no access to treatment and rehabilitation. Over the recent years, the bio-psychosocial model has recognized drug dependence as a multifaceted problem requiring the expertise of many disciplines. A health sciences multidisciplinary approach can be applied to research, prevention and treatment of drug use and related disorders.

In the past decades, depending on the different beliefs or ideological points of view, drug dependence was considered as: only a social problem, only an educational or spiritual issue, only a guilty behaviour to be punished, only a pharmacological problem. The notion that drug dependence could be considered a "self-acquired disease", based on individual 'free choice' leading to the first experimentation with illicit drugs, has contributed to stigma and discrimination associated with drug dependence. However, scientific evidence indicates that the development of the disease is a result of a complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors. Attempts to treat and prevent drug use through tough penal sanctions for drug users fail because they do not take into account the neurological changes drug dependence has on motivation pathways in the brain.

"Nothing less" must be provided for the treatment of drug dependence than a qualified, systematic, science-based approach such as that developed to treat other chronic diseases considered untreatable some decades ago. Many of these diseases are now preventable or treatable thanks to good practice clinical interventions and rigorous therapeutic strategies and cumulative scientific research.

Drug dependence and illicit drug use are associated with health problems, poverty, violence, criminal behaviour, and social exclusion. Its total costs to society are difficult to estimate. In addition to the health care costs and other costs associated with the consequences of drug use; drug dependence involves also social costs in the form of loss of productivity and family income/ savings, violence, security problems, traffic and workplace accidents, and links with corruption. These result in overwhelming economic costs and an unacceptable waste of human resources.

Drug use, especially injecting drug use (IDU) is closely linked to HIV and hepatitis B and C transmission through the sharing of needles and other contaminated injection equipment. Non injecting drug use is also linked to HIV transmission by increasing high risk sexual behaviors.

Drug dependence is a preventable and treatable disease, and effective prevention and treatment interventions are available. The best results are achieved when a comprehensive multidisciplinary approach which includes diversified pharmacological and psychosocial interventions is available to respond to different needs. Even taking into account the requirements for the delivery of evidence–based treatment, its costs are much lower than the indirect costs caused by untreated drug dependence (prisons, unemployment, law enforcement, health consequences). Research studies indicate that spending on treatment produces savings in terms of reduction in the number

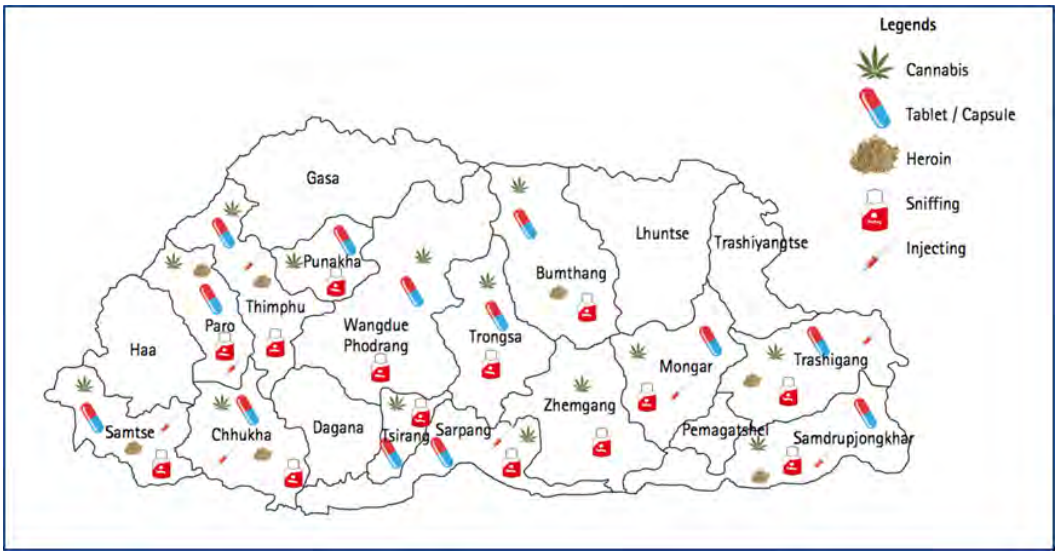
of crime victims, as well as reduced expenditures for the criminal justice system. These savings can improve disadvantaged situations where opportunities for education, employment and social welfare are undermined, and increase possibilities for families to recover battered economies, thus facilitating social and economic development.

1.2 Bhutan drug scenario

Recognising increasing drug use by youths, in recent times, has been a major concern among government agencies and civil society in Bhutan. Alcohol and cannabis are the most common drugs of use among youths in Bhutan. According to the National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan–2009 (NBA-2009), cannabis use and glue sniffing were reported from all the 14 Dzongkhags studied under the assessment. Use of pharmaceuticals like codeine-containing cough syrup, benzodiazepine or nitrazepam tablets, dextropropoxyphene and antihistaminic tablets was reported from all the Dzongkhags except Zhemgang. Brown sugar smoking within the last one month was reported from six Dzongkhags (Bumthang, Paro, Samdrup Jongkhar, Samtse, Trashigang and Thimphu). Sixty percent of the respondents for the NBA-2009 reported ever using alcohol. Both males (84%) and females (88%) had reported 'ever use' of alcohol.

A household survey on alcohol in Bhutan revealed that prevalence of low, moderate and high-risk drinking based on the AUDIT was 22.4%, 13.6% and 2.5%, respectively. Home made alcohol and home drinking with a belief of medicinal effects were the major cause of drinking and its consequences in the study area (Subady et al, 2012).

Figure 1 Dzongkhag-wise distribution of drug use pattern in Bhutan- NBA-2009



Source: National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan–2009 (NBA-2009)

1.3 Drug treatment programme in Bhutan

Responding to the growing need of the drug and alcohol problem, the Royal Government of Bhutan (RGB) formulated the Narcotic Drugs and Psychotropic Substances (NDPSS) Act, 2005 and subsequently the 'Narcotic Drugs, Psychotropic Substances and Substances Abuse Rules and Regulations 2006 Kingdom of Bhutan' based on the act (vide sections 48, 49 & 50). Based on these the RGB mandated Bhutan Narcotics Control Authority (BNCA), under the guidance of the Bhutan Narcotics Control Board (BNCB), to establish treatment and rehabilitation centres with appropriate staffing, assess the functioning and service delivery of such establishments and also facilitate coordination with other stakeholders in achieving the larger goals.

The relevant clauses of the NDPSS act:

- **Early Detection and Diagnosis**

  Clause 36: The Board shall ensure the establishment of institutions with adequate and appropriate facilities for early detection of drug users with special focus on high-risk individuals. These institutions may include mobile camps and out-reach services with appropriate testing facilities.

- **Treatment and Rehabilitation**

  Clause 37: The Board shall ensure the establishment of institutions with adequate and appropriate facilities for treatment and rehabilitation services for drug dependent per sons and users as approved treatment centres for the purpose of this Act. The quality and range of services offered by such institutions shall be reviewed from time to time by a committee constituted by the Board for the purpose.

  Clause 38: The board shall ensure the provision for treatment, rehabilitation and social reintegration of drug dependent persons. Such provisions shall include psycho-social interventions, counselling and detoxification.

  Clause 39: The Board shall ensure staffing of such institutions with adequate and appropriate personnel to deliver quality services and care.

  Clause 40: The Board shall establish a treatment assessment panel for the purposes of this Act. The panel shall consist of at least 3 persons appointed by the Board, of which one shall have legal qualifications and experience, and the others knowledge of the medical, psychosocial and other problems connected with drug abuse and addiction.

  Clause 41: The Board shall constitute committees to maintain quality, standards and range of services offered by such institutions and these shall be reviewed from time to time for effective delivery of services

- **Voluntary Submission for Treatment**

  Clause 42: Notwithstanding section 161[1] of the Civil and Criminal Procedure Code of Bhutan, any person who has committed an offence only against section 500[2] of the Penal Code of Bhutan shall not be prosecuted for that offence or identified to the public, provided the person voluntarily present to an approved treatment center before being arrested or charged for that offence, and then undertakes and success fully completes the treatment without committing any further offence.

- **Treatment if Charged, Only for Possession for Personal use**

  Clause 43: Notwithstanding section 202[3] of the Civil and Criminal Procedure Code of Bhutan, where a person has been charged only with and offence against section 500 of the Penal Code of Bhutan, the Court before which the person has been charged shall, as soon as practicable after arrest, order the person to report to an approved treatment center. If the person undertakes and successfully completes the treatment without committing any further offence, the Court may allow the prosecution to be withdrawn.

- **Treatment, if Charged with Other Offences**

  Clause 44: Where the Court finds any offence other than an offence against section 500 of the Penal Code of Bhutan proved against any person and the Court considers that the person may have been under the influence of a narcotic drug or psycho-tropic substances at the time of the offence or motivated to commit the offence by a desire either to use the substances or obtain resources to enable its use the Court may order that the person submit for assessment by a treatment assessment pane designated by the Court

Accordingly, BNCA had initiated the first Drug Treatment cum Rehabilitation Centre (TRC) for men and followed it up by another for women who use drugs - both in Serbithang, Thimphu. Initially a guideline was developed for running the centres in Thimphu. Later, with the need for establishing other TRCs across the country, BNCA felt the need for updating the initially developed guideline

[1] ***Penal code of Bhutan Section 161-Grading of reckless endangerment-*** *The offence of reckless endangerment shall be a petty misdemeanour.*
[2] ***Penal code of Bhutan Section 500 Possession of a controlled substance -****A defendant shall be guilty of the offence of possession of a controlled substance, if the defendant possesses or uses any psychotropic substance or narcotic drug without the prescription of a registered doctor.*
[3] ***Penal code of Bhutan Section 202 Compensation to victim-****The victim of rape shall be entitled to compensation as per the provision of this Penal Code. Each defendant or defendants shall be liable to pay individually.*

1.4 Importance of this document

Bhutan is in the process of opening up to multiple players providing drug treatment cum rehabilitation services to the people affected by alcohol and other drugs. While, all such efforts are welcome to bring together resources to help deal with the problem in the country- it is extremely important to ensure that some minimum standards are maintained across the centres. This will ensure that the people affected by alcohol and other drug related problems when entering into treatment under any 'such centre' shall at least receive a basic 'minimum list of services' that have been scientifically proven to help in their recovery and rehabilitation.

This guideline provides the basic minimum standards to be maintained at any 'accredited[4]' TRC for people who use alcohol and other drugs in Bhutan and shall be known as the '**New Guideline For Drug Treatment cum Rehabilitation Centres in Bhutan**'.

This will be the guiding document for all drug treatment cum rehabilitation centres established and functioning in Bhutan. The criteria for- infrastructure, human resource, services and documentation/record keeping mentioned in this document shall be the basic 'minimum' required for a TRC to be established or be certified to be 'functional' in the country. This will also provide the basic criteria for recruitment of clients and 'minimum package' of services that should be provided to them during their stay at the TRC. Moreover, this document shall also guide the service providers on the protocol to be followed for 'discharging' a client.

The criteria and services prescribed in this documents should be considered as the 'basic minimum' and neither 'optimal' nor 'ideal' when it comes to providing alcohol and drug treatment services.

BNCA as the national authority for drug related services in Bhutan shall base their accreditation, evaluation and monitoring of all existing and future TRCs in keeping with the criteria mentioned in this document.

This document has been prepared with the best available scientific information at the time of its preparation and may need to be upgraded/updated with changing evidences, drug scenario and other relevant requirement in Bhutan.

[4] Refer to 'Guidelines for accreditation of Drop in Centres & Treatment cum Rehabilitation centres in Bhutan' –BNCA- UNODC

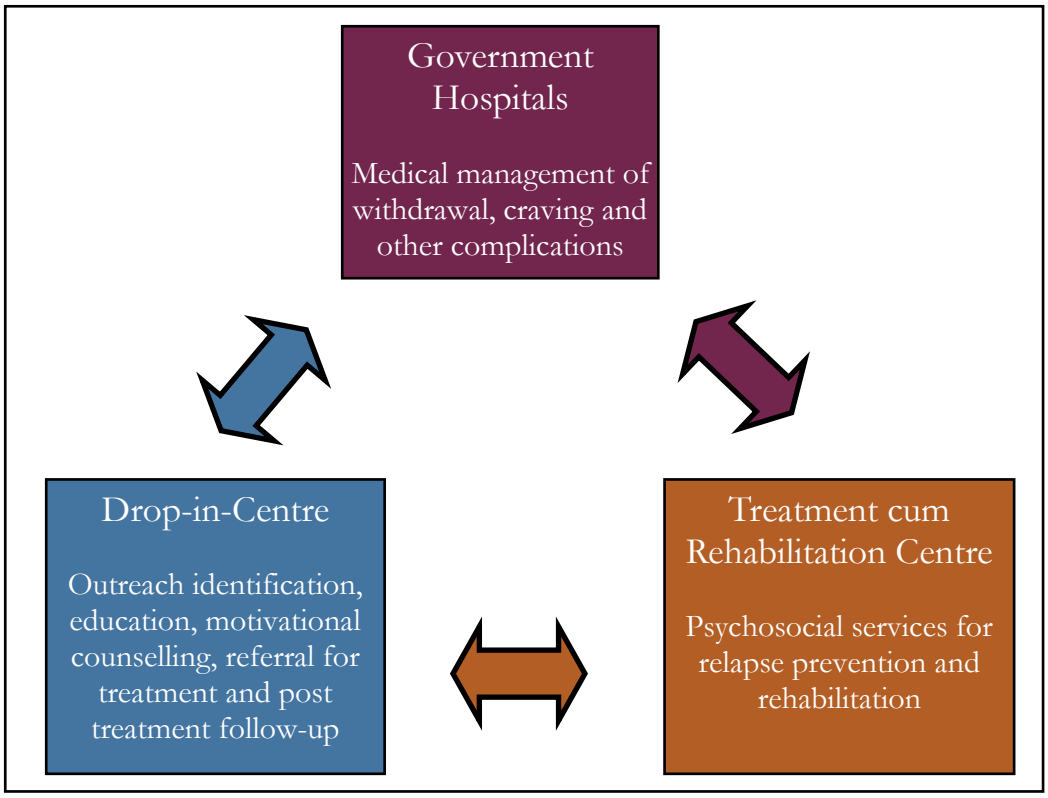
2. TREATMENT CUM REHABILITATION CENTRE AND SCHEME OF DRUG TREATMENT SERVICES

2.1 Drug treatment services in Bhutan

Drug treatment services in Bhutan have a three pronged approach:

- Drop in Centre based (DIC) -outreach services for identification of drug use, education, motivational counselling, referral for treatment and post treatment follow up, support and care
- Government hospital based- medical management of withdrawal and craving and any other drug and alcohol use related problems
- Treatment cum rehabilitation centre based- psychosocial services for relapse prevention and rehabilitation

Figure 2 Three prongs of drugs treatment services in Bhutan



These three 'prongs' work in close coordination with each other and support and complement each other's roles to ensure continuum of care required to help people who use drugs and alcohol to recover.

2.2 Role of Treatment cum Rehabilitation Centres

In the abovementioned scheme of things, the TRC plays a pivotal role in providing treatment – mainly in the form of psychosocial support to people who use drugs. The services are provided in an environment that is drug free and are supported by personnel trained to deliver evidence-based services that help prepare the affected to prevent and or overcome relapse when back in their own settings.

2.3 Objectives of Treatment cum Rehabilitation Centres

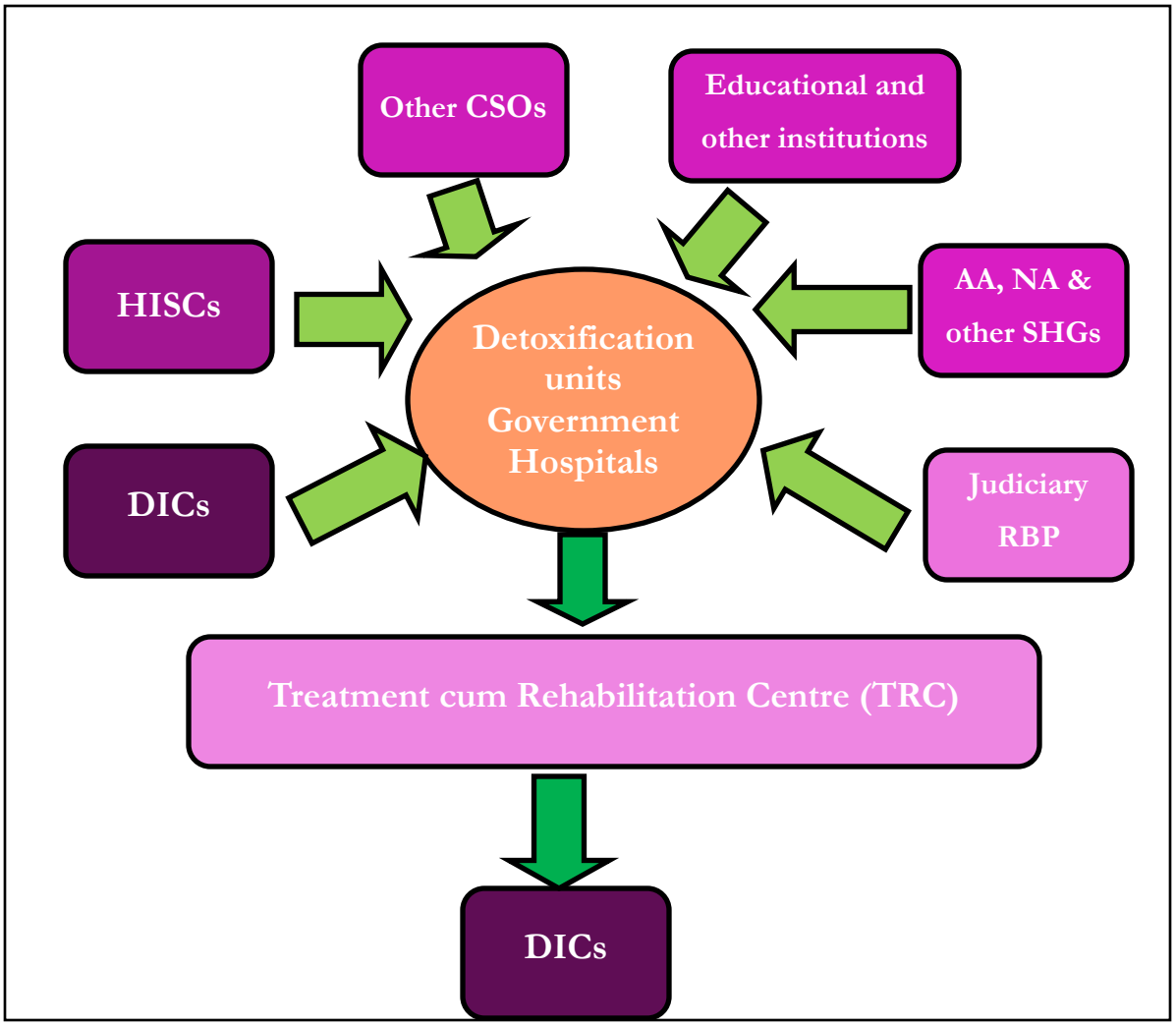
The objective of the TRCs is to provide the following services to people who use alcohol or other drugs in Bhutan:

- Assessment and diagnosis of the extent of the problem
- Psychotherapy -Individual & Group Counselling
- Educative and Skill Building sessions
- Family counselling
- Linking up for after care with support groups like the AA&NA
- Monitored discharge into the community

2.4 Flow of clients in and out of a Treatment cum Rehabilitation Centre (TRC)

The detoxification units at the government hospitals and the DICs are the primary sources for referral to the TRC. Other agencies, like CSOs working among women, children/adolescents, youths etc., educational institutions, health information centres, and SHGs like the AA/NA can also refer people affected by alcohol and other drugs to the TRCs. The Judiciary or the Royal Bhutan Police (RBP) may also choose to refer some clients for treatment cum rehabilitation rather than sending them to prison.

Figure 3 Flow of patients to and from TRCs



All clients, irrespective of their sources of referral have to come through the detoxification units of the government hospitals. This is where they are medically assessed and provided medication to manage their withdrawal and other complications as deemed necessary.

It is important to remember that TRCs are not competent to diagnose/identify medical needs of the clients or provide medical services, so it should be mandatory that all clients are examined, medicated and certified to be fit for admission in a TRC under a government hospital before they can be admitted.

One important criteria for admission (to be discussed in the next chapter) of a client shall be the referral/recommendation/certification letter from the treating government hospital.

However, clients with continuing medication as deemed necessary can be admitted by TRCs, provided they are certified to be fit for admission to TRCs by government hospitals treating them.

A client can be discharged from a TRC upon completion of treatment. Before discharge the client has to be connected with the nearest DIC through a meeting/skype/phone call held at the TRC to ensure continuity of services and care. A concise report of every client discharged shall be sent to the concerned DIC through e-mail to ensure continuity of services.

It is the responsibility of the DICs to follow up on clients after their discharge from the TRCs for a period of at least 2 years. DICs should also provide monthly updates on their follow-ups with the clients discharged from the TRCs through e-mail. In case of a client relapsing after being discharged from a TRC, the DICs shall be responsible for reaching out and bringing the client back to treatment through counselling and referral to appropriate services as necessary. The DIC shall also inform the TRC through a relapse report through e-mail at the earliest.

3. MINIMUM STANDARDS TO BE MAINTAINED IN TRCs

All TRCs in Bhutan will maintain the basic minimum standards in terms of the following components:

- Infrastructure
- Human resource
- Services
- Documentation
- M&E systems

3.1 Infrastructure

Infrastructure is the basic structural requirement of a centre within which the clients are housed and the staffs provide their services. Without it a centre cannot exist. In case of TRCs in Bhutan, infrastructure includes- the building or part of a building where the centre is located, the rooms within it and the space around, the furniture and the basic equipment for conducting day to day activities.

All TRCs should have the following minimum prescribed infrastructure for running the approved treatment centre:

S. No	Infrastructure
1	**Dormitories for patients** • Adequate bed space to comfortably accommodate all clients to be admitted • Bedrooms should be adequately equipped with separate beds for each client and closets/lockers for them to keep their belongings
2	**Hall for group sessions** • One hall for group activity adequately sized to comfortably fit the number of clients to be admitted • The hall should have adequate provision for seating all clients at the same time. If seating is arranged on the floor, then the floor should be covered with mats/ mattresses or carpets for comfortable sitting in winter months
3	**Counselling room** 1 each for 10 clients (with 2 chairs and a small table and a provision for keeping records confidentially under lock and key or in a computer)
4	**Office cum accounts room** (with 1 lockable closet, 2 chairs and 1 small table)
5	**Office room for the TRC manager** (with 1 lockable closet, 2 chairs and 1 small table)
6	**Kitchen** (with cooking equipment, provision for gas connection etc.)
7	**Toilets** (1 toilet per 10 clients and 1 per 5 staff)

3.2 Human Resources

Human resource is the most critical component of a TRC. The staff members of a TRC should have an empathetic attitude to people who use alcohol and other drugs and also be technically equipped to provide scientifically evident services.

The following are the minimum prescribed human resource required for running an approved treatment centre.

S. No	Staff Positions	Minimum requisite qualification		
		Education	Experience	Trainings
1	**Rehab Manager**			
2	**Rehab Warden (If centre has more than 20 clients then 1 rehab warden is required per 20 patients)**			
3	**Accountant -1 full or part time depending on the number of clients**			
4	**Peer Counsellors – 1 per 5 clients to admitted in a TRC**			
5	**1 Cook and additional helping hands depending on the number of clients to be admitted**			

If the centre is for meant for women- Rehab Manager, Rehab Warden, Peer Counsellors, Peer Outreach Workers, Cooks and Assistant cooks/helps, should all be women. This will help the women seek treatment and easily confide with their service providers.

Roles and responsibilities of the TRC staff members

The following are the minimum roles and responsibilities of the various staff engaged in the TRCs:

Personnel / Post	Roles and responsibilities
Rehab Manager	• Act as the manager in charge of the TRC, monitor and supervise all activities and report regularly to relevant authorities • Develop duty rosters of the staff and allot clients to various peer Counsellors • Monitor progress of services to the clients by the peer counsellors • Act as the bridge between the TRC, government hospital, nearby DICs, BNCA and other related institutions/agencies
Rehab Warden	Assist the Rehab Manager in running the centre and allied activities
Accountant	Handle all financial transaction and maintain necessary financial records of the centre

Peer Counsellors	• Provide counselling to-
	  • Clients admitted in the centre
	  • Family members of clients admitted in the centre
	• Provide educative sessions to clients admitted in the TRC on aspects of Relapse Prevention, Rehabilitation, HIV risk reduction and other related issues.
	• Conduct sessions on building skills for Relapse prevention, Rehabilitation and Risk Reduction.
	• Evaluate the progress of the clients in centre
	• Maintain records related to counselling, educative and skill building sessions provided to the clients
	• Assist the warden/manager in running the TRC

Cook	• Cook for the clients and the staff • Help the rehab manager/warden procure, store and maintain stock of raw materials for cooking

3.3 Services

The core objective of a TRC is to provide services to the clients who have been dependent on alcohol and or other drugs. The services provided should be evidence based and beneficial to the recovery of the clients dependent on alcohol and or other drugs.

The following are the minimum services that should be provided to each client by a TRC:

Sl. No	Services	Nos. for TRC
1	Assessment of drug dependence and other associated problems	At the initiation
2	Educative and skill building sessions	6 per week
3	Individual counselling	3 per week per client
4	Group therapy sessions	4 per week
5	Family counselling	1 per week per client
6	Referral	As per requirement

3.4 Documentation / record keeping

Documentation or record keeping is an integral part of service provisions at TRC. It helps measure the output of a centre- e.g. number of clients admitted/ discharged during a given time period, number of individual counselling sessions held etc. documentation also helps in continuity of services in case of a break due to client or service provider's indisposition or other reasons. The service can be picked up from where it had paused, without the need for 'beginning from the start'. Quality documentation and record keeping helps in monitoring and evaluation of services provided and their tracking for timely completion of service packages. It also helps in determining the quality of services provided and can be analysed to identify the gaps in the present system and thus make the changes necessary for improvement.

The following are the minimum documentations/records that are to be maintained at the rehab centre:

Sl. no	Documents
1	**Patient register/records**
2	**Admission Register/records**
3	**Patient Screening Register/records**
4	**Discharge register/records**
5	**Individual patients record**
6	**Educative sessions register/records**
7	**Individual counselling register/records**
8	**Individual counselling reports/records**
9	**Group Therapy Sessions register/records**
10	**Family Counselling Register/records**
11	**Family Meetings Register/records**
12	**Home Visits Register/records**
13	**Staff Movement Register/records**
14	**SHG Meetings Register/records**
15	**Referral directory/records**
16	**Referral register/records**

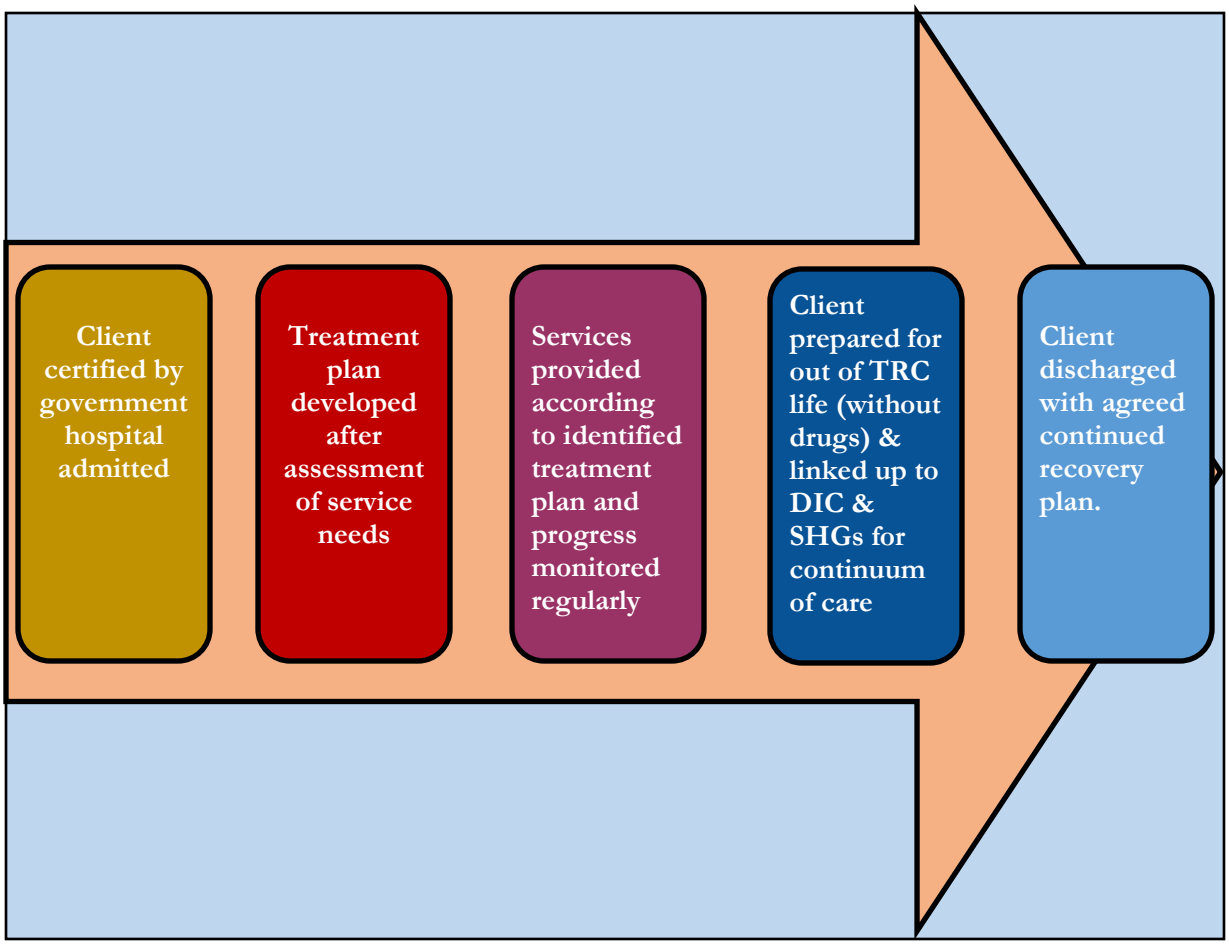
Note: The documents/records may also be maintained on computers but they should be accessible to evaluators and monitoring officers during their visit.

4. FLOW OF SERVICES FOR THE CLIENT AT THE TRC

All clients admitted in a TRC should go through a uniform process and receive uniform services.

The services begin with admission of a client, followed by developing a treatment plan with the help of a counsellor, providing services based on the treatment plan, preparing the client for life outside the TRC and how to remain drug free. The client is also connected with the DIC where he/she will continue to receive services after being discharged from the TRC. And finally discharged with plan for continued services.

Figure 4 Flow of clients through various services



5. PROTCOLS TO BE FOLLOWED IN TRC

There are certain protocols or standardised systems to be followed at the TRCs while providing the basic services at the TRCs. It is essential to follow these protocols to help ensure minimum standards of service delivery at all TRCs in Bhutan.

5.1 Admission of clients

Clients admitted at the centre should fulfil certain basic criteria. All clients admitted in a TRC should fulfil the following criteria:

⇒ Willingness to quit drugs and or alcohol and eagerness of the parents/family members/care givers to comply with the treatment cum rehabilitation procedures and guidance.

⇒ The client or his/her accompanying care givers should have a letter from a government hospital mentioning that the client has been referred for rehabilitation programme for alcohol and or other drug treatment. The referral letter should also mention that the client is free from withdrawal from any drugs or alcohol and fit for admission in a TRC. It should certify that the client is at no known medical risk if admitted at the TRC. In addition, the letter should mention if the client is in need of any continuing medication that needs to be provided during his/her stay at the TRC. The name, dosage and mode of administration of the medicine/s should be clearly mentioned in the letter or a separate prescription attached. The duration of the medication and the date for presenting the client for check up if any should also be clearly mentioned.

Instructions for the family members and care givers

- Family members/care givers or attendants of clients' should take care that once referred (discharged) from the government hospital, the client should be directly taken to the TRC as soon as possible and that the client should not be allowed to use any medicine (other than those provided at the hospital according to the prescription) or drug or alcohol during the journey or the interim period.

- No client can be admitted in the state of intoxication or under the influence of drugs and or alcohol even with a referral letter from a government hospital as this may prove to be hazardous for the client's health and well being.

- In case the family members/care givers need any help they can call up the nearest DIC or the TRC and request for support. In such cases the family members/care givers should follow the instructions given by the DIC or TRC.

- The client accompanied by parents, family members or attendants should present themselves with the referral letter to the TRC and see the Rehab Manager (in his/her absence the peer counsellor) on Mondays to Fridays between 10.00 am-4.00 pm.

Instructions for the family members and care givers (Cont'd….)

- The clients should carry their own bed covers (2), pillow with cases (2) and blankets as necessary. They should also have a bag with personal belongings like-clothes to wear at the centre, toothbrush and paste, comb, towel, soap, shampoo etc. needed for their stay at the centre.
- No weapons (even small scissors, penknives etc), expensive ornaments (like gold, silver chains, rings etc.), drugs or medicines without valid prescriptions or money can be allowed with the client.
- The client will be admitted into the centre only upon physical screening of the belongings and the person.

Stepwise client admission protocol

The following steps are to be followed when admitting a client in a TRC:

Steps	Procedure	Activities by rehab staff	Main Responsibility	Documentation
1	Client accompanied by family members \friends\care givers arrives at the TRC to meet the Rehab Manager (between 9.00am-4.00pm Mon-Fri)	Welcome him/her and request the care givers to fill the 'Visitors Register'	Rehab Manager / Peer counsellor	Entry in the Visitor's Register[5]
2	Client doesn't have a referral letter[6] from a government hospital	Refer the client to the nearest government hospital for check up and obtaining the required referral letter.	Rehab Manager / Peer counsellor	• Referral card[7] • Referral Register[8]
	Client has a referral letter from a Government Hospital	Check the Referral letter and other documents. Enlist the client in the client register.		Client Register [9]

[5] Annexure-1- Visitor's Register
[6] Annexure-2- Sample referral letter from a government hospital
[7] Annexure-3- Referral card
[8] Annexure-4-Referral Register
[9] Annexure-5-Client Register

Steps	Procedure	Activities by rehab staff	Main Responsibility	Documentation
3	If bed not available	Keep the client on waiting list and inform about the probable dates of admission. If agreeable, refer to the nearest DIC for interim support.	Rehab Manager / Peer Counsellor	• Referral Card • Referral Register • Waiting List Register[10]
	If bed is available	Proceed for Admission : • Explain the service provisions and their limitations, Fees & mode of payment, rules & regulations of the centre and Clients Rights.[11] • Obtain the signed indemnity bond from the client's family\ friend\Care givers, if Agreeable. • Register the client in the Admission Register and file his/her documents.		• Declaration cum Indemnity bond[12] • Admission Register[13] • Individual Client File
4	Before admitting the client in the ward	Screen the client & his/her belongings for drugs, weapons, expensive articles like gold chain\ rings etc	Peer Counsellor in the presence of another Peer Counsellor or Rehab Manager	Client Screening Register[14]
	If any drugs are found	List the items in the presence of the family members\ friend\care giver & destroy (burn) as soon as possible.		Items seized and details of the process to be documented in the Client Screening Register (duly signed by staff member\s present)
	If any weapons or expensive articles are found	Handover the weapons and expensive items to the family members \ friend \care giver and obtain a signed receipt from them	Peer Counsellor / Rehab Manager	Signed receipt to be kept in a separate file with a copy in the client's file.
5	Admit client in the patient ward on satisfactory completion of the screening formalities.		Peer Counsellor/ Rehab Manager	

[10]Annexure-6- Waiting List register
[11]Annexure-7- Clients rights
[12]Annexure-8- Declaration cum Indemnity bond
[13]Annexure-9-Admission Register
[14]Annexure-10-Client Screening Register

5.2 Providing educative sessions

Clients should be made aware about the basics of drugs, how they affect the human body and mind and how to overcome the related problems during their stay at the TRC. It has been evidenced that clients respond better to the treatment with knowledge, better understanding of the disease and requisite skills to deal with the problem (in this case relapse) and related issues.

A minimum of 6 educative sessions per week (72 during the entire stay) are to be provided to the clients by trained counsellors and documented in 'Educative Sessions Register[15]. The TRC should develop a quarterly routine for conducting the sessions and ensure that each topic is repeated twice so that every client can attend at one session on each of the topics during their stay at the TRC.

The counsellors should use power point presentations or other visual aids like short films on the topics being discussed, as and when possible. They should make the sessions interactive by asking questions to the clients and seeking answers from their personal experiences. The counsellors should encourage the clients to share their experiences related to the issues discussed and clarify by asking as many questions as possible.

For the skill building sessions, e.g. communication skills, skills for coping with craving, the counsellors should use role-play techniques. The counsellor can give the clients situations based on the topic and ask them to act out how they will conduct themselves in the given situations. The counsellors, with the help of the other clients, can discuss the pros and cons of a certain action and help the clients get their perspectives clarified.

The list of educative and skill building sessions to be conducted at the TRC:

Time Period	Sessions
Preferably within 1st week of clients stay	What are drugs? Why is this disease? The nature and symptoms of the disease
	Impact of different drugs in the human body and mind
	Socio-economic and legal impact of drugs.
	Impact of drug use on relationships, jobs\studies, aims and achievements in life
	High-risk practices associated with substance abuse (including drunken driving, violence and risky sex).
	The treatment components and the clients' role in recovery

[15]Annexure-11 Educative Sessions Register

Time Period	Sessions
Preferably within the 2nd week of stay	Costs and Benefits of continued drug use versus stopping Physical, Psychological Relationships
	Costs and Benefits of continued drug use versus stopping. Socio-economic, legal issues. Studies\ jobs and aims and achievements in life
	Basics of HIV/AIDS-Routes of transmission and modes of prevention
	How abuse of drugs including alcohol and volatile solvents drive HIV transmission
	STIs\ STDs and their role in HIV transmission
	Safer sex practices including condom demonstration[16]
Preferably within the 3rd week of stay	Distinguishing between- slips, lapse and relapse. Causes of relapse.
	Process of relapse and the relapse warning signs.
	Understanding the basics of Cognitive Behaviour Therapy (CBT)
	Understanding the treatment plan under CBT
	Understanding the role of triggers, thoughts, feelings and craving in drug use\ relapse
	Dealing with thoughts and feelings to prevent drug use\relapse
Preferably within the 4th week of stay	Skills for coping with craving (Distraction).
	Skills for coping with craving (Recalling the negative consequences of drug abuse).
	Skills for coping with craving [Going with the craving (Thinking through the high)].
	Skills for coping with craving (Thought stopping).
	Skills for coping with craving (Challenging the thoughts).
	Skills for coping with craving (Talking about craving).
Preferably within the 5th week of stay	Communication skills.
	Communication skills for preventing relapse.
	Decision making skills.
	Problem solving skills.
	Anger management skills.
	Money management skills.

[16]Annexure-12 Condom Demonstration Register

Time Period	Sessions
Preferably within the 6th week of stay	Time management skills.
	Relationship management skills.
	Stress management.
	Learning to plan.
	Working in team.
	The win-win system.
Preferably within the 7th week of stay	Injecting drug use and Transmission of Blood Borne Viruses like HIV, Hepatitis - B & C.
	Abscesses and their management, Preventing Vein damage & Injecting in dangerous sites.
	Dealing with overdose.
	Basics of HIV/AIDS-Routes of transmission and modes of prevention
	How abuse of drugs including alcohol and volatile solvents drive HIV transmission.
	STIs\ STDs and their role in HIV transmission
Preferably within the 8th week of stay	Safer sex practices including condom demonstration.
	Testing for HIV-the advantages & disadvantages.
	People living with HIV, Hepatitis- B & C
	Dealing with love affairs and marital problems.
	Problems related to sex in recovery.
	Dealing with sexual problems in recovery.
Preferably within the 9th week of stay	Understanding the role of triggers, thoughts, feelings and craving in drug use \ relapse.
	Dealing with thoughts and feelings to prevent drug use\relapse.
	Skills for coping with craving (Distraction).
	Skills for coping with craving (Recalling the negative consequences of drug abuse).
	Skills for coping with craving [Going with the craving (Thinking through the high)].
	Skills for coping with craving (Thought stopping).

Time Period	Sessions
Preferably within the 10th week of stay	Skills for coping with craving (Challenging the thoughts).
	Skills for coping with craving (Talking about craving).
	Communication skills for preventing relapse.
	Decision making skills.
	Problem solving skills.
	Anger management.
Preferably within the 11th week of stay	Understanding crisis and handling crisis.
	Money management.
	Time management.
	Relationship management.
	Stress management.
	Injecting drug use and Transmission of Blood Borne Viruses like HIV, Hepatitis- B & C.
Preferably within the 12th week of stay	Abscesses and their management, Preventing Vein damage & Injecting in dangerous sites.
	Dealing with overdose.
	Fears and risks of the world outside.
	Maintaining the system.
	Seeking help.
	Keeping in touch.

Note- *All clients are not admitted to the TRC in the first week of a month –they get admitted at various points of time. The sessions are suggested to be repeated during the course of a 12 week roster to ensure that all clients admitted receive at least one educative session on a particular topic during their stay at the TRC*

5.3 Providing one on one counselling

Individual counselling is the process of supporting a person overcome his/her problems through a therapeutic relationship based on mutual faith and trust between the client and the counsellor. It helps in detailed understanding of the problems, concerns and processes affecting the individual and subsequent individualized care in looking for solutions while also creating a confidential space for discussion of private issues.

At least 3 individual counselling sessions are to be provided to each client every week (36 during the stay of 90 days). Such sessions should be provided in spaces (counselling rooms) free of disturbances where confidentiality can be maintained.

Client Assessment

While assessment is usually useful to diagnose and treat a client, in drug dependence treatment, its utility goes much beyond that. Assessment also helps build a rapport with the client – the time spent in assessment provides an opportunity for the counsellor to build a relationship of trust and harmony with the client and helps in building faith, trust and confidence of the client in the counsellor.

It is important to remember that assessment is not a one-time task. Often, the counsellor is not able to complete all the aspects of assessment within the first few sessions with the client. Thus, more than one session may have to be conducted to complete the required assessment. Moreover, it can be continuing process, resulting in adding new findings as and when the client reveals.

The first assessment should be done as early as possible within 72 hours of the client's admission in the TRC using 2-3 sessions depending on the client's comfort level and the counsellors rapport with him\her.

General skills and principles of client assessment

As with any assessment, the aim here is to obtain information necessary for the counsellor to formulate an appropriate treatment/management plan to address the client's needs. Information related to drug dependence and associated psychosocial issues are sensitive in nature and many clients may feel uncomfortable talking about these issues in the beginning. The counsellor needs to be aware of this and must respond sensitively. By successfully *engaging* the client the counsellor can help him\her feel at ease and assist in gathering a complete history

Adopting the following "micro skills" during the assessment can help to engage the client:

⇒***Empathy:*** Try to see the client's world from his\her perspective. Use the skills of *reflective listening* to *hear* the client accurately and reflect these to the client in a way that the client is able to understand and relate to.

⇒***Positive regard:*** Give selective attention to positive aspects of the client's behavior and what they say.

⇒***Respect:*** Offer positive statements to the client and encourage them to move forward. If differences arise between the client and therapist\s, it is essential that these differences be dealt with openly, honestly and with tolerance.

⇒***Warmth:*** Display warmth towards the client through the way you speak and through nonverbal communication such as facial expression and other gestures. Smiling is an especially important way of communicating warmth.

⇒***Concreteness:*** Be clear and specific when asking questions or giving information.

⇒***Confrontation:*** Be direct when pointing out differences, mixed messages, incongruities and discrepancies in the client's verbal and non-verbal behavior.

⇒***Genuineness***: Be yourself and be sensitive to the needs of the client and their ability to be in a therapeutic relationship.

⇒***Cultural empathy:*** Be aware of the client's cultural background if it is different from your own, and act sensitively and appropriately.

The information gathered should be organized in a systematic fashion and recorded in the Client Assessment Form[17].

Objectives when taking a drug use history

Drug use due to the attached stigma and susceptibility to legal consequences is commonly underreported and can be missed if not asked about specifically. Drug use, especially dependent drug use, can have a significant impact on a client's health and can complicate the treatment of other conditions too.

Drug use, and in particular injecting drug use, is a major risk factor for blood borne virus transmission. A counsellor should be aware of the various drugs used by the client as well as their mode of use so that he/she can provide the client with information and advice on how to reduce their risks and bring about changes.

Different people use drugs in different ways. A given client may also have used drugs in different ways at different times. To get a clear idea of a client's drug use, it is necessary to determine the following:

- What drugs is the client currently using?
- What drugs has the client used in the past?
- How has the client used these drugs (modes of administration), including the pattern of drug use?
- Whether the client is dependent on these drugs? (Use Drug Dependence Assessment checklist[18])
- Whether this drug use is causing problems in the client's life?
- How the client feels about his\her drug use and whether or not he\she wants to change drug use and related high risk behaviour.

[17]Annexure-13 Client Assessment Form
[18]Annexure-13 Client Assessment Form

Drug use assessment and the principles of behavioural change

If a client's drug use is problematic, it is critical to assess how motivated the client is to change. Each individual will be at a different "readiness" to change. Some clients may not feel their drug use is a problem and they may wish to continue using drugs. Others may want to stop using drugs and may be ready to start treatment for their drug use. Clearly, a client's attitude will determine what type of intervention is appropriate and will influence the outcome of this intervention.

By encouraging the client to talk about their drug use and examine the impact it has upon their life, the assessment process itself can form the first part of the intervention and can help promote or initiate a change in the client's drug using behaviour. It is important to make the most of this opportunity.

One on One Counselling can be provided using the following steps:

Time period	Counselling sessions	Objectives of individual counselling sessions (for the client)	Objectives of individual counselling sessions (for the counsellor)	Documentation
Preferably within 1st week of clients stay in the TRC	Client Assessment exercise	To help the client assess the extent of his/her drug use and problems/issues related to it.	To have a clear understanding of the present issues related to client's drug use and their effects to aid in motivating the client and also provide care and services as required.	• Individual Counselling Register[19] • Individual Counselling Report[20] • Client Assessment form[21]
Preferably within the 2nd week of stay	Pros and cons exercise	To provide feed back to the client based on his / her personal experiences of consequences faced due to drug use and help motivate him/her to seek help/ change	• To asses the level of motivation of the client. • To understand the reasons for client's drug use and problems faced due to it. • To identify the various drug related issues in order of their priority as related to the client's drug use (assets and liabilities) and use them for motivation.	Pros and cons analysis tool[22]

[19]Annexure-14 Individual counselling register
[20]Annexure-15 Individual counselling report
[21]Annexure-13 Client assessment form
[22]Annexure-16 Pros and cons analysis tool

Time period	Counselling sessions	Objectives of individual counselling sessions (for the client)	Objectives of individual counselling sessions (for the counsellor)	Documentation
Preferably within the 2nd week of stay (con'd..)	Cost benefit analysis exercise	• To help motivate the client -through the technique of decision Balancing- helping him /her recognise the future disadvantages (costs) of continuing with drug use as compared to its benefits vis-a vis the future advantages (benefits) of stopping drug use in contrast to the disadvantages (costs). • Be optimistic about stopping drug use • Resolve the intention to change	• To understand from the client's perspective-the benefits and costs of continuing with drug use in contrast to stopping. • To pin point the issues that can motivate the client's recovery. • To measure the client's readiness to change. • To deal with the client's ambivalence and help him/her resolve to stop drug use.	• Individual Counselling Register • Individual Counselling Report • Cost Benefit Analysis Tool [23]
Preferably within the 3rd week of stay	Functional analysis exercise	To help the client analyse the drug use related high risk situations, thoughts, feelings, associations, etc that may trigger his/her craving/relapse.	To pin point the places, people, time, themes, (situations), thoughts, feelings and behaviours related to the client's drug use, both before and after use, to help in the trigger analysis of the client for relapse prevention.	• Individual Counselling Register • Individual Counselling Report • Functional Analysis Tool [24]
Preferably within the 4th & 5th week of stay	Trigger (External & Internal) identification and rating exercise	To help the client identify and recognise the external and internal triggers and rank them according to their risk ratings	To identify (from the client's perspective) the (probable) triggers (both internal and external) and their levels of risk (probability of drug use) for the client	• Individual Counselling Register • Individual Counselling Report • Trigger Analysis and Trigger Rating Tool [25]

[23]Annexure-17 Cost benefit analysis tool
[24]Annexure-18 Functional Analysis tool
[25]Annexure-19 Trigger analysis and trigger rating tool

Time period	Counselling sessions	Objectives of individual counselling sessions (for the client)	Objectives of individual counselling sessions (for the counsellor)	Documentation
Preferably within the 6th & 7th week of stay	Trigger handling plan exercise	To help the client develop a plan to change (avoid the high risk situations that they cannot handle and cope with those they can) behaviours that lead to and are related to drug use and practice the avoidance and coping skills	To help the client develop strategies to avoid the high risk situations that they cannot handle and cope with those they can.	• Individual Counselling Register • Individual Counselling Report • Trigger Handling Plan Form[26]
Preferably within the 8th week of stay	Coping with Craving sessions	To help the client in: • Understanding craving • Describing craving • Avoiding cues • Cope with craving	To help the client to understand the role and nature of craving and triggers in relapse and recovery and help him to deal with them	• Individual Counselling Register • Individual Counselling Report • Trigger Handling Plan Forms
Preferably within the 9th week of stay	Sessions on developing strategies and skills to cope with craving (at least 5 sessions	To help the client in developing various skills for coping with craving and triggers like: • Distraction • Talking about craving • Going with the craving (Thinking through the high) • Recalling the negative consequences of drug abuse • Challenging the thoughts • Using self-talk	To help the client build skills for handling craving and triggers.	• Individual Counselling Register • Individual Counselling Report • Trigger Handling Plan Forms

[26]Annexure-20 Trigger handling plan form

Time period	Counselling sessions	Objectives of individual counselling sessions (for the client)	Objectives of individual counselling sessions (for the counsellor)	Documentation
Preferably within the 10th week of stay	Sessions on developing strategies and skills to cope with anger, money stress and also handle money and relationship	To help the client develop strategies for: • Anger management • Stress management • Money management • Time management • Relationship management	To help the client develop strategies for handling stressful situations	• Individual Counselling Register • Individual Counselling Report • Individualized Anger, Stress, Money, Time Relationship management plans
Preferably within the 11th week of stay	Money management plan exercise	To help the client make plans to handle money safely.	To help the client deal with money safely and learn to use it meaningfully	• Individual Counselling Register • Individual Counselling Report • Money Management Plan
	Hourly Scheduling exercise	To help the client manage his/her time efficiently and use it meaningfully.	To help the client make a daily schedule with hourly details of things that he / she will do in order to ensure the behaviour changes as planned and aimed at keeping away from drugs	• Individual Counselling Register • Individual Counselling Report • Weekly Schedule Form [27]
	Crisis plan exercise	To help the client review the plan and its effectiveness & reduce risks if any	To help the client develop plans for dealing with any crisis that may lead to drug use as well as slips and lapses	• Individual Counselling Register • Individual Counselling Report • Crisis Handling Plan Forms

[27]Annexure-21 Weekly schedule form

Time period	Counselling sessions	Objectives of individual counselling sessions (for the client)	Objectives of individual counselling sessions (for the counsellor)	Documentation
Preferably within the 12th week of stay	Trigger handling plan review	To help the client review the plan and its effectiveness and reduce risks if any	To help the client review their relapse prevention plan and to continue practice of the requisite skills	• Individual Counselling Register • Individual Counselling Report • Trigger Handling Plan Forms
	Home trial exercise	Planning for home trials and monitored release	To help the client gradually get used to the world outside the TRC and review his/her plans before finally leaving the centre	• Individual Counselling Register • Individual Counselling Report • Trial Visit Reports

5.4 Providing group therapy

Group therapy is a process of counselling that helps people learn from the shared experiences of others who have been in similar situations or are facing similar problems. It helps individual clients overcome isolation and realise that they are not the only one's facing the problem or struggling to overcome them.

Roles of the group counsellor

Group counsellors function as educators and counsellors, and they use a variety of interventions to conduct group sessions. At least 4 group sessions are to be held per week (48 sessions during the stay) by trained counsellors and documented in the 'Group Sessions Register'[28]

[28]Annexure-22 Group Sessions Register

These interventions include:

- Providing information about addiction and recovery and clarifying issues and answering questions related to the content of the sessions.
- Helping members relate personally to the psycho-educational concepts discussed. The group counsellor tries to get members to relate less intellectually and more personally to the material.
- Facilitating group interaction among clients so that all members participate and share their thoughts, feelings, and experiences.
- Validating issues or struggles presented by individual members. If a group member is struggling with recent relapse or some emotional crisis, the group counsellor acknowledges the struggle without being judgmental and tries to elicit support from other members of the group.
- Modelling healthy behaviours. This may involve providing positive reinforcement or modelling healthy communication with others.
- Monitoring drug use or "close calls." The group counsellor structures group sessions to discuss episodes of substance use as well as strong cravings or close calls. Members can learn a lot from each other's mistakes.
- Encouraging attendance at self-help groups, particularly 12-step groups. This therapy model supports a positive view of AA, NA, programmes. However, it is recognized that some group members won't attend 12-step meetings but may benefit from other types of self-help programs.
- Motivating members to talk directly to each other when sharing their opinions, discussing experiences, or providing feedback.
- The group counsellor should be less of an "expert" and more of a facilitator during discussions of recovery concerns, problems, and issues.
- Group counsellors should encourage all members of the group to participate in every session by voicing their opinions, feelings, and experiences as they relate to the topic covered. Group counsellors should draw quiet members into the discussion by asking them direct questions or seeking their opinions.
- Group counsellors should not let a member dominate the group discussions and should set limits as needed to ensure participation of all.
- Group counsellors should provide positive reinforcement to both the group and individual members to foster group cohesion and trust.
- Reinforcement should be given even when a member talks about a lapse or relapse. A key component of group sessions is realistic feedback about members' attitudes or behaviours. When possible, the group counsellor should encourage group members to provide feedback to another member who shows negative attitudes or behaviours in a constructive manner
- The group counsellor can also provide direct feedback to an individual client or to the group by simply commenting on what he or she has observed. This type of intervention serves as a "model" for the other group members to use to provide feedback. It also provides members of the group with an opportunity to hear the group counsellor's perspective on an individual member or on the group.
- At times, a group member is in a state of crisis because he or she has suffered a recent lapse or relapse. The group counsellor can enlist some group members to help this member explore the lapse/relapse so that he or she may learn from it and develop a way to stop it. Other life

problems may create crises for some group members, as well. Although the group counsellor can adhere to the principle of "disturbance takes precedence," the group counsellor must guard against spending too much time helping individual members resolve specific crises at the expense of reviewing the psycho-educational material pertaining to recovery. The group counsellor should refer such cases for individual counselling to the specified counsellor. This member also can be encouraged to discuss the current crisis in a Self Help group.

The following sessions need to be conducted under group therapy in a TRC

Time period	Suggested topics for Group therapy sessions (4 per week)	Objectives of Group therapy Sessions
Preferably within the 1st week of clients stay in the TRC	• Why we used drugs? • What were the benefits of using drugs? • What happened over the period? • What were the effects on the body? • What were the effects on the mind? • What were the effects in the family? • What were the effects on occupation/ studies/ finance? • Who all suffered? And how? • What was the root cause of all these? • What is\are the solution\s?	To personalize experiences of drug use and its impacts and help the clients openly share their 'stories' and also learn from other's experiences- all aimed at highlighting as well as underlining the problems of drug use and internalizing them to help motivate the change.
Preferably within the 2nd week of stay	Costs and Benefits of continued drug use versus stopping- i. Physical, Psychological Relationships ii. Socio-economic legal issues iii. Studies\ jobs and aims iv. achievements in life	To help the clients evaluate the cost and benefit of continued drug use as opposed to stopping to help motivate the change.
Preferably within the 3rd week of stay	Process of relapse: • Slips-Lapses and Relapses • Causes of Relapse • Relapse warning signs • Preventing relapse	To help the clients understand: • 'relapse' and internalize the process of relapse with regard to their own experiences replenished by the experiences of the others in the group • the steps of relapse progression-(slip, lapse and relapse). • the process of relapse (stress\lack of supervision\ relaxation of guard/ disregard for rules etc. leading to feelng→thought→craving→Use).

Time period	Suggested topics for Group therapy sessions (4 per week)	Objectives of Group therapy Sessions
Preferably within the 4th week of stay	• How various thoughts and feelings, both related and unrelated to drugs, can lead to relapse? • What is craving? How cravings lead to relapse? • What are triggers? What role do they play in relapse? • Common list of triggers and methods of dealing with them.	To help the clients understand and internalize the roles of thoughts, feelings, craving and trigger in relapse, based on their own experiences
Preferably within the 5th week of stay	• Saying 'NO' to drug offers • Managing anger • Managing money • Managing stress	To help the clients prepare to deal with some common triggers.
Preferably within the 6th week of stay	Sessions for seeking options from group members to develop strategies to deal with personal triggers.	To help the clients plan to deal with their triggers by seeking options from the group members and reducing their chances of relapse.
Preferably within the 7th week of stay	Discussion sessions on strategies developed to deal with triggers.	To enable the clients contemplate personal plans for relapse prevention to suit the individual one's drawn from the experiences of the group.
Preferably within the 8th week of stay	• Learning to recognize changes in thoughts and feelings leading to drug use. • Strategies to deal with thoughts, feelings. • Understanding and coping with craving • Strategies to deal with craving	To help the clients learn to deal with their thoughts, feelings and cravings that may lead to relapse.
Preferably within the 9th week of stay	Discussions sessions on developing a strategy for dealing with crises of any kind without resorting to drug use.	To help the client develop a crisis plan by seeking options and learning from experiences in the group
Preferably within the 10th week of stay	Discussions sessions on handling stress originating from • Anger • Money • Time • Relationship	To help clients develop strategies and strengthen the skills for handling stressful situation from the experience of the group members

Time period	Suggested topics for Group therapy sessions (4 per week)	Objectives of Group therapy Sessions
Preferably within the 11th week of stay	• Hiding slip- lapse and relapse. • Dealing with denial and guilt in relapse • Stopping the progress of relapse i.e not letting slip- lapse progress to relapse • Learning from relapse • Dealing with relapse	To assure the clients that relapse is not very uncommon and very much a part of the recovery process for many and so should never be considered as the end of everything (in case it occurs). One should rather use experiences from it to strengthen recovery by revisiting his/her relapse prevention plan.
Preferably within the 12th week of stay	• Fears and risks of the world out-side • Maintaining the system • Seeking help • Keeping in touch	To help the client prepare for life outside the centre by reviewing his/her plans for life out-side the centre

5.5 Providing family counselling sessions

Family members of a drug user face a number of problems including violence, risk of communicable (e.g HIV) and non-communicable diseases (e.g, hypertension), disruption of family structure, separation/divorce, financial problems and stigma. Drug use, like all behaviours, is learnt and family members- biological or otherwise play a pivotal role in this learning 'system'. Both their action and inaction influence drug use. Research has strongly linked the following roles of the family members to individual's drug using behaviours:

⇒ Parental drug use or other antisocial behaviour
⇒ Parental under- or over-involvement with the individual when growing up
⇒ Parental over- or under-control of the individual, especially in adolescence
⇒ Poor quality of communication between family members
⇒ Lack of clear rules and consequences and inconsistent application of them in the family
⇒ Inadequate monitoring and management of activities of family members
⇒ Lack of family supervision
⇒ Poor bonding to family
⇒ Poor family cohesiveness

Many of these problems may have already existed in the 'family' and may have causative relationship with the individual's drug use or may have been caused as responses to his/her drug use.

Some families may serve as "protective factors", that is, the family members may take initiative to bring the drug users to the treatment centre and may extend logistic and emotional support during process of recovery. Some families may also act as a "risk factors"; interpersonal problems in the family may be a source of stress which may be a reason behind initiation,

maintenance or relapse into drug use. Indeed when family members are overcritical or suspicious of recovering drug users, the risk of relapse may be high. Thus a counsellor working with drug users must be fully familiar with various issues involved in family counselling.

Family and Co-dependency

Many members of dependents' families do not have a separate sense of self. Either they never had one or they lost it as they learned both to deny the dependence and to adapt to it in order to maintain their connection with the dependent individual. Adaptation to drug or alcohol dependence has been called co-dependence. (It involves a sacrifice of self and is the pathology of members of a dependent's family). Co-dependency can be defined as an addiction to people and behaviours that are self-defeating in nature and are oriented solely to please others.

The members of a user's family have their lives intertwined with the user and experience the fallout of his disorders. Coping with this bizarre situation, the family as a unit becomes dysfunctional and individual members develop obsessive and compulsive disorders. When a family member comes for help, he/she becomes a client in his/her own right

Assessment of the family members' roles and responsibilities in the client's drug using behaviour and its potential in recovery.

It must be determined at the outset-

- To what extent does the client use distortion, rationalization and denial about the addict's substance abuse (these defences are signs of active co-dependency).
- What are the family's thoughts, perceptions, feelings and behaviours about the client's drug use.
- To what extent have drugs taken on a central organizing role in the family (the more this has happened the harder it will be for the family member to see the problem of change).
- What behaviours contribute in maintaining drug use (this will help the counsellor to help the client eliminate these behaviours or explore his resistance to change).
- The following additional information will provide a great deal of insight into the family dynamics
    - Family structure (Who has the power? Who does what?)
    - Family processes (How does the family conduct itself? Where are the alliances? Where is the hostility?)
    - Family history (The individuals within the family and the family as an entity will have a history which can provide insight into the core problem)
    - Family patterns of communication (Who talks to whom? about what? when?)
    - Family lifecycle (the family will be at a particular period in its lifecycle e.g. a baby born, a parent dead etc.)
    - Family crisis (How has this crisis affected the family? Why has the family come for help at this point?)

This can be done by one on one counselling interviews with the family members (parents, spouses, siblings or other significant ones) using the Guideline for Family Interview[29]

[29]Annexure-23 Guideline for Family Interview

Counsellor can help the family through the following steps:

- Understand the problem of drug use and the nature of the problems to enable them to provide better support to the client..
- Understand the impacts of drug & alcohol use in the short and long term to help them take appropriate steps to support the client's recovery.
- Get in touch with their problems caused due to the client's drug use and in turn how their behaviours and actions affected the client.
- Develop problem solving skills.
- Get the support of self-help groups (e.g. family anonymous).
- Identify and stop their enabling behaviours and develop a sense of therapeutic detachment to help the client in recovery.
- Communicate effectively to help in the client's recovery.
- Identify and better deal with their own thoughts, feelings, emotions that can trigger the client's cravings.
- To be an integral part of the client's recovery programme by helping plan their own roles and responsibilities.
- Understand the significance of money, time and stress in relapse and plan to support the client deal with them.
- Develop their own Do's and don'ts lists to help in the clients recovery.
- Resolve for the clients recovery outside the centre.

In trying to achieve these the counsellor might face the following difficulties:

- Family members disagreeing.
- Family members arguing.
- One member being defensive while the other hostile.
- Members making threats to the client or one another.
- Counsellors being pulled in, and colluding or allying with the client or the family.
- Having to decide who is right or wrong in an argument.
- Sympathize more with one client than another.

The following sessions are to be conducted during family counselling:

Time period	Activities	Objectives	Documentation
Preferably within the 1st week of stay	Assessment of the clients drug use and related issues- the family's version	To help in assessment of the client's drug use, the causative factors and the potential assets and liabilities of his recovery from the family's version	• Guideline for Family Interview • Individual Counselling Report • Family Counselling Register[30]

[30]Annexure-24 Family counselling register

Time period	Activities	Objectives	Documentation
Preferably within the 2nd week of stay	Assessment of Family's roles and responsibility's in clients drug use and potential for recovery	To help in assessment of the family's roles and responsibilities in the client's drug use, the strengths and weaknesses of the family members and identify their potential roles in the clients recovery.	• Guideline for Family Interview • Individual Counselling Report • Family Counselling Register
Preferably within the 3rd week of stay	Individual counselling of family members for co-dependency	To identify the extent and pattern of co-dependency	• Individual Counselling Report • Family Counselling Register
Preferably within the 4th week of stay	Individual counselling of family members for co-dependency	To help the family understand their roles till date and its impact on the client's drug use	• Individual Counselling report • Family Counselling Register
Preferably within the 5th week of stay	Individual counselling of family members for engaging in therapeutic relationship with the client	To enable the family member to understand their role in recovery of the client and forge the therapeutic contract	• Individual Counselling Report • Family Counselling Register
Preferably within the 6th week of stay	Individual counselling of family members for problem identification	To help the family member identify problem areas in their behaviours enabling the client's drug use and their future impact on his recovery	• Individual Counselling Report • Family Counselling Register
Preferably within the 7th week of stay	Individual counselling of family members for action plan	To help the family members in planning their own roles and responsibilities to facilitate the client's recovery	• Individual Counselling Report • Family Counselling Register
Preferably within the 8th week of stay	Individual counselling of the family members for ' seeking help in case of slip lapse, relapse.	To help the family member understand that relapse is a possibility and plan to seek help in case it happens	• Individual Counselling Report • Family Counselling Register
Preferably within the 9th week of stay	Individual counselling of family members for skill development	To help the family members in developing skills to help the client in recovery	• Individual Counselling Report • Family Counselling Register

Time period	Activities	Objectives	Documentation
Preferably within the 10th week of stay	Joint counselling of the family member/s and the client for review of the 'Trigger Dealing plans'	To engage the family members in the therapeutic partnership with the client and the counsellor by contributing in strengthening the plans for recovery	• Individual Counselling Report • Family Counselling Register • Trigger Dealing Plans
Preferably within the 11th week of stay	Joint counselling of the family member/s and the client for finalizing the 'Trigger Dealing plans'		• Individual Counselling Report • Family Counselling Register • Trigger Dealing Plans
Preferably within the 12th week of stay	Joint counselling of the family member/s and the client for the recovery plan outside the centre		• Individual Counselling Report • Family Counselling Register • Trigger Dealing Plans

Family meetings:

To be conducted by trained counsellors, at least once every week (12 sessions in total during the stay of the client) suiting the timing and day of the family members. These sessions are meant for the education of the family members in relation to drug use-its related problems, relapse and means of overcoming them.

The records of the meeting are to be maintained in the 'Family Meeting Register'[31].

Time period	Sessions	Objectives
Preferably within the 1st week of stay	Understanding drugs and drug (alcohol) dependence. The nature and symptoms of the disease.	To help the family understand the problem of drug use and the nature of the problems to enable them to provide better support to the client.
Preferably within the 2nd week of stay	Impact of different drugs in the human body and mind	To help the family members understand the impacts of drug & alcohol use in the short and long term to help them take appropriate steps to support the client's recovery.

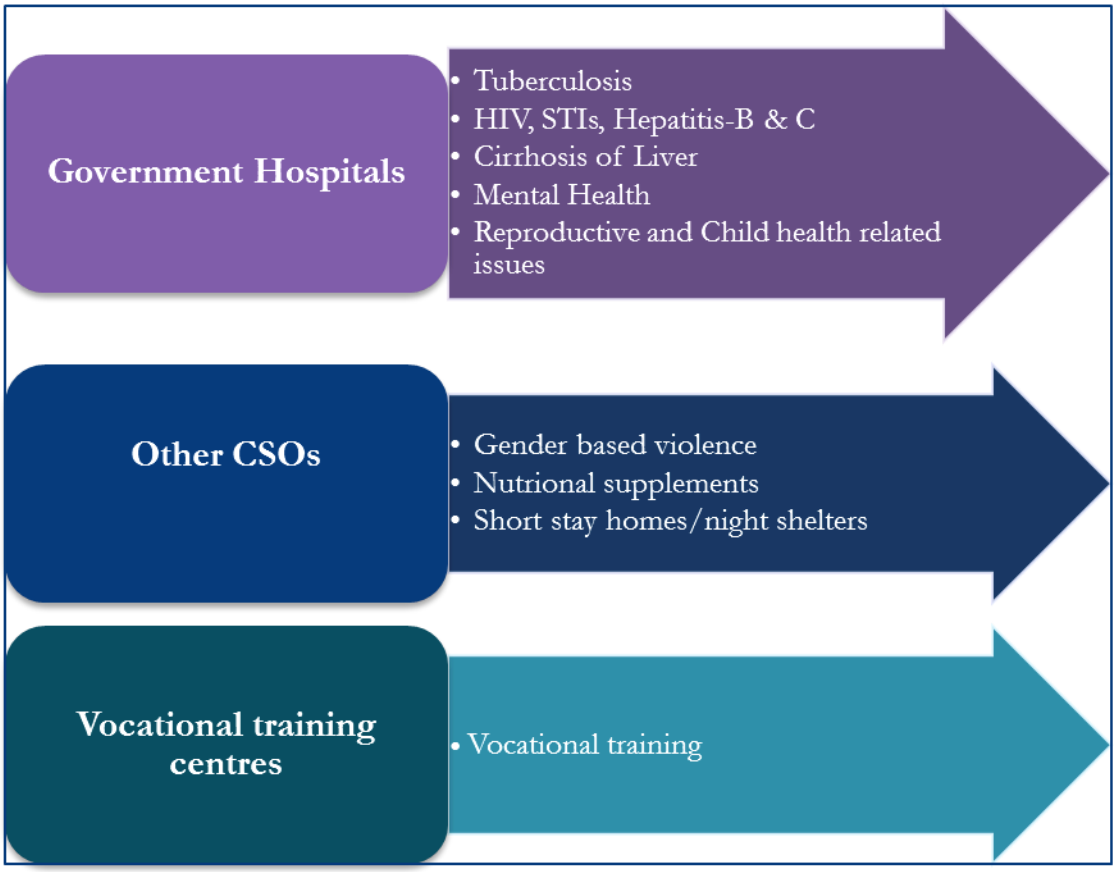
[31]Annexure-27 Family Meeting Register

Time period	Sessions	Objectives
Preferably within the 3rd week of stay	Family and co-dependence	To help the family members get in touch with their problems caused due to the client's drug use and in turn how their behaviours and actions affected the client.
Preferably within the 4th week of stay	Goals and components of treatment and the family's role in recovery	Develop problem solving skills Get the support of a self-help group
Preferably within the 5th week of stay	Dealing with family fears, denial, guilt and enabling behaviours (drug use) to help the client in recovery	To help the family members identify and stop their enabling behaviours and develop a sense of therapeutic detachment to help the client in recovery.
Preferably within the 6th week of stay	Communicating effectively to help the client in recovery	To help the family members to communicate effectively to help in the client's recovery
Preferably within the 7th week of stay	Understanding role of thoughts, feelings, emotions, triggers, craving in drug use	To help the family members to identify and better deal with their own thoughts, feelings, emotions that can trigger the client's cravings.
Preferably within the 8th week of stay	Planning to deal with the clients' triggers and cravings	To help the family members to be an integral part of the client's recovery programme by helping them plan their own roles and responsibilities.
Preferably within the 9th week of stay	Role of money, time and stress management in recovery	To help the family members understand the significance of money, time and stress in relapse and plan to support the client deal with them.
Preferably within the 10th week of stay	Appreciating, acknowledging, growth in recovery	To help the family members provide positive strokes to aid in client's recovery
Preferably within the 11th week of stay	Family's plan to help clients' recovery	To help the family members develop their own Do's and don'ts lists to help in the client's recovery
Preferably within the 12th week of stay	Recovery outside the centre -helping the client follow the plans and seeking help.	To help the family members finally resolve for the client's recovery outside the centre

5.6 Providing referral services

People who use drugs face a number of other physical, psychological and social problems beyond drug dependence and may generally suffer from poor health; conditions such as anaemia, poor nutrition, weight loss, and diseases such as tuberculosis, blood-borne infections such as HIV, Hepatitis B and C and mental illness. In case of people who use alcohol, they may be additionally suffering from liver diseases (cirrhosis of liver) and may need additional care and support. A TRC may not be in position to provide all such support and will need to arrange to make them available through referral.

Figure 5 Some common services required and their probable sources:



The following steps should be carried out in a TRC for effective referral:

Mapping referral service providers

At the time of establishing a TRC a mapping needs to be conducted for the basic services required through referral. The peer counsellors and guided by the rehab manager will conduct

the mapping exercise. During mapping the following should be noted:

- Distance of referral agencies/service centres from the TRC
- Services offered by these agencies/centres
- Timing of operation
- Mode of service delivery-whether free or costed
- Systems to be followed for availing services
- Key personnel and his/her contact numbers

Mapping for referral services may need to done again when need for new services come up or old service providers cannot provide services for some reason.

Establishing contacts with the referral agencies/centres

After identification of the service agencies, a senior member of the TRC, preferably the rehab manager should formally meet the key personnel at the centre. He/she should explain about the role of the TRC and also the objectives and purpose of establishing linkages.

Preparing a referral directory

Details of all potential referral agencies/centres should be documented in a referral directory. The details should include:

- Name of the agency
- Name of the contact person
- Address of the agency
- Time of operation
- Distance from the TRC

The directory should be easily accessible to all staff members of the TRC. It should be updated at least once in six months.

Making referrals

Referral can be made depending on the service needs of a client. A client can be referred by a peer counsellor. All referrals made needs to be documented in the referral register[32]. Moreover a reference card in triplicate copies should also be filled up for all referral. The referral card[33] should be signed by the peer counsellor referring and also the rehab manager. While one carbon copy of the referral card should be kept in the referral file- two others (the original and a carbon copy) should be sent with the person accompanying the client. The original copy is for submission at the referral agency and the other is to be brought back after being duly signed and with remarks/note from the personnel providing services at the referral centre. Tracking of these countersigned referral slips will help in monitoring of effective referral. In case the client is admitted in the TRC while being referred he/she should always be accompanied by a peer counsellor.

[32]Annexure-4– Referral Register
[33]Annexure-3– Referral Card

Conducting a networking meeting

Regular meetings (once in a quarter) should be organised by the rehab manager with the key persons of the referral agency. During the meeting, the rehab manager should explain the nature of clients who are provided services through the TRC, its goals and objectives and nature of services provided. He/she should thank the referral agencies for providing the services to the clients of the TRC and give an update on the number of successful referrals conducted. During these meetings the rehab manager should also discuss problems faced, if any, and seek solutions from the referral agencies for overcoming the barriers.

Referral analysis

Every month, the rehab manager should go through the referral records and analyse the referrals made in the previous month. In addition, he/she should get feedback from the TRC staff as well as the clients referred on difficulties/problem faced in accessing the services, if any. The achievements with relation to referrals should be discussed at the staff meeting, and a consensus should be reached on the challenges faced, if any. The barriers/challenges for effective referrals should be addressed by the rehab manager in networking meetings.

5.7 Linking clients up with DICs

The DICs are responsible for providing services to clients in the post rehab phase and also follow up. DICs are also responsible for tracking of client's recovery and bringing them back into the fold of treatment as soon as possible in case of relapse. Thus it is important that the clients are introduced to the DIC counsellors even before discharge.

It is best to conduct a meeting where the rehab counsellor of the client, the DIC counsellor and the client are all-present. During this meeting TRC counsellor introduces the client to the DIC counsellor who shall be continuing to provide future in the post rehab phase. He/she, with the permission of the client shares his/her drug use history, treatment plan and post rehab relapse prevention plan with the DIC counsellor. This will help ensure that a rapport between the client and the DIC counsellor is already built which will make providing continued scare easier.

Such meetings can be conducted twice a month when the upcoming clients are also introduced to their DIC counsellors.

A copy of the clients case history, treatment plan, relapse prevention plan should also be shared with the DIC through mail before the client is discharged from the TRC. It is to be noted that the client needs to be informed and the reasons explained before sending such documents to the DIC so that he/she does not feel that confidentiality is being breached.

The DIC counsellor shall be informed on the day the client is discharged.

5.8 Discharge of clients

Duration of stay

Optimum period of stay at the centre is 90 days. But the actual duration may vary depending on client's requirement and comfort level.

Discharge of clients

Normally clients who were admitted under voluntary treatment should be discharged after the completion of the therapy in the presence of a family member. Those referred under compulsory treatment by police or judiciary should be discharged upon the written advice of the Treatment Assessment Panel (TAP). During discharge the clients should be equipped with-

- Discharge certificate[34]
- Trigger dealing plan
- Crisis plan
- Follow up plan

Clients (other than those referred by the judiciary for compulsory treatment) are allowed to leave the centre before the completion of treatment by submitting a personal bond by a family member after being thoroughly informed and explained the risks attached to such actions. Those leaving before the completion of treatment (by submitting a 'Personal Bond'[35] by a family member) are not entitled to a discharge certificate. However, Trigger dealing plan\Crisis plan\Follow up plan if completed may be provided to the client. All discharge cases should be duly documented in the 'Discharge Register'[36].

5.9 Reporting missing clients

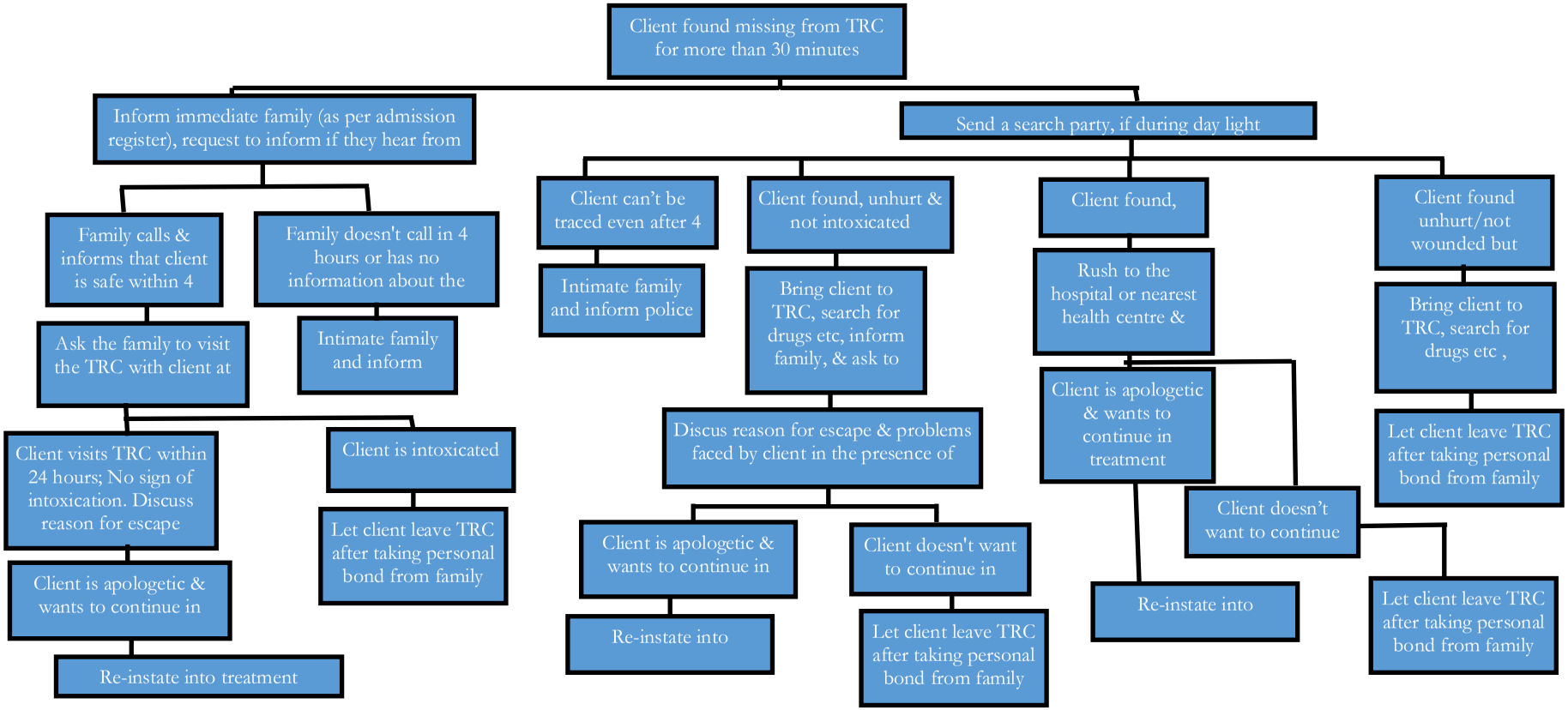
TRCs are advised to maintain an open system with minimum security. Use of chains and locks to bar clients are strictly allowed. The idea is to have a open rehab where the services and attitudes of the service providers will motivate the clients to stay rather than locks and bolts as in a prison.

It is important, however to keep track of clients. In case a client is found missing from a TRC for more that half an hour- the immediate family members should be informed and if not traced within the first 4 hours the police should be informed and a missing complaint should be lodged at the nearest police station. The family should be intimated before lodging the complaint with the police.

A search party comprising of two peer counsellors (at least one of them must be female in case the client is female) and some senior stable clients should be formed and sent out to look for the client at the earliest. The search party should be clearly told that they are not to use any force while trying to catch him/her or bring back to the TRC. If the client is not eager to come back, they should insist that the client makes a call to the family members and tell them about his/her intention to leave the TRC.

[34]Annexure-26– Discharge Certificate
[35]Annexure-27– Personal Bond
[35]Annexure-28– Discharge Bond

Figure 6: Protocol for dealing with missing clients



5.10 Screening TRCs for drugs

It is very important that TRCs remain drug free at all times. The clients, their families and also the staff need to be screened when entering the TRC. While drug screening exercises within the TRC should be conducted regularly (once a week), surprise checks should also be conducted by the rehab managers.

The rehab manager shall organise a team of 2 peer counsellors and 2 senior stable clients to conduct the drug screening. The team shall search through all beds, closets and under the carpets in all the rooms- occupied by the clients as well as the peer counsellors. They shall also search the toilets, kitchen and the open spaces if any. All such screening shall be documented in the drug screening register. If any drug is found it should be reported to the rehab manager immediately and the drug submitted to him/her.

5.11 Dealing with misconduct

Though it is advised to maintain an open and friendly rehab it is also important to maintain certain basic minimum codes of conduct at the TRC. This is important for quality service delivery and well being of the clients as well as the staff members engaged in the TRC. Any misconduct should be dealt with judiciously but strictly and appropriate actions should be taken at the earliest to restore stability at the TRC.

Issues to be considered as grave misconduct (by staff, client or visiting family members):

⇒ Intentional damage to the property of the TRC including the building and the surrounding
⇒ Causing or attempting to cause (intentionally) physical injury to person (fellow client, centre staff, visiting family members or other visitors)
⇒ Causing (or attempting to cause) sexual abuse or being involved in mutually agreed sexual activities while attached to the centre for treatment, either with persons at the centre (fellow clients, staff, visiting family members or other visitors) or outsiders (on visits to the hospitals/ referral centres, family, home trials or during outdoor activities-jogging, games, trekking, hiking, camping etc.)
⇒ Attempting to smuggle any drugs/psychoactive or controlled substance into the centre or pass it on to any staff, client, visiting family members
⇒ Use of any kind of drugs/psychoactive or controlled substances while attached to the centre for treatment, whether inside the centre or outside (on visits to the hospitals/referral centre, family, home trials or during outdoor activities-jogging, games, trekking, hiking, camping etc.)
⇒ Being in possession of any kind of drugs/psychoactive or controlled substances, weapons or valuable items (not registered with the centre) while being attached to the centre.
⇒ Any kind of theft by staff, client or visiting family members at the centre (money, valuable items, documents of the centre or belongings of fellow client)
⇒ Stigmatizing staff, fellow clients or visiting family members
⇒ Using abusive languages with staff, fellow clients, visiting family members or other visitors
⇒ Attempting to leave the centre without permission
⇒ Consistent disregard for the rules of the centre

Steps for dealing with misconduct	Person responsible	Documentation
Report to the Rehab manager as soon as the misconduct is noticed\reported.	Anyone who notices –staff or clients.	
In case someone (whether the perpetrator or the victim) is wounded first provide medical assistance. Take him/her to the nearest government hospital/health centre as soon as possible. Especially in case of bleeding, having difficulty in breathing, complaining chest pain, vomiting, head injury, unconscious, hallucinating etc take the person/s to the hospital immediately. If the person needs to be taken to the hospital inform the family and seek consent (at least over the phone).	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register [37] Referral register
Register the misconduct as a 'Misconduct register	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register
In case of clients being involved, inform the families concerned (perpetrator and victim) and ask them to meet the rehab manager immediately. In case the family does not respond within the stipulated time seek advice of implementing agency for further action.	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register
In case of misconducts numbered 1-4 in the above list (of misconducts), report to the police immediately. Inform the implementing and supervising agencies.	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register
In case of misconducts numbered 5-6 in the above list (of misconducts), ask the family concerned to come to the centre immediately and take the client home by submitting personal bond. In case a staff is involved suspend with immediate effect and ask to leave the TRC premises till further notice. Inform the implementing and supervising agencies.	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register

[37]Annexure-29– Misconduct Register

Steps for dealing with misconduct	Person responsible	Documentation
In case of misconducts numbered 8-11 in the list (of misconducts), the rehab committee needs to decide on the future actions depending on the gravity of the misconduct.	Rehab Manager. In his/her absence Peer Counsellor	Misconduct register
The rehab management committee (for all incidents of misconduct) should call a meeting as soon as possible and discuss the incident in the presence of those involved and their concerned family members to decide on actions to be taken.	Rehab Manager. In his/her absence Peer Counsellor	Minutes of the meeting
A detailed report of the incident including description of the incident, persons involved, witness reports (if any) and actions taken (hospital reports, police complaints, discharge \suspension certificates etc.) along with the findings of the committee and recommendations or action taken should be filed to the implementing agency and the supervising agency for advice on further action.	Rehab Manager. In his/her absence Peer Counsellor	Detailed report of the incident

6. CODE OF ETHICS FOR STAFF

The primary obligation of all staff members is to ensure quality of services to clients in treatment. The relationship between the staff and the client is a special one and it is essential that staff have both the maturity and the ability to handle the responsibility entrusted upon them.

All TRCs should uphold a basic code of ethics for the staff members. The TRC management should ensure that the staff members abide by them and take strict actions if not adhered to.

Code of ethics for staff members at TRC

⇒ Conduct oneself as a mature individual and a positive role model by not using psychoactive drugs of any kind.

⇒ Respect client by treating him/her with dignity.

⇒ No sexual relationship of any kind with client or member of client's family (engaged in treatment support system) inside or outside the TRC.

⇒ No physical restraint to be used to detain or restrain clients.

⇒ No corporal punishment (physical therapy) or physical or verbal abuse of any kind may be used for any misbehavior\misconduct of the client.

⇒ No locking or tying up of any client for any reason.

⇒ No denial of food or any services as a means of punishment.

⇒ Not to make use of /exploit the client for the personal gains of a staff member / organisation.

⇒ Recognize the best interest of the client and refer him/her if necessary to another agency or a professional for further help.

⇒ No photographic, audio, video or other similar identifiable recording to made of clients without their prior and informed consent. If done for research / training, the purpose has to be explained and formal consent obtained.

⇒ Maintain all client information in the strictest confidence. Information about the client or his/her progress in treatment not to be divulged to any individual or authority without the client's consent.

⇒ No discrimination to be made against a HIV, Hepatitis- B, C, TB positive clients or regarding admission or in providing any other services as long as he/she is certified fit to

7. ROLES AND RESPONSIBILITIES OF IMPLEMENTING AGENCY & BNCA

BNCA has been mandated by the Royal Government of Bhutan, by virtue of the Narcotic Drugs and Psychotropic Substances (NDPSS) Act, 2005 and the subsequently formulated 'Narcotic Drugs, Psychotropic Substances and Substances Abuse Rules and Regulations 2006 Kingdom of Bhutan' based on the act (vide sections 48, 49 & 50) to oversee the process of granting 'an institution, organisation or community' the permission to act as an 'drug treatment centre' based on criteria developed for the purpose. Furthermore, BNCA has been authorised to supervise the performance of the 'drug treatment centres' and continue or discontinue with the permission based on rules and regulations set for the purpose in coordination with other laws/ rules and regulations of the Kingdom of Bhutan.

An implementing agency is 'an institution, organisation or community' that has been approved (accredited) by BNCA to run a TRC.

Both the supervising agency (i.e. BNCA) and the implementing agency have important roles to play in running the centre, facilitating service delivery, evaluating and monitoring of the TRC to ensure standardised quality service across the country. While, BNCA will be taking lead in developing policies and guidelines, accreditation and monitoring and evaluation of centres, the implementing agency will be responsible for setting up, resource mobilisation and day to day activities related to running the centre.

Overview of roles and responsibilities of BNCA and the implementing agency

S. No	Responsibility	Implementing Agency	BNCA
1	**Policy making**		
1.1	Developing policies and guidelines related to setting up, running, evaluating and monitoring TRC	X	√
1.2	Developing basic criteria and minimum standards for setting up and running TRC	X	√
1.3	Developing systems of accreditation evaluation and monitoring of TRCs	X	√
2	**Setting up of centres**		
2.1	Providing accreditation to TRCs	X	√
2.2	Arranging appropriate space for setting up TRCs based on criteria prescribed	√	X
2.3	Recruitment of 'appropriate' staff for TRCs based on criteria prescribed	√	X
2.4	Capacity building of staff recruited for TRCs	√	√
2.5	Resource mobilisation for running TRCs	√	X
2.6	Developing in house administrative systems for running TRCs	√	X
2.7	Setting up in house administrative committees for running TRCs	√	X

S. No	Responsibility	Implementing Agency	BNCA
2.8	Mapping for referral agencies and setting up linkages	√	X
3	**Providing services to the clients**		
3.1	Assessment of drug dependence and other associated problems	√	X
3.2	Educative and skill building sessions	√	X
3.3	Individual counselling	√	X
3.4	Group therapy sessions	√	X
3.5	Family counselling	√	X
3.6	Linking clients up with DICs for relapse prevention and after care	√	X
4	**Management of Rehabilitation Centre**		
4.1	Day to day administration of the centre	√	X
4.2	Monitoring of activities and staff	√	X
4.3	Documentation	√	X
4.4	Networking for referral	√	X
4.5	Maintaining accounts	√	X
4.6	Reporting to supervising authorities	√	X
4.7	Monitoring and evaluation of TRCs	√	√
4.8	Reporting to RGOB, funders and relevant agencies	X	√

8. Annexures

Annexure 1

Visitors Register

Date	Name of the visitor	Purpose of the visit	Time in	Time out	Signature of the visitor	Remarks

Annexure-2

Sample Referral Letter from Approved Treatment Centre for admission to Treatment & Rehabilitation Centre for Drug and Alcohol Dependence

Referral Letter	
Name of the client	
Address	
Name of the guardian	
Phone	
Drugs used	
Date of admission\registration at Approved Treatment Centre	
Treatment received	Indoor for drug\ alcohol\drug & alcohol dependence
	Outdoor for drug\ alcohol\drug & alcohol dependence
	Medical examination for signs of withdrawal
	Medical examination for other significant problems

To the Rehab Manager

Dear Sir\Madam,

Kindly admit the above mentioned in your rehabilitation centre for long term treatment and relapse prevention support for

- ☐ Drug dependence
- ☐ Alcohol dependence
- ☐ Drug & alcohol dependence.

He\she has undergone treatment\ medical examination and has been found fit (without any signs of physical, psychological withdrawal or other significant medical complications) for long term rehabilitation.
Please find attached :

- ☐ Case history (drug use related)
- ☐ Medical history (including examination reports)
- ☐ Treatment plan
- ☐ Prescription and direction for continued medication

for your use.

Thanking you

Yours truly
(Name and signature of the Medical Officer)
Dated:

Annexure 3

Referral card

(Should be prepared in 3 copies- one original and two carbon)

Referral Card	
Name of the TRC	
Date	
Name of client referred	
Org./Inst./Specialist referred to	
Service/s referred for	
Feedback of referral	
Remarks	
Name and signature of the referring peer counsellor	**Signature of the Rehab Manager**
Signature of the referral agency personnel	

Annexure 4

Referral register

Date	Name of client referred	Org./Inst./Specialist referred to	Referred for	Feedback of referral	Remarks

Annexure 5

Client register

Date	Name of the client	Address	Phone number	Age	Sex	Remarks (admission\ services sought\ referral related)	Signature of client	Signature of Rehab staff

Annexure 6

Waiting list register

Date	Name of the client	Address	Phone number	Date to report for admission

Annexure 7

Client's rights

All clients and their family members have the right to the following:

⇒ A supportive drug-free environment.

⇒ To dignity, respect and safety.

⇒ To be fully informed of the nature and content of the treatment as well as the risks and benefits to be expected of the treatment. To be made aware of conditions and restrictions prescribed in the centre before admission.

⇒ To wear their own clothes in keeping with local customs and traditions

⇒ To have contact with, and visits (on scheduled days) from, family or support persons while in treatment.

⇒ To have confidentiality of information regarding participation in the program and of all treatment records.

⇒ To have permission to get discharged from the program due to personal reasons at any time without physical or psychological harassment.

⇒ Access to the project-in-charge or management to air out grievances / register complaints about the treatment or the staff.

Annexure 8

Declaration cum Indemnity bond

Declaration cum Indemnity Bond

I, (name of the signatory) _____

aged_____ years and presently residing at _____

_____

the (relationship with the client) _____ of

(name of the client) _____

aged_____ years presently residing at

_____

_____do hereby solemnly declare and state as under:

⇒ I have voluntarily and of my own accord admitted the above mentioned to the 'Treatment and Rehabilitation Centre for Drugs and Alcohol Dependents' facility.

⇒ I state that I have been informed about the entire treatment and rehabilitation process in detail and that I also fully understood and am aware of the implications and consequences thereof.

⇒ I declare and confirm that I have taken upon myself the entire responsibility, liability, risk and consequences as may arise during or after the said treatment and rehabilitation and that I shall not in any manner and at any time hereafter hold the said treatment cum rehabilitation centre, the staff / management liable and or responsible in any manner whatsoever.

⇒ I agree to indemnify and absolve this treatment cum rehabilitation centre for the following situations:

- ◊ Sustaining injury / fatal or otherwise while trying to escape from the centre and or trying to procure drugs.
- ◊ Attempting to commit suicide.
- ◊ During post acute withdrawal and in case becoming violent or suicidal.

⇒ I state that I am aware of all the statements and declarations made by me in the Declaration-cum-indemnity executed by me on _____day of the month _____and year 200_____ and I hereby confirm and ratify the same.

⇒ I am making this declaration solemnly and sincerely without any force, coercion or undue influence and the full force and effect should be given to all the statements and declarations made by me herein above.

Name and signature of the signatory _____	Dated :
Name and signature of the Witness _____	Dated :

Annexure 9

Admission Register

Date of admission	Registration Nos						Name of the client	Address	Phone Number	Age	Sex	Drugs Used	Remarks (any special precautions)	Signature of the client	Signature of the staff
	Year		Month		S. No										

Annexure 10

Client Screening Register

Date	Registration number	Name of the client	Screened by	Restricted items found			Action taken	Signature of the client's family member	Signatures of staff involved in screening
				Drugs	Weapons	Expensive articles			

Annexure 11

Educative sessions register

Date	Topic	Duration	Name of the clients attended	No. of clients attended	Conducted by	Signature

Annexure 12

Condom Demonstration Register

Date	Name of the spot	Session conducted by	Duration	Name of the clients attended	No. of clients attended	Conducted by	Signature

Annexure 13

Client Assessment Form

Section A: Demographic information	Registration Nos.
Name	Yr: ☐☐ Mth: ☐☐ sl. no: ☐☐☐
Age ☐ (in years)	**Sex** ☐ (M-male, F-Female)
Birthplace : Village name-	**Dzongkhag name-**
Currently living at (place)-	**Living with (relation with the client)-**
Education- ☐ Illiterate-1 Before primary-2 Primary school-3 Lower secondary school -4 Middle secondary school-5 Higher secondary school-6 Bachelor's Degree or higher-7 Non Formal education-8	**Marital Status** ☐ Married & lives with Spouse-1 Married but stay away from spouse for job-2 Married but separated-3 Married but divorced-4 Widower\Widow-5 Never married-6
Employment-☐ Never employed-1 Presently employed(fulltime)-2 Presently employed (part time)-3 Was employed but not presently-4	**Monthly income** (average) in the last 3 months Nu. ☐☐☐☐☐

Section B: Drug & Alcohol History						
Drugs	Ever used (Yes=1 \No=2)	Age of first use (in completed years)	Age at daily or regular use	Duration of use\ regular use	Frequency of use in the last 90 days (number of times per day/week/ month)	Average quantity used per episode in the last 90 days
Alcohol (beer, whisky, rum, ara, bangchang, singchang, chankey, zhor)						Bottles
Marijuana (ganja, mal, hash, bhang, grass, dope, black, etc)						In gms.
Corex or Phensedyl cough syrup or Codeine tablets orally						Bottles\Tabs
Heroin (brown sugar) by smoking or chasing						In gms.
Heroin (brown sugar) by injections						In gms.
Proxyvon / Spasmo proxyvon (SP)\ Relipen capsules orally						Tab\Caps
Proxyvon / Spasmo proxyvon (SP) \ Relipen capsules by injections						Tab\Caps
Nitrosun/ Nitrazepam tablets orally						Tab\Caps
Diazepam tablets orally						Tab\Caps
Glue (dendrite, nail polish, correction fluid, petrol, thinner) by sniffing						Tubes \Files
Others _____ (specify)						
Others _____ (specify)						

Section c: Withdrawal History			
Have you ever experienced withdrawal from the following drugs?			
Drugs	Yes=1\ No=2	When was the last severe one (year\ month\and if possible dates)	Problems (Complications) faced
Alcohol			
Marijuana			
Corex or Phensedyl—cough syrup or Codeine tablets			
Heroin (Heroin, Brown sugar)			
Proxyvon / Spasmo proxyvon (SP)\ Relipen – capsules\tabs			
Nitrosun/ Nitrazepam tablets			
Diazepam tablets			
Glue			
Others _____ (specify)			
Others _____ (specify)			

Section D: Assessment of Dependence		
Drugs	**According to ICD-10** Assessment of dependence YES-Dependence identified=1 NO-Dependence *not* identified=2	**'Yes' response to Question Numbers** (Assessment of dependence format)
Alcohol		
Marijuana		
Corex or Phensedyl -cough syrup or Codeine		
Heroin (Heroin, Brown sugar)		
Proxyvon / Spasmo proxyvon (SP)\ Relipen		
Nitrosun/ Nitrazepam		
Diazepam		
Glue		
Others _____ (specify)		
Others _____ (specify)		

Section E: Drug Injecting History (Enter one response code only)		
Have you ever injected drugs? ☐ Yes -1 No- 2 Don't Know-0	**Have you *ever* used a needle or syringe that had previously been used by someone else?** ☐ Yes -1 No- 2 Don't Know-0	**During the LAST TIME you injected, did you use a needle or syringe that had previously been used by someone else?** ☐ Yes -1, No- 2, Don't Know-0
You mentioned that the LAST TIME you injected, the needle or syringe had been previously used by someone else. Whose was it? ☐ Usual Drug using friends -1, Drug users you did not know before-2, Your regular sexual partner-3, A sexual partner you did not know-4, A drug dealer-5, A professional injector-6, Some one in the prison\treatment centre—7 Others-8 (please specify_____) Don't know-0		
During the LAST TIME you injected, did you clean your needle or syringe before injecting? ☐ Yes -1, No- 2, I don't remember-3, Don't Know-0	**You mentioned that you cleaned the needle or syringe before injecting the LAST TIME, how did you clean them?**☐ Cold Water-1, Hot Water-2, Boiling Water-3, Bleach-4, Alcohol-5, Blowing-6, Other-7(Describe) _____ Don't Know-0	
With how many different individuals did you share needles or syringes IN THE PAST ONE MONTH? Number of People- ☐☐ Don't know-0 **(Record best estimates)**		

Section F: Sexual History (Enter one response code only)		
Have you *ever* had sexual intercourse? ☐ *[For this assessment, "sexual intercourse," is defined as vaginal or anal sex.]* Yes -1, No- 2	**If yes, at what age did you FIRST have sexual intercourse?** Age in years ☐☐ Don't Know-0	**Did you use condom while having sex the FIRST time? ☐** Yes -1, No- 2, Don't Know-0
Did you use condom while having sex the LAST time? ☐ Yes -1 No- 2 Don't Know-0	**Did you have lower abdominal pain (for female respondents) / painful scrotal swelling (for male respondents) within the LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0	**Did you have ulcer on your genitalia within the LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0
Did you have ulcer around your anus within the LAST ONE YEAR? ☐ Yes -1 No- 2 Don't Know-0	**Did you have small cauliflower-like growth on your genitalia within the LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0)	**Did you have small cauliflower-like growth around your anus within the LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0
Did you have burning sensation during urination with urine in the LAST ONE YEAR? ☐ Yes -1 No- 2 Don't Know-0	**Did you have discharge of pus with urine in the LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0	**Have you had sexual intercourse in THE LAST ONE YEAR? ☐** Yes -1 No- 2 Don't Know-0
If yes, did you seek any treatment for any of the above symptoms? ☐ (Yes-1, No-2)		
If "yes", where did you receive treatment? ☐ (Self medication-1, Hospital-2,Traditional healer-3, Medicines advised by friends-4, Others (please specify) _____		

Section F: Sexual History (Enter one response code only)		
In *total,* how many different sexual partners have you had in the LAST ONE YEAR? Total ☐☐ Don't Know-0	**How many *Commercial* sex partners have you had in the LAST ONE YEAR *(*partners with whom you bought or sold sex in exchange for money or drugs)?** Commercial ☐☐ Don't Know-0	**How many *Non-regular* sex partners have you had in the LAST ONE YEAR** (sexual partners that you are NOT married to and have never lived with and did not have sex in exchange for money? Do not include current spouse (s) or Live in partner\s). Non- regular ☐☐ Don't Know-0
Did you use condom the LAST time (within the last one year) you had sex with a commercial sex worker? ☐ Yes –1 No- 2 Not applicable-3 Don't Know-0	**Did you use condom the LAST time (within the last one year) you had sex with a casual sex partner? ☐** Yes -1 No- 2 Not applicable-3 Don't Know-0	**Did you use condom the LAST time (within the last one year) you had sex with a regular sex partner? ☐** Yes -1 No- 2 Not applicable-3 Don't Know-0

Section G: Drug treatment History

When (year)	Type of intervention (codes)*	Where (Place & if possible name of the centre etc.)	Duration of treatment	Treatment Outcome (codes)**	(drug free period)
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days
			Yr/s Mth/s Days		Yr/s Mth/s Days

*__Codes for 'Type of intervention'__--For overall substance use problem-1; Alcohol (Only) treatment and rehabilitation centre-2; Detoxification at Govt. Hospital -3; Stopped at home with help from family or friends with some medications -4; Stopped at home with help from family or friends with no medications-5; Stopped by attending meetings-6; Others-7________________________________specify

** **Codes for 'Treatment Outcome'**- Used drug \alcohol within the first week (7days)-1; Remained drug (including alcohol) free for the first week (7 days) and then used-2; Remained drug (including alcohol) free for ____________days and then used-3 (for response 3 record the duration in number of days approximately) .

Section H: Problems related to drug use	
Problem Areas	Problems faced with duration in number of months
Health	
Family	
Other Social relationships	
Education	
Employment	
Financial	

Section I: Legal Issues	
Have you ever been arrested by police due to alcohol or drug related offences? ☐ (Yes -1,No- 2)	If yes, give details. Why? When? Etc.
Have you ever been sentenced to serve time in jail due to alcohol or drug related offences? ☐ (Yes -1,No- 2)	If yes, give details. Why? When? Duration of sentence. Etc.
Have you ever been arrested for other reasons? ☐ (Yes -1,No- 2)	If yes, give details. Why? When? Etc.
Have you ever been sentenced to serve time in jail for other reasons? ☐ (Yes -1,No- 2)	If yes, give details. Why? When? Duration of sentence. Etc.

Section J: Social Assessment	
Family	
Does the client have siblings? ☐ (Yes -1,No- 2)	If yes. No. of sister\s ☐ and brother\s ☐
Does the client have any children? ☐ (Yes -1,No- 2, Not applicable-3)	If yes. No. of daughter\s ☐ and son\s ☐
Is the client's mother alive? ☐ (Yes -1,No- 2)	Is the client's father alive? ☐ (Yes -1,No- 2)
What is the type of relationship with these family members and the extended family? Give details.	
Do these family members provide emotional and other support to the client? Are any family members dependent on the client? Give details.	
Does the client provide support to these family members? Give details.	
Has the client's drug\ alcohol use affected family relationships? Give details.	
Has the client's drug\ alcohol use affected relationship with non drug \alcohol using friends and other members of the society? Give details.	
Major life events and crisis: Has the client experienced the death of a relative, divorce, migration or other major and disruptive life event? If yes, give details.	
History of trauma: Has the client experienced sexual, physical or emotional abuse or witnessed conflict, violence, natural disaster or some other traumatic event? If yes, give details.	

Drug dependence assessment checklist

Name of the drug	_____	_____	_____	_____	_____	_____
1. Did you have a strong desire or sense of compulsion to use [*name of drug*]? (craving)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Did you find it difficult or impossible to control your use of [*name of drug*]?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Did you experience withdrawal symptoms after going without [*name of drug*] for a while?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you use [*name of drug*] to relieve or avoid withdrawal symptoms?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Did you notice that you required more [*name of drug*] to achieve the same physical or mental effects? (tolerance)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Over time, did you tend not to vary your pattern of use of [*name of drug*]?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Did you increasingly neglect other pleasures or interests in favour of using [*name of drug*]?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Did you experience psychological or physical harm because of your [*name of drug*] use?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Did you persist with using [*name of drug*], despite clear evidence of harmful consequences?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. How long did you experience this pattern of problem drug use?	☐☐years & ☐☐months	☐☐years & ☐☐months	☐☐years & ☐☐months	☐☐years & ☐☐months	☐☐years & ☐☐months	☐☐years & ☐☐months
If the client answers "yes" to *three or more* of questions 1, 2, 3, 5, 7 and 9, this is taken as an indication of significant dependence on the drug.						

Annexure 14

Individual counselling register

Date	Time	Name of the client	Counsellors brief	Name of the counsellor	Signature

Annexure 15

Individual counselling report

Name of the client_____	
Date_____	**Registration no.**_____
Counsellor's report	
Remarks	
Name of the peer counsellor	**Signature of the peer counsellor**

Annexure 16

Pros and Cons Analysis Tool

The Pros & Cons Form	
Please list the pros (advantages) and cons (disadvantages) of our drug and alcohol use.	
Pros (+)	**Cons (-)**
Review the list and rate the different factors in terms of importance to you. Rate them from 1 (the most important) to the least important.	

Annexure 17

Cost Benefit Analysis Tool

Cost Benefit Analysis Tool	
Benefits of Continued Use (+):	**Costs of Continued Use (-):**
Benefits of Stopping Use(+):	**Costs of Stopping Use (-):**

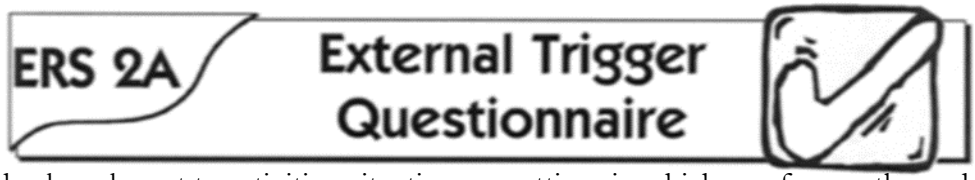
Annexure 18

Functional Analysis Tool

Functional Analysis				
Antecedent Situation	**Thoughts**	**Feelings and sensations**	**Behaviour**	**Consequences**
Where was I? Who was with me? What was happening?	What was I thinking?	How was I feeling? What signals did I get from my body?	What did I do? What did I use? How much did I use? What paraphernalia did I use? What did other people around me do at the time?	What happened after? How did I feel right after? How did other people react to my behavior? Any other consequences?
The time periods **when** the client uses drugs ·The places **where** the client uses and buys drugs ·The external cues and internal emotional states that can trigger drug craving **(why)** ·The people with **whom** the client uses drugs or the people from **whom** she or he buys drugs ·The effects the client receives from the drugs — the psychological and physical benefits (**what happened**)				

Annexure 19

Trigger analysis and trigger rating tool



Place a checkmark next to activities, situations or settings in which you frequently used substances; place a zero next to activities, situations or settings in which you never have used substances.

☐ Home Alone	☐ During a date	☐ Before going out to dinner
☐ Home with friends	☐ Before sexual activities	☐ Before breakfast
☐ Friend's Home	☐ During Sexual activities	☐ At lunch break
☐ Parties	☐ Before work	☐ While at dinner
☐ Sporting events	☐ When carrying money	☐ After work
☐ Movies	☐ After going past dealer's residence	☐ After passing a particular street or exit
☐ Bars/Clubs	☐ Driving	☐ School
☐ Beach	☐ Liquor Store	☐ The park
☐ Concerts	☐ During Work	☐ In the neighbourhood
☐ With Friends who use Drugs		☐ Weekends
☐ When gaining weight	☐ Recovery Groups	☐ With the Family Members
☐ Vacations/holidays	☐ After payday	☐ When In pain
☐ When it's raining		
☐ Before a date		

List any other activities, Situations or settings where you frequently have used

_____

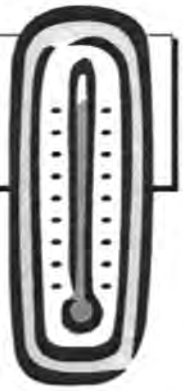
List activities, Situations or settings in which you would not use

_____

List people you could be with and not use

_____

ERS 2B External Trigger Chart



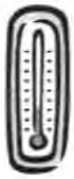
Name: _____ **Date:**_____

Instructions: List people, places, objects, or situations below according to their degree of association with substance use.

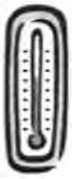
0% Chance of Using — **100% Chance of Using**

Never Use	Almost Never Use	Almost Always Use	Always Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

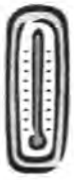
These situations are "safe."



These situations are low risk, but caution is needed.



These situations are high risk. Staying in these situations is extremely dangerous.



Involvement in these situations is deciding to stay addicted. Avoid totally.

ERS 3A Internal Trigger Questionnaire

During recovery certain feelings or emotions often trigger the brain to think about using substances. Read the following list of feelings and emotions, and place a check mark next to those that might trigger thoughts of using for you. Place a zero to those that are not connected with using.

☐ Afraid	☐ Criticized	☐ Excited	☐ Aroused
☐ Frustrated	☐ Inadequate	☐ Jealous	☐ Revengeful
☐ Neglected	☐ Pressured	☐ Bored	☐ Worried
☐ Angry	☐ Depressed	☐ Exhausted	☐ Grieving
☐ Guilty	☐ Insecure	☐ Lonely	☐ Resentful
☐ Nervous	☐ Relaxed	☐ Envious	☐ Overwhelmed
☐ Confident	☐ Embarssed	☐ Deprived	☐ Misunderstood
☐ Happy	☐ Irritated	☐ Humiliated	☐ Paranoid
☐ Passionate	☐ Sad	☐ Anxious	☐ Hungry

What Emotional states that are not listed above have triggered you to use substances?

_____
____

Was your use in the weeks before entering treatment

_____ Tied primarily to emotional conditions?

_____ Routine and automatic without much emotional triggering?

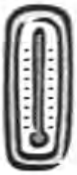
Were there times in the recent past when you were not using and a specific change in your mood clearly resulted in your wanting to use (for example, you got in a flight with someone and wanted to use in
response to getting angry)? Yes_____ No _____ If Yes, describe:

_____-
_____

ERS 3B Internal Trigger Chart

Name: _____ **Date:** _____

Instructions: List emotional states below according to their degree of association with substance use.

0% Chance of Using		**100% Chance of Using**	
Never Use	Almost Never Use	Almost Always Use	Always Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
 _____ _____	 _____ _____	 _____ _____	 _____ _____
These emotions are "safe."	These emotions are low risk, but caution is needed.	These emotions are high risk.	Persisting in these emotions is deciding to stay addicted. Avoid totally.

Annexure 20

Trigger dealing plans

Trigger dealing plan				
Name of the client				
Trigger description –				
		People who can help	Possible ways of help	Things to remember
Plans to avoid				
Plans to cope				

Annexure 21

Sample weekly schedule form

Weekly scheduling of activities							
Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00							
7.00-7.30							
7.30-8.00							
8.00-12.30							
12.30-1.30							
1.30-6.00							
6.00-6.30							
6.30-7.00							
7.00-8.00							
8.00-8.30							
8.30-10.00							
10.00-10.30							
10.30-11.00							

Hours of sleep	**Hours of work**	**Personal time (free hours\ entertainment\relaxation)**
Precautions:		
Other Remarks:		

Annexure 22

Group Sessions register

Date	Duration of the Session	Name of the clients attended	No. of clients attended	Issues Discussed	Name of the moderator\ counsellor	Session attended by (Name of the clients)

Annexure 23

Guideline for Family Interview

Name of the client _____	**Date**_____
(Use the following guide to get details about the client and note them in separate white sheets)	
A general life history of the client beginning at birth including his childhood, education, adolescence, relationships, aims and objectives in life, family's expectations etc.	
History of drug use	
⇒ When did he begin using drugs? How?	
⇒ What drug\s did he use? For how long?	
⇒ How would he pay for his (Source of money) drugs?	
Problems faced by the drug users and the family	
⇒ Health	
⇒ Family	
⇒ Other Social relationships	
⇒ Education	
⇒ Employment	
⇒ Financial	
⇒ Legal	
⇒ Sexual	
⇒ Any other issues	
Social Assessment	
⇒ What is the importance of this family member in the life and drug use of the client?	
⇒ What is the type of relationship with this family members and the extended family? Give details.	
⇒ Does this family member provide emotional and other support to the client? Give details.	
⇒ Does the client provide support to this family member? Are any family members dependent on the client? Give details.	
⇒ Has the client's drug\ alcohol use affected family relationships? Give details.	
⇒ Has the client's drug\ alcohol use affected relationship with non drug \alcohol using friends and other members of the society? Give details.	
⇒ Major life events and crisis: Has the client experienced the death of a family member\ close relative, divorce of parents or self, migration or other major and disruptive life event? If yes, give details.	
⇒ History of trauma: Has the client experienced sexual, physical or emotional abuse or witnessed conflict, violence, natural disaster or some other traumatic event? If yes, give details.	
⇒ What role can this family member play in the recovery of the client?	

Annexure 24

Family Counselling Register

Date	Time	Duration of the Session	Name of the client	Name of the family member	Counsellors brief	Name of the counsellor	Signature

Annexure 25

Family Meeting Register

Date	Time	Duration of the Session	Name of the clients whose family member attended	Name of the family members attended	No. of family members attended	Issues discussed	Name of the Moderator	Signature

Annexure 26

Discharge Certificate

DISCHARGE CERTIFICATE

TREATMENT & REHABILITATION CENTRE FOR DRUG & ALCOHOL DEPENDENCE, (Name of the centre)

_____

This is to certify that Mr/Ms. …… son/daughter of …… has attended the treatment and rehabilitation program at the Treatment & Rehabilitation Centre for Drug & Alcohol Dependence based at _____ (name and venue of the TRC) from the _____ to the _____

He/she is advised to follow the instructions mentioned below upon discharge:-

1. Abide by his plan for dealing with his triggers
2. Follow his hourly schedule
3. Money management plan
4. Attend the nearest Drop in Centre or Self Help\Support Group (NA\AA) at least twice every week
5. In case facing problems like having recurrent thoughts about drug use, cravings he is having difficulty in managing or handling his triggers he should contact his counsellor or the nearest Drop in Centre or Self Help\Support Group (NA\AA) as soon as possible.

We wish him/her a peaceful life filled with contentment, meaningful employment and all the joys of life without drugs.

Personal Counsellor	**Rehab Manager**
Dated:	

Annexure 27

Personal Bond

Personal Bond

The Rehab Manager
Treatment cum rehabilitation centre for Drug and Alcohol Dependents
Serbithang, Thimphu,
Bhutan

Respected Sir/Madam,

This is to request you to kindly discharge my (relationship family member)_____

(name of the client)_____ admitted at your centre for treatment of Alcohol & Drug dependence on _____, in spite of his/her treatment being incomplete and fully comprehend the risks involved.

The reason for my request is stated below for your kind consideration.

Reason for requesting discharge:

I hereby also state that I have no complaints against the centre or its staff.

Thanking you

With regards

_____ (Signature)
_____(Name of the family member)
_____(Relationship with the client)
_____(Date)

Legal Stamp

_____ (Signature)
_____(Name)
_____(Relationship with the client)
_____(Date)

Annexure 28

Discharge Register

Date of discharge	Registration Nos.							Name of the client	Address	Phone number	Reasons for discharge	Signature of client's family member	Signature of staff
	Yr		Mth		sl. no								

Annexure 29

Misconduct Register

Date	Name of the person\s involved	A brief description of the misconduct including names of the witnesses	Time	Details of action taken	Signature

Some additional registers to be maintained at the centre:

Home Visits Register

Date	Time	Duration of the Session	Name of the client	Name of the family members met	Purpose of visit	Remarks	Name of the Peer outreach worker	Signature

Staff Movement Register

Date	Name of staff	Place visiting	Purpose of visit	Visit authorized by	Remarks	Time out	Time In	Signature

SHG Meetings Register

Date	Time	Duration of the Session	Name of the clients attended	No. of clients attended	Issues discussed	Name of the Moderator	Signature

Referral directory

Name of the Individual \ institute	Address	Contact person	Contact Nos.	E-mail	Services Available	Timings of services	Mode of Service Delivery