COSUP

COMMUNITY ORIENTED SUBSTANCE USE PROGRAMME

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

Performance & Review Report

May 2018

This document references the service level agreement and addendum entered into between the City of Tshwane (CoT) and the University of Pretoria for the provision of services to address the use of substances among the communities of Tshwane. The purpose is to:

- report on the deliverables against payments received,
- provide an overview of the cost effectiveness,
- describe the benefits and achievements of the Community Oriented Substance Use Programme (COSUP),
- include a proposal on how to sustain COSUP, and
- assist the City of Tshwane comply with Act 32 of 2000, The Local Government and Municipal Systems Act, (specifically section 76 to section 86), when considering the continuity of the delivery of COSUP, and the entering into future service level agreements with the University of Pretoria.

This report provides an overview of COSUP and related activities. For further details refer to the quarterly or monthly reports provided.

Where there is no vision, the people perish. —Proverbs 29:18

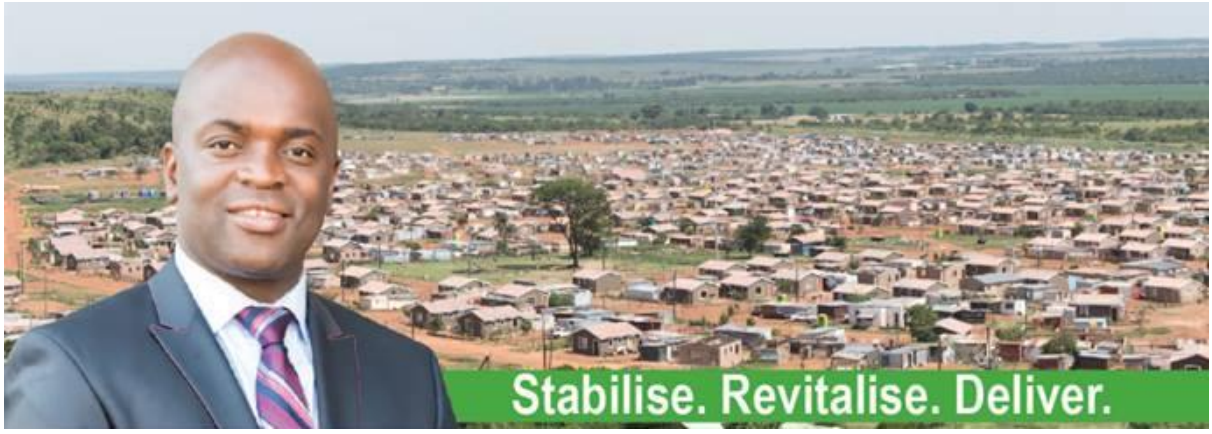
CONTENTS

WHY NOT STOP

One may suggest that people who use drugs should simply stop using drugs, but the reality is far more complex than that. For many people who use drugs and are living on the street, the use of drugs carries meaning and benefits that are not apparent unless one understands their experiences and listens to their narratives.

The meaning and purpose of drugs may come from a traumatic past, (data shows that a child who has six or more adverse childhood events has a 4,600 times greater chance of injecting drugs than one who has none) social exclusion, the need to self-medicate medical and psychiatric conditions and a variety of other issues. Sadly, experience has taught many people who use drugs, that even if they stopped their use of drugs, the stigma, criminal records and social exclusion remain, and their lives are unlikely to improve significantly. The volatility, violence, rejection and stigma they experience daily make the immediate comfort of drugs and the avoidance of withdrawal far more attractive than any long-term dreams that are unlikely to become reality.

These mothers, fathers, sisters, and brothers, are community members and citizens of Tshwane, and considering the undue burden of disease they carry, they are patients of the health system. There is, therefore, an ethical responsibility to protect them and the communities they live in – there is an obligation to provide them with the essential medical care that is the right of every South African. This not only means treating the medical conditions they are suffering, but also preventing the spread of diseases across communities of people who do or don't use drugs.



"The approach to dealing with substance abuse has shifted from sending users either to jail or to rehabilitation centers where withdrawal and total abstinence are the sole aim. It has now moved to a human rights, harm reduction and health care approach where early detection, harm reduction and care in the community through relationship building, support and re-integration into the society are the main focus."

Tshwane Mayor, Solly Msimanga

"There never is a good time for tough decisions. There will always be an election or something else. You have to pick courage and do it. Governance is about taking tough, even unpopular, decisions."

Jairam Ramesh

Key Points

- **17 COSUP** service delivery sites have been established in communities (see Addendum A)
- **8** drop in centres have been established (see Addendum A)
- Over **2 900** people have received direct assistance from COSUP
- **>19 000** clinical and counselling sessions have been attended
- **606** opioid substitution therapy[1] clients have been initiated
- **3 933** sterile needles[2] have been distributed and **3288** collected
- **>200** people have attended skills development and training
- **139** people are confirmed to be 'self-sustaining'
- **24** former service users are now employed as peers in COSUP
- **64** Transitional housing spaces have been created
- **3** hospice beds have been secured
- **64 000** households have been assessed
- **11** Community Advisory Groups (CAGs) have been formed
- **129** CAG meetings have been held
- **65** NPOs have been engaged with
- **46** professionals have been employed and trained
- **>700** medical students, doctors, clinical associates and allied health service providers have been trained on substance use and interventions
- **5** cooperative sub-agreements have been concluded
- **3** research projects have been initiated
- **24** soccer teams have been formed

[1] Opioid substitution therapy is the most evidence based of interventions for heroin use disorders. It reduces mortality, morbidity and the spread of blood-borne viruses and other negative impacts of heroin and injecting drug use.

[2] The provision of sterile injecting equipment is recommended by the World Health Organization and is essential to stop the spread of HIV and hepatitis C.

The City of Tshwane is the first city in South Africa to:

- provide services for all people who use drugs, including those who may not want to or be able to stop using drugs,
  - ✓ meaning progression is less likely and resolution is easier;
- promote services that are proven to reduce the drug-related risks and harms people who use drugs and the communities they live in may face,
  - ✓ ensuring people remain healthy and can contribute to their community;
- support and fund the World Health Organisation package of disease prevention services for people who inject drugs, including opioid substitution therapy and the provision and collection of sterile injecting equipment,
  - ✓ reducing infections like HIV and hepatitis C and the health burden on the individual and wider community;
- include substance use in the community oriented primary care (COPC) programme,
  - ✓ developing an accurate understanding of the prevalence of drug use, improving chances of preventing the development of substance use disorders and providing accurate information to families.

> *"Life just keeps getting better since I met the COSUP programme. Now I am even back at night school and help others who need this help. I have attended a life skills course at POPUP and I am ready for the next phase of my life, thanks to COSUP!"*

Executive Summary

On 18 May 2016 the City of Tshwane (CoT) signed a three-year Service Level Agreement with the University of Pretoria (UP) to assist with the implementation of a community based substance use intervention project to minimise the health, social and economic impacts of substance use through the prevention, identification and resolution of substance use disorders in the City of Tshwane using a community oriented primary care approach.

In June 2017, CoT and UP signed the Addendum (budget R6 697 782.00) to the SLA for the following additional deliverables: 1) to establish a helpline for substance users; 2) capacity building, and 3) monitoring & evaluation of CoT funded NPOs.

COSUP (Community Oriented Substance Use Programme) provides a community based, low-threshold response to the use of drugs, which seeks to reduce harm, and adds to and is integrated with the primary health, HIV and social services of the City of Tshwane. By being collaborative and inclusive, COSUP maximizes and builds on existing infrastructure (e.g. engaged with 65 NPOs, SAPS, Tshwane District, clinics, etc.; and signed five cooperative agreements with NGOs), enabling the sharing of knowledge and evidence-making through research and learning. This makes any investment in COSUP an investment in all the people of the City of Tshwane, with excellent returns.

We are satisfied that COSUP is well on target and within budget with the delivery of all the project targets as per the SLA. To date, a total of 17 substance use service delivery sites have been established across Regions 1, 3, 4 and 6, with more potential sites being negotiated in Regions 2 and 7. More than 2 900 service users have been enrolled in COSUP and more than 19 000 clinical and counselling sessions have been attended to, with retention rates at a minimum of 59% and increasing. Six hundred and six (606) clients have been initiated on opioid substitution therapy (OST), with retention rates exceeding international standards. This is done by 16 clinical associates, 2 nurses, 14 social workers, 7 CHWs and 15 peers, supported by 2 doctors, 2 experts and the project management team, who function in teams serving 17 COSUP sites.

Based on the data and analyses provided through the literature the COSUP programme at scale would be very cost effective. Although a formal full cost benefit analysis (CBA) has not been done, there is a clear indication that a CBA is likely to return a dominant result – that is, the programme would produce a net saving. At scale it will be very cost effective (less than half the WHO threshold of cost effectiveness) and if integrated as a part of COPC will be extremely cost effective (less than a third of the threshold).

Comparison with other alternatives namely Abstinence Based Programmes, Outpatient Programmes, Residential Rehabilitation Centres and High Threshold Programmes are discussed, and it is shown that they are all significantly less effective and costlier than COSUP.

Wide consultation with community stakeholders including SAPS and Community Advisory Groups are on-going, for the purposes of sharing and understanding approaches to helping people who use drugs, minimising the duplication of services, collaborating, providing training and support, identifying potential challenges and developing referral opportunities and mechanisms. Eleven Community Advisory Groups (to date) have been formed for homeless people, people who use drugs, and parents

and families affected by substance use, to get their input in improving the relevancy of the services provided to them.

COSUP participated with Tshwane District Gauteng DOH from the beginning and works to integrate substance use interventions with clinics and CHC. Now the Eersterust COSUP site is integrated with the Eersterust CHC and similar is planned for Laudium CHC. The development of an Integrated Health Care Platform in Tshwane is now an important process and COSUP is an important element of integration.

Several research projects have been initiated while others are in the planning stage. One research protocol entitled *The prevalence of substance use, associated morbidities, and responsiveness to COSUP referral among adolescents and adults admitted to UP affiliated hospitals in Tshwane* was developed in 2017. Two manuscripts are planned for this protocol and the first paper is expected to be ready for submission by June 2018. A research project focussing on the role of peers in substance use programmes has been completed and another is planned for the second half of 2018. As the service is getting more established, research is becoming a greater focus.

Two COSUP projects that are planned for this year are Sports is your gang! and a small-scale housing project. Sports is your gang! is recreational tournament with the purpose of bridging gaps between the community, the youth, homeless people, people who use drugs and the SAPS. The purpose of the small-scale housing model is to address the continuous challenge of retaining homeless people who use drugs by housing them in temporary structures while they receive treatment and training, with the focus on successful reintegration into society.

In the addenda, documents provide details about Norms and Standards, Standard Operating Procedures, Clinical Governance, Monitoring and Evaluation, Intellectual Property Rights and Finances.

The sustainability of COSUP is discussed stating that the needs for services are vast and that the COSUP service would have to continue and be expanded. Three options for continuation is provided with the advantages and risks of each.

The City of Tshwane is the first city in South Africa to provide services for all people who use drugs, including those who may not want to or be able to stop using drugs. The promotion of services that are proven to reduce the drug-related harms and risks to people who use drugs and the communities they live, is shown here to be cost effective, sustainable and successful in retaining clients. With the approval by the Governance Committee Meeting (July 2017) of the inclusion of opioid substitution therapy, and the provision and collection of sterile injecting equipment at the COSUP sites, the City of Tshwane undeniably established itself as a leader in the support and funding of the World Health Organisation package of disease prevention services for people who inject drugs.

Key Performance Indicators

Indicators	To Date	Comments
Number of service users enrolled in the Substance Use Programme	2957	This is over the two-year target of 2100, which was set for June 2018.
Number of visits by enrolled service users to COSUP Sites	19 533 TOTAL 2 315 April	This figure is increasing as a % of people repeatedly accessing services.
Number of service users retained in the programme after six (6) months	59%	This is increasing as services become more established and trust increases. It is far better than the benchmarks and international and local experiences.
Number of COSUP service delivery sites established	17	This is on target
Number of service users enrolled in and/or completing a skills development programme	201	Now that sites have been established and new partners contracted, this figure will rise significantly over the next 12 months.
Number of service users who are placed in self-sustaining initiatives and opportunities 'post-rehabilitation' (or find their own jobs)	139	This is difficult to gauge, and responses from the community would suggest these figures are higher, and certainly figures for social integration are higher. Better measures and tools are suggested.
Number of service users initiated on OST	606 TOTAL 337 CoT 269 Self	This is a significant achievement and ahead of the targets. CoT needs to lobby NDoH for registration on EDL and new products to reduce costs.
Number of service users retained in OST Programme	66.7% COM 87.2% CoT 62% Self	These are excellent figures that may highlight the importance of funded OST.

Beyond the Indicators

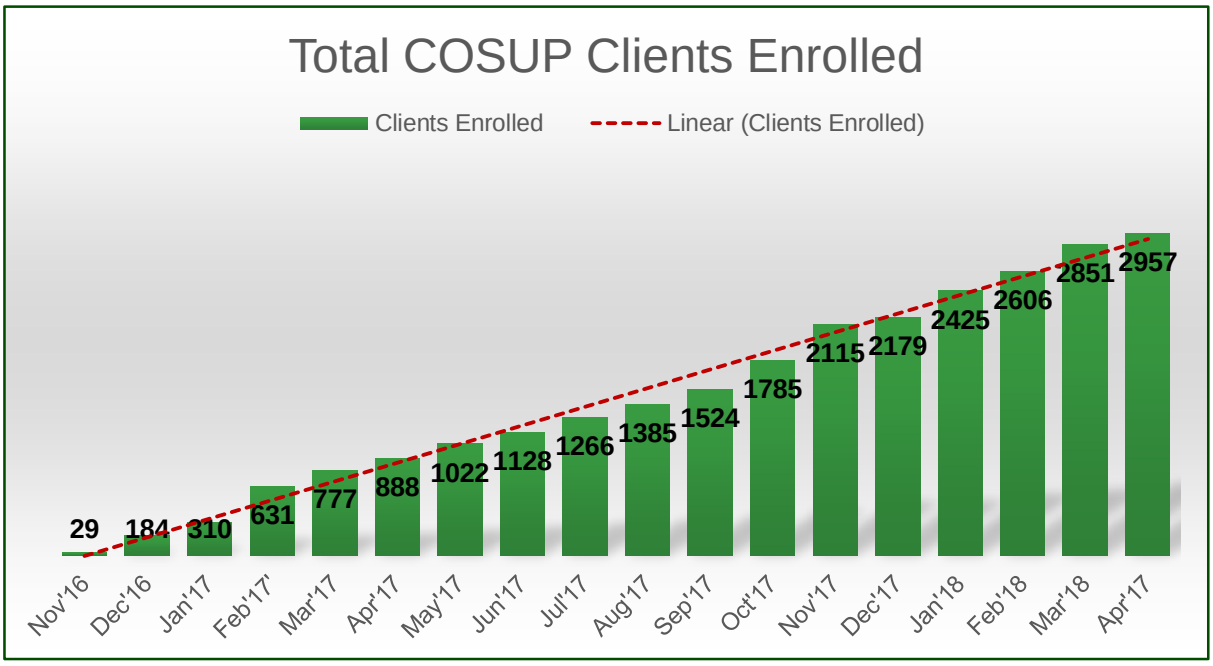
COSUP is more than just a set of numbers. While the performance indicators are important, there are a number of very important aspects to the programme and approach that are not conveyed in the figures.

COSUP not only provides a framework for addressing the use of drugs in the city, but also for addressing the wellbeing of many marginalised people, the families of people who use drugs, the communities they live in and the overall creation of an enabling environment that is essential in delivering health and wellbeing services to people. The role of COSUP and harm reduction services in reducing the incidence of HIV and HCV in both the people who inject drugs and the broader community so as to achieve the commitments made by government in reaching the targets of 90-90-90[3] is essential.

COSUP reaches out to communities through home visits, the use of peers, outreach, training, collaboration and by being part of the community rather than separate from it. The programme is built on trusting relationships that are essential in the resolution of substance use disorders and the prevention of their development. Such relationships are extremely difficult to build in an environment when one is at 'war' with those most in need of services.

COSUP forms collaborations with existing NGOs, businesses and stakeholders such as law enforcement and community organisations. This helps strengthen ties with the communities, provides the space for innovation, ensures consistent and supportive messaging, and, above all, contributes to sustainability.

COSUP both applies evidence and makes evidence through implementation science and research. By monitoring programmes, by evaluating performance and disseminating the information through

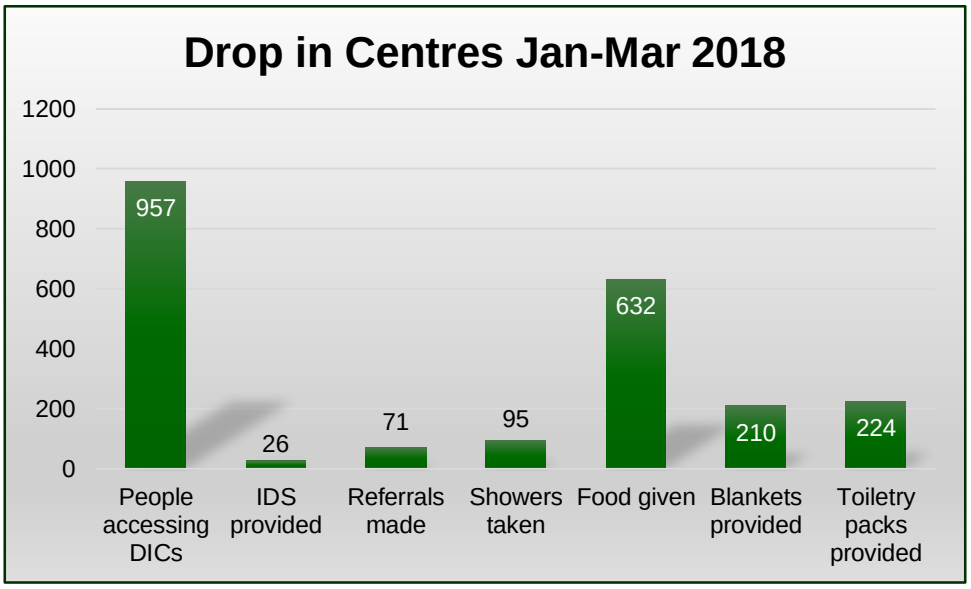


[3] 90% of people with HIV know their status–90% of those people are on treatment–90% of people on treatment are virally supressed

academic discourse and the media, COSUP firmly places the City of Tshwane at the forefront of innovation.

But most of all, COSUP provides the hope of a better future for all the people of Tshwane, and by extension, South Africa, through an effective, compassionate, rights-affirming and scientific model of dealing with one of the most pressing issues of our time, and the people most impacted by the use of drugs.

> *"What people addicted to drugs need is sensitive, intelligent social scaffolding to hold the pieces of their imagined future in place — while they reach toward it."*
>
> *Marc Lewis*
> *Neuroscientist and author*



Statistics for Tshwane Leadership Foundation (TLF) Drop In Centres

Cost Benefit

Problem Statement

Although it is not possible in the timeframe for this report to carry out a full cost benefit analysis specific to South Africa or Tshwane, it is possible to review studies in other countries and assess the implications for Tshwane. There are two components to this. The broader issue is general substance misuse of all types. The impact of excessive use is generally felt in terms of societal costs – loss of earnings and productivity, and the financial and emotional burden on families. However, the health system carries a burden in terms of the hospitalisation and visits to emergency departments because of substance use. The larger issue in terms of public health and the burden of disease is from heroin-based substance (opioid) use and in particular the proportion of opioid users who inject (PWID). Heroin is the most commonly injected drug, yet the same risks would apply to people who use stimulant drugs. The reasons for this are that because of criminalization and stigma attached to PWID, needle sharing is common, and this results in high levels of HIV and Hepatitis C virus (HCV) transmission. This leads to the triple burden of a) hospitalisation and emergency visits because of opioid use, often related to the reuse of injecting equipment (whether shared or not); b) increased HIV and HCV prevalence; and c) the societal costs described above.

The Numbers

According to the UN World Drug Report 2014, 7.06% of South African adults (or of 1.89 million in Tshwane) are drug users (excluding alcohol). Schneider (SAMJ 2007) estimated 12% of adults were heavy or very heavy alcohol users. That totals 360 466 substance users in Tshwane who are at risk of use-related health (and social) problems.

According to the Australian National Drug Alcohol Research Centre, 0.61% of adult substance users were hospitalised because of use. This implies 11 579 annual hospital inpatient episodes in Tshwane from substance use. In reality, this may be significantly higher because Australia was an early-adopter of harm reduction strategies. The US Drug Abuse Warning Network (DAWN) reports 8.5% of users visited the Emergency Department (ED) for substance related issues. This implies a further 11 398 annual emergency attendances in Tshwane. Stenbacka et al. (Drug Alcohol Review 2009) calculated that mortality in substance users was 3.4 times that in the general population, which would mean 10 295 substance use related deaths in Tshwane. Stenbacka also found that 50% of the cohort died 25–30 years early. Assuming a median value, the average life years lost would be 13.75 per user, or a total of 141 555 life years lost.

According to the World Drug Report 2016, 0.1% to 0.25% of adult South Africans are PWID. Setswe et al. (2015) estimated 0.2% (75 700). Of PWID, 85% are in major cities which account for 50% of the population. On this basis we estimate 7 839 PWID in Tshwane. Out of these, 4,233 (54%) have HCV and 1 489 (20%) are HIV+.

What It Costs Us Now

Unemployment in South Africa is around 25%. Because of the demographic of excessive substance users and the social and emotional distress behind substance use, we conservatively use 50% unemployment for these calculations. In terms of lost income, for the above reasons we also use the average income for income quintiles 1 to 3 (R11 225). The HARM study (Netherlands 2009) estimated

costs for inpatient rehabilitation at Euro 5 461 per separation plus Euro 1 712 for production cost losses. Converting these costs using purchasing power parity (PPP) rates and adjusting for inflation and unemployment in South Africa, the production loss cost per episode is R3 169. The loss of income for each death is discounted and calculated at R69 873. Applying the WHO-CHOICE country specific rates for South Africa for inpatient and outpatient visits, the total cost to the health system for these interventions would be R239 million. Based on life years lost and the assumptions described above, the cost to society would be R719 million and production losses R37 million.

The total estimated annual cost of substance use in Tshwane is R995 million.

THE ALTERNATIVES

(See Comparators Section for further details.)
We believe none of these estimates include prison populations or drug use in prisons, which is comparatively very high, and require separate approaches.

There are three approaches applied in South Africa. The first prevailing approach is the criminalization of substance users and doing no more than exacerbating the problem by incarcerating them. The second is a combination of mandated, coerced, semi-coerced or voluntary inpatient or outpatient rehabilitation that is abstinence-focused and expectant, high-threshold and low tolerance in nature. The third is harm reduction-informed approaches delivered through community based and outreach programmes, like the CDC PEPFAR funded OUT Harm-Less programme, the Global Fund/Right to Care programmes run by TBHIV Care and Anova Health, and COSUP, which focus on user needs rather than coercion and applying, inter alia, needle services and OST programmes. COSUP is the only programme that is moving towards a community-integrated, peer-informed programme that is self-sustaining through a cascade model of learning and the transfer of essential skills to communities.

The costs of the first approach are described above, and there are no offsetting benefits or outcomes.

The second approach is now generally regarded as being inappropriate and ineffective for the majority of people who use drugs. Inpatient facilities should be reserved for people with dual diagnosis or those who have a chronic dependence, are self-motivated with a desire to be abstinent from all drugs, and they have a good community support structure to return to. Out-patient services that are abstinence focused are only able to address the needs of people who have already developed a dependence, are well motivated and well supported. This leaves the majority of people who use drugs without any services and only addresses the resolution of substance dependence, adding little to the prevention of the development of substance use disorders. It is also expensive, with high capital costs for the institutions and very limited capacity.

The COSUP programme over its two start-up years has a projected cost of R61.8 million and treated 2 900 patients; or R21 310 per person reached. This is a conservative estimate because it includes all the programme start-up costs, and as the programme expands it will achieve efficiencies of scale. Further, the number of people by project end are likely to have increased significantly, and this cost will have reduced to around R10 000. What is also not included in these figures is the additional benefit through the approaches that are self-sustaining and preventative.

COSUP is also currently a standalone programme with dedicated staff. If it was integrated into COPC as well as into the community services supplied by existing NGOs and Social Development, the programme would become a marginal cost within the current budgetary landscape by sharing resources, systems and management costs. Preliminary estimates indicate a 4% maximum marginal cost increase to the fully implemented COPC programme, equating to R10.5 million for Tshwane with the capacity to cover all 7 389 PWID in the city at a cost of R1 424 per PWID reached (6.6% of current cost with 2.55 times current coverage).

Cost Effectiveness of Harm Reduction Strategies

In cost effectiveness terms, community based harm reduction strategies provided through COSUP dominate. That is, they are cheaper and better than the other options.

The consistent finding in the literature reviewed is that Needle and Syringe Programmes (NSP) are the most cost effective, followed by Opioid Substitution Therapy (OST), but the most effective is combined NSP and OST. Other interventions, for people who use but don't inject drugs and people dependent on non-opioid drugs, such as alcohol, cocaine and cat, include interventions built into the primary health system, such as brief interventions, motivational interviewing and referrals to specialist services as well as peer-facilitated support groups and community based support services delivered by existing NGOs. These interventions become self-sustaining once a cascade model of knowledge and skills transfer is combined with an integrated peer-review process.

Over the past decade the body of research into the cost-effectiveness of harm reduction has also grown. It is now indisputable that harm reduction works, is cost-effective and can be implemented successfully in a variety of settings. In Australia, for example, it was estimated that every dollar invested in NSPs returned four dollars in healthcare savings. In eight countries in Eastern Europe and Central Asia, NSPs were found to be extremely cost-effective when considering prevention of both Hepatitis C and HIV infections, with a return on investment of between 1.6 and 2.7 times the original investment. The National Institute on Drug Abuse in the United States concluded that methadone treatment is 'among the most cost-effective treatments, yielding savings of $3 to $4 for every dollar spent'. Similarly, studies from China concluded that investment in OST provision would yield substantial savings for the government through averted HIV infections and decreased HIV treatment costs. Research suggests that the combined implementation of harm reduction interventions and HIV anti-retroviral therapy for people who inject drugs offers the highest return on investment. This has been demonstrated by modelling the potential impact of scaled-up NSPs, OST and HIV testing and treatment in Kenya, Pakistan, Thailand and Ukraine from 2011 to 2015. Researchers have also found that the peer distribution of naloxone to people who inject drugs is among the most cost-effective of all lifesaving interventions.

Harm Reduction International Report: The case for a harm reduction decade. 2016

In Australia, States that introduced NSP saw a reduction of 18.6% incidence in HIV compared to an increase of 8.1% in States where NSP was not used. This result is also replicated elsewhere (see attached harm reduction motivation). Wilson et al. (International Journal of Drug Policy) found NSP reduced HIV infection amongst PWID by 54%.

The cost of HIV treatment is US$ 875 (R11 025) per person per year (Center for International Health and Development, University of Boston, 2006, adjusted for recent agreement to move to Dolutegravir FDC at US$ 75 ppy).

The cost of TB treatment is US$ 436 (R5 362) per month (US$ 1 744 [R21 451] for a four-month regimen in community) plus R2 880 community care costs.

The cost of a HCV 12-week treatment is: Drugs – $750 (R9 225), plus hospitalisation (excluding drugs at 10%) – $6 868 (R84 475). Thus, a total R93 700 per case.

A number of 7 839 HIV+ cases will generate at least 302 new infections annually (at current rate of 0.038 infections per PLHIV in South Africa). The reduction of 54% through NSP/OST will save at least 163 HIV infections, 88 HCV infections and 10 TB infections (6% coinfection rate).

The direct savings to Tshwane are: HIV – R1.8 million, plus HCV – R8.2 million, plus TB – R296 940. Thus, a total of R10.3 million. The major saving however is in the reduction of hospitalisation and production costs. Using the same calculation for PWID as for all users, the saving would be R12 million to the health system and R153 million to the community and the economy. This leads to a total saving of R165 million. If we conservatively assume that the reductions can only apply to the 50% who died prematurely, then the savings would be R6 million to the health system and R76 million to the community and the economy. **Total R82 million.**

It needs to be noted that these are conservative estimates. The latest TIPVAL study's preliminary results show a prevalence of 93% of HCV and 43% HIV among people who inject drugs in Tshwane. If harm reduction services are not ramped up, it will become impossible to eradicate HCV in the population, and the costs of HCV treatment far exceed those of HIV treatment.

Conclusion

Based on the data and analyses provided through the literature the COSUP programme at scale would be very cost effective. Although this is not a formal full cost benefit analysis (CBA), there is a clear indication that a CBA is likely to return a dominant result – that is, the programme would produce a net saving. Rather than use the WHO threshold of cost effectiveness as the GDP per capita, we have taken a more realistic view based on the demographics of substance use and we have used the average income of quintiles 1 to 3. Even at that level, and ignoring the system and community savings, the current COSUP programme is cost effective (less than the threshold). At scale it will be very cost effective (less than half the threshold) and if integrated as a part of COPC will be extremely cost effective (less than a third of the threshold).

These results are considered conservative because we have taken the costs of all substance use issues and estimated the savings and benefits of PWID only.

Comparators

In order to decide if the City of Tshwane is getting 'value for money', it is essential to understand how COSUP compares to the alternatives. In this section some of the alternatives and their results are described.

APPROACHES

Abstinence focused approaches

These include residential rehabilitation centres and community based services. An example of this would be Cape Town's approach to substance use. This includes both rehabilitation centres and Matrix clinics that are based at community clinics. The cost of these services is: R104 million plus a further R101 million for specialist youth services from the Western Cape Department of Social Development and excludes the more than R7 000 000 that the city spends per year on eight Matrix clinics.

Abstinence-focused approaches potentially address the needs of around 10% of people who use drugs – those with a chronic dependence and who are self-motivated to be abstinent from all drugs. The majority of people who use substances therefore receive almost no benefit from these programmes.

Almost all treatment approaches available promote abstinence as the only way to address substance use. Stopping use is a requirement for accessing many services, such as housing and specialist care or treatment for other conditions. The evidence and data show the following:

- 40 years of research has shown that confrontation does not work, and can often do more harm.[4]
- The majority of people who use drugs will never access services if they are expected to stop using drugs. This increases risks and takes away vital opportunities of assisting the person with making better choices.
- Often, living conditions prevent people from stopping or reducing the use of drugs. To deny services because of drug use is to virtually ensure continued drug use. The Housing First model has proven this.
- Abstinence-only approaches do not include the provision of sterile injecting equipment or maintenance treatment. This increases the spread of HIV and HCV.

Outpatient services

In the Cape Town example there are eight Matrix clinics established at community health facilities. In a 2015 study by NIDA it was shown that of those who attended the clinic to seek help and were screened as having a substance use disorder, 88% attended the initial treatment session, 10% the second session and only 3% attended the third. Only 13% of people completed the programme. A more recent study by Magidson shows that 47% of people screened and found to have a substance use disorder attended an initial session and of that number, 23% completed the programme – 10% of the initial number with a confirmed substance use disorder. In the case of heroin use disorders, only

[4] White WL, Miller WR. The use of confrontation in addiction treatment: History, science and time for change. Counselor. 2007; 8(4):12–30.

4% of those found to have a heroin use disorder completed the programme after 37% had attended the first session.

Residential rehabilitation centres

Residential rehabilitation centres are expensive with a direct cost to the state or individual of around R40 000 per person.

The benefits are limited because:

- Although some people may need some form of temporary residential care, there is no proof that this is any more effective than brief interventions and community based support in helping resolve substance use disorders.
- The investment in the centre only directly benefits a small number of individuals.
- The skills of staff and professionals are not transferred as part of daily operations to other organisations, and expertise remains seated in the centre.
- The services only offer assistance to the most chronic and affected substance users.
- Most people require multiple contacts over a period of time and across domains of intervention and expertise, and multiple entries are therefore costly and difficult to secure at short notice if needed.
- There is still a need for continued community based care for the reinforcement of lessons learned in rehab.
- The artificial environment inside the facility does not prepare the person for a community setting.
- People need to be removed from society – their families, work and other activities to attend residential rehabilitation.

> *"There's no such thing as an evidence-based rehab…. That's because no matter what you do, the whole concept of rehab is flawed and unsupported by evidence."*
>
> *Dr Mark Willenbring, former Director of Treatment & Recovery Research at the National Institute of Alcohol Abuse and Alcoholism (NIAAA)*

High threshold programmes

Many countries only allow for high threshold OST programmes. Such programmes have long waiting periods and demand abstinence from all drugs, regular urine testing, and daily observed doses at the clinic for periods of two years or more. Programmes insist people attend sessions, and refuse services if the person is non-compliant.

The results are:

- an oppressive form of social control, violating many patient rights;
- those most at risk are discouraged and are unlikely to access the programme;
- a compromised therapeutic relationship where people feel it is difficult to return to services if they default or are expelled; and
- additional challenges for people to re-integrate into society due to being committed to daily observed doses.

INVESTING IN COSUP

COSUP provides a community based, low-threshold response to the use of drugs, which seeks to reduce harm, adds to and is integrated with the primary health, HIV and social services of the City of Tshwane. COSUP offers a continuum of care that includes abstinence as an end goal, but does not neglect those who are unwilling or unable to stop their use of drugs, or even those who have not started using drugs.

By being collaborative and inclusive, COSUP maximizes and builds on existing infrastructure, enabling the sharing of knowledge and evidence-making through research and learning. This makes any investment in COSUP an investment in all the people of the City of Tshwane, with excellent returns.

BENCHMARKS FOR INTERVENTIONS

The following information will assist in assessing current performance and return on investment.

Retention rates in outpatient services

The City of Cape Town Matrix Programme: 44% of people screened and found to have a substance use disorder, returned for an intervention. Of these, 20,8% were retained over four months. For opioid dependent people, 37% found to have a heroin dependency were initiated and 11,6% were retained over four months.

Internationally, retention rates vary widely (e.g. 15–75% in the UK) and according to context. Rates above 50% are considered good, especially if clients are able and willing to return later. Most programmes measure three-month retention, which gives an inflated rate compared to six months when many people may have resolved issues.

Retention rates in OST

Internationally, for middle income countries, the rate of retention in methadone programmes is expected to be around 50%.[5]

Distribution and collection of sterile injecting equipment

The recommended standard from the World Health Organization is 200 needles per person per year.[6] Currently, COSUP is a new programme being tested by the City, but coverage should increase with time. Return rates above 70% are considered good, and needle distribution has been shown in studies to decrease needles in the community.[7] According to a 1997 statement by the National Institutes of Health, 'individuals in areas with needle exchange programs have an increased likelihood of entering drug treatment programs.'[8]

[5] Feelemeyer J, Des Jarlais D, Arasteh K, Abdul-Quader AS, Hagan H. Retention of participants in medication-assisted programs in low- and middle-income countries: An international systematic review. Addiction. 2014; 109(1):20–32. Available from: https://www.ncbi.nlm.nih.gov/books/NBK159297

[6] World Health Organization. HIV/AIDS: Needle and syringe programmes. [homepage on internet]. c2018. Available from: http://www.who.int/hiv/topics/idu/needles/en/

[7] Avert. Needle and syringe programmes (NSPS) for HIV prevention. [homepage on internet]. c1986-2017 [updated 13 June 2017].

[8] National Institutes of Health Consensus Panel, Interventions to Prevent HIV Risk Behaviors (Kensington, MD: NIH Consensus Program Information Center, February 1997), p. 6.

> *"After reviewing all of the research to date, the senior scientists of the Department and I have unanimously agreed that there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs."*
>
> *US Surgeon General Dr. David Satcher, Department of Health and Human Services.*

The Service Level Agreement

On the 18th of May 2016 the City of Tshwane signed a Service Level Agreement with the University of Pretoria as service provider to assist with the implementation community oriented substance use programme (COSUP) in the greater Tshwane area. The project is to run for a period of three years from March 2016 until June 2019.

The Project is aimed at providing health, wellbeing and supportive services to people who use and may be dependent on drugs. A community based primary care intervention will be used to assist people to resolve their drug use issues, reduce the levels of individual harm wider impact of substance use. This will contribute to the creation of sustainable communities with clean, healthy and safe environments and integrated social services.

In June 2017 the CoT and UP amended the agreement and extended the scope to include:

1. establishing a help line (Hopeline),
2. capacity building of local/regional drug action committees (network), and
3. monitoring and evaluation of CoT funded NPOs.

The project aligns with the City of Tshwane's strategic objective 3: "Sustainable communities with clean, healthy and safe environments and integrated social services"

The related key performance areas are:

KPA 3.1: Decrease the vulnerability of targeted groups through mainstreamed programmes of youth, women, people with disabilities and older persons.

Outcome 4: an equitable city that supports happiness, social cohesion safety and healthy citizens with a target of 700 people in year one and a five-year target of 5000.

KEY PERFORMANCE INDICATORS (KPI)

1. Number of service users enrolled in the Substance Use Programme
2. Number of service user visits managed at COSUP sites in the Substance Use Programme
3. Number of service users retained in the programme after six (6) months
4. Number of service users completing a skills development programme

5. Number of service users who are placed in self-sustaining initiatives and opportunities post-rehabilitation
6. Number of service users initiated on OST
7. Number of service users retained in OST Programme

BROAD OBJECTIVES

- ✓ Research for short and long-term strategies
- ✓ City-wide capacity to address drug use
- ✓ Integration with COPC and clinics
- ✓ Training and technical assistance
- ✓ Tools and equipment
- ✓ Engagement and collaboration
- ✓ Identify and mitigate risks
- ✓ M&E

Project will include

- ✓ Identifying people with drug issues
- ✓ Health assessments
- ✓ Opioid substitution therapy
- ✓ Harm reduction services
- ✓ Psychosocial services
- ✓ Ongoing support

Learning

- ✓ OST training
- ✓ Materials and modules
- ✓ Work integrated learning

IT and DATA

- ✓ AITA Modules
- ✓ Assessment tools
- ✓ Data reports
- ✓ Database with access
- ✓ Data protection
- ✓ Rights of city to use data and software

Deliverables

- ✓ Expert group
- ✓ Workable model
- ✓ Protocols, guidelines
- ✓ Research plan
- ✓ Data system for households
- ✓ 20 regional support centres
- ✓ Training materials
- ✓ Monthly reports

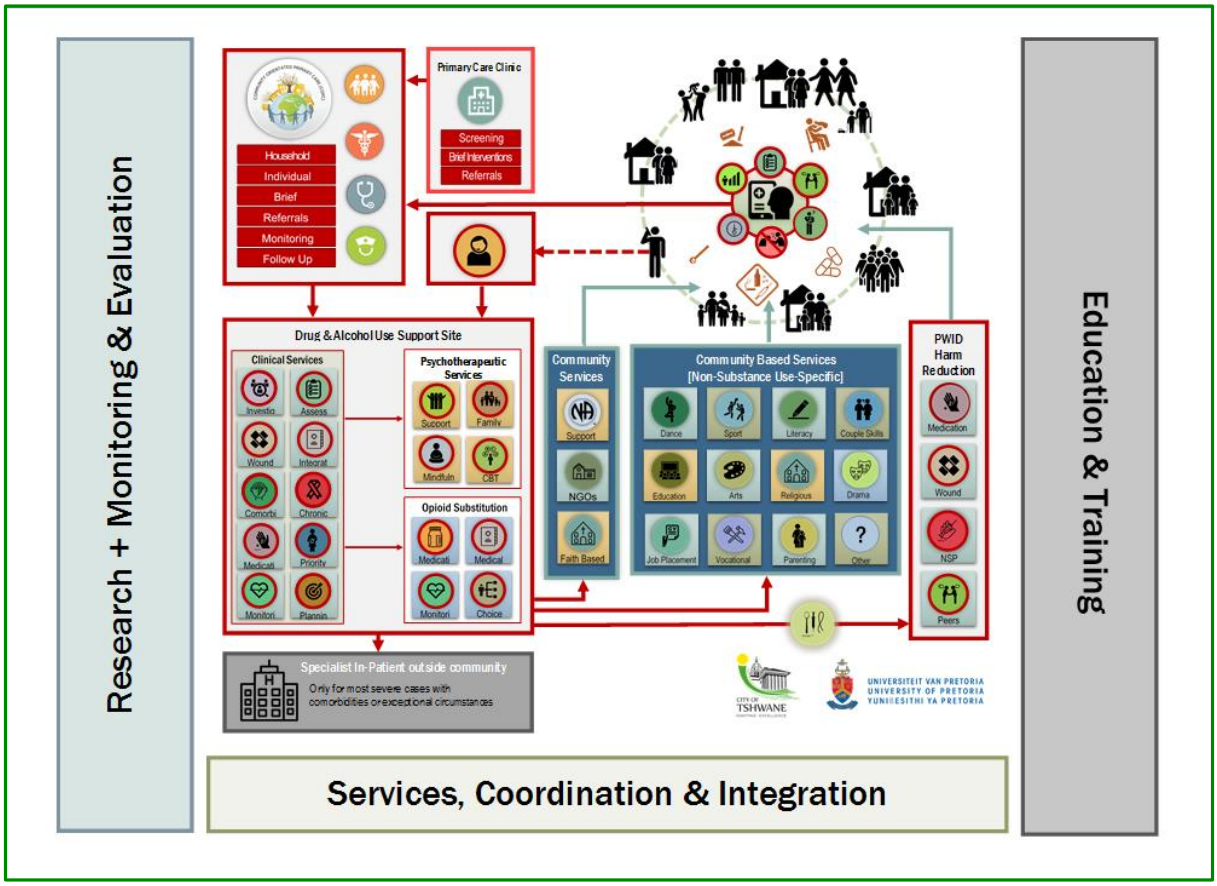
Addendum:

- ✓ LDACs
- ✓ Helpdesk
- ✓ NGO monitoring

"This project is unique because most cities are not prepared to back the science and approaches that work. They are so used to the 'war on drugs' talk that when you start talking harm reduction, inclusion, access to services and approaching this from a rights and developmental perspective, they are simply afraid to take the brave steps that the City of Tshwane has taken. I have presented this concept around the world at various conferences, and the experts agree that the COSUP approach, if supported, will be the way of the future. And it was done here, in Tshwane, first."

Shaun Shelly,
COSUP Consultant
Deputy Secretary:
UN Vienna NGO Committee on Narcotic Drugs;
Management Advisory Committee,
International Drug Policy Consortium

Figure 1: a diagram of the COSUP model of integrated substance use interventions



Third-Party Agreements

HOPELINE – C3

Contract Duration	Contract Amount
01 July 2017 30 June 2018	R 2 029 556.00

Hopeline was established in 2017 to provide a 24/7 option for people in crisis to call. While the call volume is not high, the service provides a very necessary life-line for the people of Tshwane. Recently the service has been changed to a toll-free number so as to make it more accessible to those in need.

Tshwane Mayor, Solly Msimanga, answering calls from the public during the launch of Hopeline.

OUT WELL-BEING

January 2017 December 2017	R 1 272 000.00
January 2018 June 2019	R 1 042 320.00

An agreement was entered into with OUT Well-Being for 1 Jan – 31 Dec 2017 and renewed for 1 Jan – 31 Dec 2018.

This was a part of the University's responsibility to appoint non-governmental organisations to assist in the implementation of the COSUP project by building on the community oriented primary care model. OUT provided its facilities, personnel and infrastructure to assist UP in delivering the project. OUT also provided its expertise and

COSUP EXPERIENCES

The Story of Sibo*, a peer on the project:

"Having support and deciding to do something about the use of the substance, having it coming deep in your heart", he says that what it took him to change his behaviour around the use of substance. Sibo* continued to receive COSUP services until such a time when the opportunity for peer training emerged, he appeared to be a perfect candidate and was therefore selected for the training with STEP UP project.

He finished the two to four weeks of training. Upon completion he was awarded a contract to come back to his neighbouring site and work with COSUP to provide services to his fellow substance users who may be in need of such services.

**not his real name*

A medical student, Matome Lebogo, who worked at a COSUP site wrote:

I believe COSUP can be the answer and the solution to some of the most pressing problems that are faced by the people who use drugs, the communities around Tshwane and the country as a whole. The government can look into this as a solution to South Africa's current crisis of substance abuse and invest in it. As a medical student, I personally would love to form part of the group of COSUP health care workers upon completion of my studies, because I have realized the impact this will have on the lives of the people who are using drugs, since they also provide primary health care to the homeless people who use substances.

Images of COSUP

From top: Planting a vegetable garden, outreach, providing meals and training.

experience in the field of substance use (most especially in the inner city area).

SEDIBA HOPE/PEN

01 January 2017	R 218 543.25
31 December 2017	
01 July 2017	R 1 920 081.99
30 June 2019	

There were 2 agreements that were entered into with Sediba Hope. The first was for use of 2 sites (namely Sunnyside and Bosman) and also for the provision of an administrator and a social worker at the Bosman site.

The second agreement was in furtherance of Addendum to SLA between UP and CoT. This was specifically to increase capacity building to localize the implementation of the National Drug Master Plan (NMDP) by administrating funding for new programs by Regional Drug Action Committees (RDAC's) and other non-profit organisations.

DREAM TEAM FOUNDATION

01 June 2017	R 1 500.00 PM
31 June 2019	

The contract with Dream Team is a rental agreement for use of premises

TSHWANE LEADERSHIP FOUNDATION (TLF)

01 July 2017	R 1 751 600.00
30 June 2019	

The Tshwane Leadership Foundation (TLF) was launched in 1993 and is committed to model innovative social change and a high degree of social inclusion in the capital city of South Africa. TLF is an umbrella organization that comprises seven programmes and five institutions, all working towards healthy urban communities that are socially inclusive and viable, and towards a policy environment that would enable social attachment and human rights protection.

The COSUP experience has highlighted the plight of many inner-city dwellers. In order to address this appropriately, the Tshwane Leadership Foundation is contracted to provide services and expertise. In terms of the agreement, TLF has agreed to the following services.

Recognising the high burden of terminal illness among people accessing COSUP services, TLF will make three hospice beds available at a time for service users on the Community Oriented Substance Use Programme for Hi-Care. The service user will be referred from a COSUP site. The service user will remain in the care of the hospice of TLF for a period agreed upon by the matron of the hospice and the admitting physician, subject to policies and procedures negotiated and agreed upon between the parties. TLF will be responsible for providing holistic, palliative services during the time of admission with support from the COSUP programme.

The stigmatisation, exclusion and marginalisation of indigent people makes the need for specialist safe spaces essential. TLF provides three Drop-in Centres for service users: Burgers Park precinct, the North-East precinct of the inner city and Arcadia. The aim of the Drop-in Centres is not to provide physical support only, but also to create a community for the service users and a place of belonging.

MMC for Health and Social Development, Cllr Du Plooy, with a COSUP peer team member from OUT Well-being.

TLF will provide outreach programmes that will support service delivery. The outreach programmes will work in collaboration with the COSUP Sites and will support service delivery by: i) Building relationships with current and potential service users; ii) Referring potential service users to COSUP sites; iii) Conducting prevention and awareness campaigns; and iv) Tracing defaulting service users. The areas of outreach will include, but not be limited to: a) Burgers Park–Berea Park Precinct; b) Marabastad; c) Identified areas in Hatfield; d) Arcadia; and e) Salvokop.

As an ongoing priority to address the incidence of HIV and other diseases as detailed in the National Strategic Plan on HIV, TB, and STIs, the TLF will provide HIV Testing Services (HTS) support and mobile services at various COSUP sites for service users. Each client that is tested, receives HIV counselling and Testing, TB Screening, STI Screening, and vital screening.

TLF supports the COSUP transitional housing for services users. The support will include, but not be limited to: technical and strategic support; training for the housing supervisor and other relevant people; continual review of the process; and relationship brokering. The parties will negotiate any other responsibilities of TLF in terms of the transitional housing.

Image 1: Facilities for a clinic and transitional housing at 'Reliable House'

TLF has appointed Community Health Workers (CHW) for the substance use programme and TLF provides the following services: i) Appointment of CHWs on a fixed term contract; ii) Provision of all relevant and associated Human Resources (HR) support; and iii) Placement of CHWs at various COSUP sites. The site manager where the CHW will be placed will be responsible for: a) The day-to-day schedule and oversight of the CHW; and b) Reporting to TLF's HR office on the performance of the CHW on a monthly basis.

TLF has started providing skills development programmes for service users. The services users will be referred for skills development from the COSUP sites. The training includes life skills and work readiness training.

> "The War on Drugs and the War on Homelessness are on a collision course that no one in the media or in public life are willing to acknowledge. Ostensibly aimed at decreasing the use of illegal drugs, the War on Drugs succeeds only in increasing homelessness."
>
> Thomas Szasz

Stakeholder Engagement

The war on drugs and abstinence approach is very entrenched in society as well as in the response from the Provincial Departments of Health and Social Development and services for people who use drugs. Thus, a lot of time and energy in this project had been spent on engaging with existing structures and projects in order to understand and share information and evidence to help people understand the importance of changing the approach. This included engagement with law enforcement.

Community Organisation Consultations

COSUP invited NGOs and stakeholder organisations to regional meetings with the purpose of sharing information and developing relationships. COSUP does not look to replicate or offer parallel services in communities. We look to co-ordinate, align, augment and support organisations providing services in the community. Through this process we established opportunities to collaborate, provide training

and support, develop referral opportunities and mechanisms as well as identify potential challenges. To date COSUP has engaged with 65 community organisations. Refer to NPO List and Map in Addendum A.

COMMUNITY ADVISORY GROUPS

Often when organisations try to assist people, they exclude the people they are trying to assist. Community participation is essential in order to ensure services are appropriate and address the needs and concerns of the community. Organisations are encouraged to meet with the population groups they are working with and providing services for. The Community Advisory Groups (CAGs) are able to inform the service providers about

- what challenges they face on a daily basis;
- what they can do differently to overcome challenges;
- what they need to improve quality of life and living; and
- what services they need.

From there, the information is used to help develop services for those regions. COSUP assisted with the establishment of CAGs in Regions 1, 3 and 6 for homeless people, people who use drugs, and parents and families affected by substance use, to ask them to gather information about what services were needed and how they should be delivered.

To date 11 CAGs have been formed with over 129 meetings held.

In addition to the CAGS, COSUP has established further stake-holder groups in each region to ensure a broad and accurate understanding of the communities and their priorities. These include groups of and from: families of people who use drugs, schools, community elders and leaders, community health workers, South African Police Service (SAPS), Tshwane Metro Police Department (TMPD), churches and Car Guard Associations.

In addition to these activities, regular outreach sessions are arranged so that the service providers can walk through the communities and meet the people who they are hoping to provide services for.

South African Police Services

There have been several meetings with both the South African Police Service (SAPS) and the Tshwane Metro Police Department (TMPD) led by Prof Jannie Hugo, Director Nkuna and Superintendent Mathabathe, who runs the Drug Unit for TMPD. A special request was put forward to COSUP (UP) to assist with training of members of the Drugs Unit on various topics including different substances, first aid for over-dosing, procedure for managing dirty needles and such.

Classes will be facilitated by Shaun Shelly (COSUP), Connie van Staden (StepUp) and Sasha Lalla (COSUP). Prof Hugo has recommended that we also involve the University of Pretoria Social Development and Criminology Department so that police have a better understanding of the law around substance use.

Relationship with Gauteng DOH

In the long-term, substance use interventions need to be part of the general health service. COSUP participated with Tshwane District Gauteng DOH from the beginning and works to integrate with clinics and CHC. At the moment the Eersterust COSUP site is integrated with the Eersterust CHC. Similar is planned for Laudium CHC.

In the initial project it was envisaged that Gauteng DOH will provide OST medicine. Although a lot of work is done to make that possible in the long run, it is not happening yet.

The development of an Integrated Health Care Platform in Tshwane is now an important process and involves CoT and Tshwane District. COSUP is an important element of integration and COSUP management actively participates in the integration.

Sport is Your Gang!

The Sport is Your Gang! initiative and tournament has two main goals:

First, we aim to engage our youth with positive activities which will allow them to grow, learn and become good citizens and allow them to find new positive role models in our society, rather than see drugs as the solution to their problems.

We also understand that people who use drugs and homeless people are a stigmatized population group, and because of this often their basic human rights are ignored or violated. The goal of TLF, OUT Well-being, The University of Pretoria and COSUP in particular is that we aim to build a society that allows these vulnerable population groups to be seen as people and to be treated as such.

The South African Police Service was once called the South African Police Force and in the past, heinous and violent crimes were committed against the people of South Africa, by the Police Force. As South Africa transitioned into a democracy and under the leadership of the late Nelson Mandela and late Steve Tshwete so too did the Police, and they were no longer called the 'Force', but now the 'Service'. And I truly believe it is organisation which serves the People. Unfortunately, like the Homeless Population Group and PWUD, the police too face stigma.

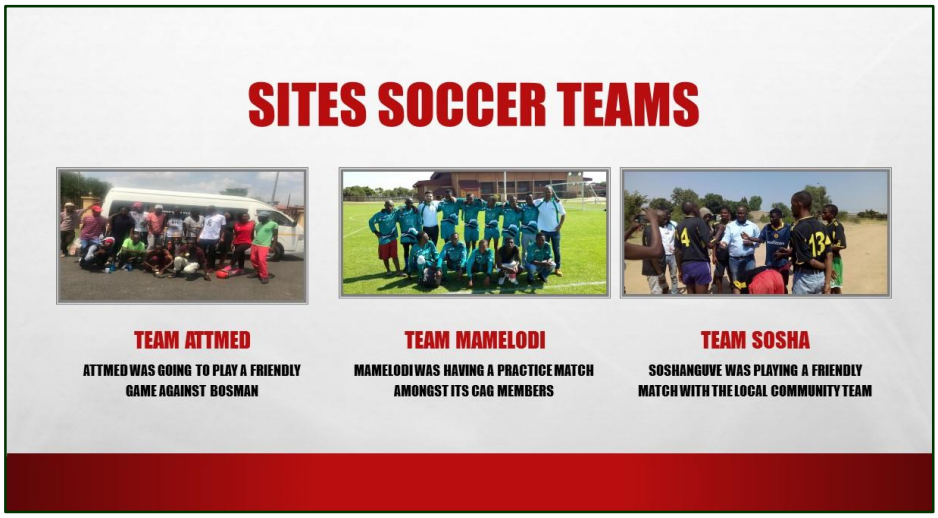
Secondly, our goal is to therefore bridge the gap between these groups so we can help each other achieve our goals. Protect Police and Protect South Africa's People. Respect and uphold each other's rights. Injustice anywhere is injustice everywhere.
Our mandate is not to change the law, our mandate is to serve people in a humane way.

We therefore are proposing a soccer tournament and indigenous games as a way to allow these various communities to see each other as people again. And inspire the youth to a better life.

Recreational Event 22nd of June:

- Twenty-four five-a-side soccer teams
    - Each Police Station will form a Hub for a team.
    - A team will consist of:
        - Homeless People
        - People Who Use Drugs (PWUD)

  - Volunteers
  - Youth
  - Department of Correctional Services (DCS)
- Eight Netball teams
- Arts and Culture



Key

A COSUP soccer team.

Interventions

COSUP coordinates and ensures a range of services to provide the essential continuum of care needed to address substance use in the City of Tshwane. This is achieved by using existing service providers for residential rehabilitation services and other traditional services, as and when needed. Where previously there have been significant gaps, these have been filled through the direct delivery of opioid substitution therapy and needle and syringe programmes, delivered as part of a package of health, psychosocial and wellbeing services.

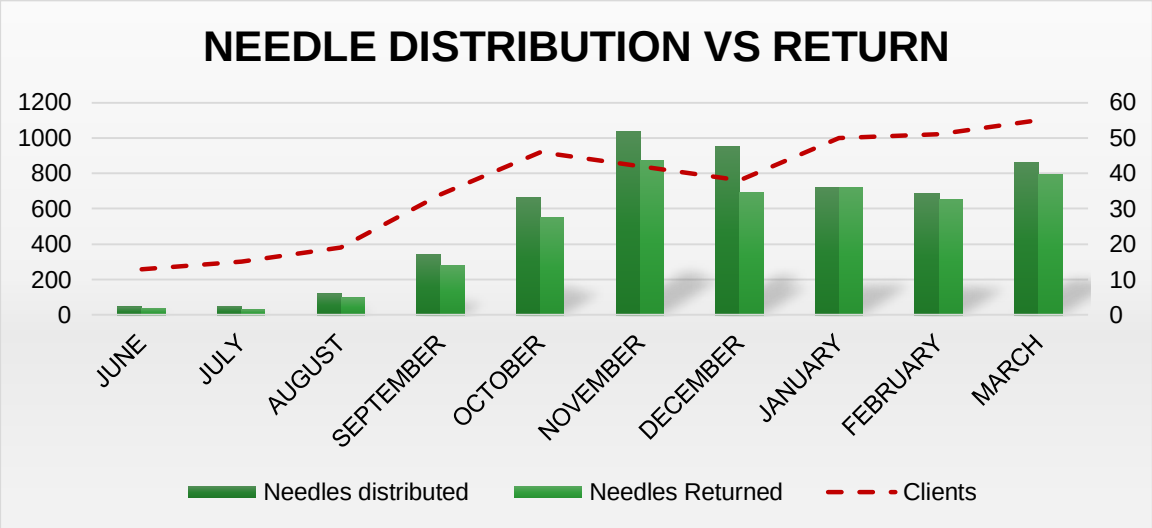
Opioid Substitution Therapy

As of March 2018 a total of 606 clients had been initiated on opioid substitution therapy (OST). Of these, approximately 56% are COSUP-funded and 44% are self-funded, with the majority

(approximately 77%) on Methadone and the rest on Suboxone. Of these clients, 351 clients have been retained in the programme on OST for more than 6 months, and 421 are still active members of the programme. Overall there is a 74% retention rate with 87% of the City of Tshwane-funded clients retained, and 63% of the self-funded clients retained. This could demonstrate the effect of affordability on retention, but further research is needed to confirm this theory.

Needle and Syringe Programme

Needle and syringe Programmes (NSP) are an essential component if harm reduction as they relieve the biggest burden of disease and attract people who inject drugs to services because the needles and syringes are needed. It has been shown that in areas where NSPs operate there is a higher probability of people seeking to moderate their drug use. After a pilot phase the project is being initiated at all sites from March 2018. An ongoing issue is police harassment arrest and confiscation of syringes.



Skills and Employment

To address the continuous challenge of retention of homeless persons using substances, and successfully treat (medical and psychosocial), upskill and reintegrate them in society, a model will be developed at one site whereby a small group (max 12) will be housed in temporary structures whilst receiving comprehensive services from COSUP. Partners include UP Community Engagement, COSUP and TLF. OST and/or NSP will be provided to clients that fulfil the criteria and these clients will be equipped with necessary skills to enable them to become self-sufficient. Assistance from the CoT will be requested with regards to the supply of food on a regular basis.

> *"Our clients who are in a family that is open to practicing a non-judgmental and supportive environment with well communicated expectations and boundaries are coping exceptionally well based on our assessment and reports from their family members."*

Research

A research workshop was held on the 7th of May 2017. Research priorities were identified and a research plan developed. Research priorities included understanding the burden of substance use within hospital settings in Tshwane and understanding the knowledge, attitudes and practices of health workers in hospital settings around substance use and its management.

A research protocol entitled *The prevalence of substance use, associated morbidities, and responsiveness to COSUP referral among adolescents and adults admitted to UP affiliated hospitals in Tshwane* was developed and submitted to the University of Pretoria's Research Ethics Committee on 18/08/2017 and approved on 30/08/2017, under certificate number 369/2017.
Permission to conduct research was granted by Kalafong, Steve Biko Academic, Mamelodi and Tshwane District Hospitals between September and early November 2017.

Two training workshops led by Drs A Scheibe and NR Gloeck in ethical research and data collection took place on 27 September and 19 October 2017. These workshops were designed to upskill the social workers, clinical associates, and a small group of 3rd and 4th year medical students in preparation for data collection at the hospitals, as well as for conducting their own research in the future.

Research tools and processes were piloted on 20 October 2017 at Daspoort Clinic with all the trained clinical associates, social workers and medical students in attendance.

Data collection and entry using Qualtrics commenced at Kalafong Hospital on 12 November 2017. Data collection was completed by 30 November 2017 and data entry by 8 December 2017. During this time the full sample of 425 people were recruited. Twenty-four people declined to participate and no adverse events were reported.

Data cleaning occurred between January and March 2018. Dr Scheibe started data analysis in March 2018. The research team plans to develop two manuscripts for submission. The first paper is expected to be ready for submission by June 2018.

Monthly research teleconferences have taken place amongst the COSUP research team to discuss progress, challenges and next steps.

The protocol for the next research priority is expected to be developed by Dr L Faul and will be linked to her MMed in Family Medicine.

The role of peers in substance use programmes is an important research focus. One project is completed while a further international study is planned for the second half of 2018.

Personnel

COSUP Sites	Area	Site Managers	Social Workers	Clinical Associates	Peers	Nurses	CHWs
1. AttMed	Atteridgeville		1	2	3		1
2. Eersterust Community Health Centre	Eersterust		1	1	2		
3. Ikageng Hall	Mamelodi	1	2	3	2	1	2
4. Lusaka							
5. Nellmapius Skills Centre							
6. Mamelodi West Community Hall							
7. Sediba Hope Community Clinic – Bosman	CBD		2	2	1	1	1
8. Sediba Hope Community Clinic – Sunnyside	Sunnyside		1	1	1		
9. Daspoort Poli Clinic	Daspoort	1	1	1	2		2
10. M17 (Dream Team Foundation)	Soshanguve		3	3	3		1
11. Block DD (Heavens Defence Force)							
12. Bock V (Elim Tabernacle Church)							
13. Stand No. 1812 (Thulasizwe Primary School)							
14. OUT Well-being	Hatfield	1	1	1	1		
15. Reliable House							
16. Olievenhoutbosch	Olievenhoutbosch		1	1			
17. Laudium Community Health Centre	Laudium		1	1			
Total		3	14	16	15	2	7

CLINICAL ASSOCIATES

Clinical associates are members of the healthcare team playing a critical role in ensuring that Community Oriented Substance Use Programme (COSUP) sites runs optimally by observing the clinical, social and psychological needs of substance users. As part of their work, clinical associates have responded to the call of managing the dual diagnosis of homelessness and substance use by making use of the harm reduction methodology, facilitating social integration of substance users around the City of Tshwane, and providing hope by fighting the stigmatization of substance users.

With 17 sites between the 15 of them and more than 2900 clients to manage, they have played an integral role as primary healthcare workers to safeguard the health and social needs of substance users by employing harm reduction methodologies and the biopsychosocial approach when taking

patients' histories, conducting physical examinations, ordering and interpreting diagnostic studies, engaging in appropriate management and patient referrals, counselling and the provision of Directly Observed Therapy.

Clinical associates also provide assistance in coordinating the activities of COSUP peers and Ward Based Outreach Teams (WBOT), consequently ensuring that the management of substance use is community oriented and contributes to the overall health needs of the clients. Moreover, they played a pivotal role in establishing COSUP sites, managing the sites' day to day work, engaging the community on harm reduction methodologies and ensuring easy access to care by using an outreach model to ensure that the primary health care of substance users is no longer a far cry.

Substance use has also been a contributing factor to the incidence of HIV and hepatitis B & C, and the provision of the Needle and Syringe Programme (NSP) has seen fewer users sharing contaminated needles in desperation. This befitting programme is coordinated and overseen by clinical associates at the sites with the help of the entire medical team.

Additionally, they conduct voluntary counselling and testing of HIV, and manage the ART treatment of HIV positive substance users.

Having formed part of the programme since its inception and engaging mostly with opioid dependant clients, they have played a necessary role in choosing the appropriate Opioid Substitution Therapy (OST) as an inclusive decision with a client, OST adjustment, and educating clients for safe usage as a model of harm reduction to avoid overdose and other adverse events for those who are not ready for OST.

Social Workers

Social workers in the COSUP program are tasked with the role of facilitating the process of successful re-integration of service users back into society. The reintegration process aims to increase the ability to access basic resources such as shelters, skills and employment. The service users receive individual counselling, group work and family intervention services. The individual sessions provide a confidential and structured atmosphere where service users are able to share experiences with the social worker. In these sessions, the Social Worker and service user work on creating an Individual Development Plan (IDP). The IDP looks at short and long-term goals which the service users hope to achieve. The group sessions provide a platform where topics can be discussed with fellow peers and also create a support structure amongst COSUP clients.

Social Workers also support the service users by mediating family integration and enhancing skills for employment. The aim of family integration sessions is to facilitate a process where service users are able to return to their families and communities. During skills and employment support, service users get assistance in getting employment, access to vocational training and assistance with getting identity documents from home affairs. Social Workers are currently implementing a programme in collaboration with POPUP to provide basic literacy skills and training to address low literacy levels. This will improve service users' ability to access vocational training and employment. There is continuous assessment done to identify gaps in the service delivered to enhance access to employment.

PEERS

(This section is taken from current research being conducted by a Dutch researcher, Sophia Heijnen, and will feed into a broader study by the University of Pretoria and Kings College, London)

Peer education is an intervention using individuals from a target group to provide support and information to their peers. Peers are determined by social or demographic characteristics (e.g. age and education) or by risk-taking behaviour (e.g. injecting drug use or sex work). Peers are trained and make it possible to give information to hard-to-reach populations effectively. In COSUP, peers are either currently using or have recovered from drug use and have maintained a connection to the community.

The peers are often the first point of contact for people, assessing clients for appropriate referral and providing information about COSUP. They also assist the clinical staff, clients and client's family members with communication, translation and interpretation of situations. Research has shown peer education consisting of for example enhancing risk-reduction skills and motivating behaviour change can be effective in the reduction of risk behaviours in young injecting substance users. Other benefits of using peer educators is that they are more likely to be trusted by the target group, being drug users, and therefore giving well-founded referrals to services, because the peers are using those services themselves. With this trust, there is a higher chance that the people who use drugs will follow up on these referrals, persist in their treatment and develop health-seeking behaviour.

The role of a peer is both explained by peers and professionals. One of the peers explained the belief that the peer is of much importance. Stating that a peer makes a client feel welcome and lets them see their own development, the participant illustrated how a peer is a role model for clients. The professionals also agreed on the fact that a peer is a role model. "OK, some clients, our clients, might look at a peer as I want to be them, you understand." One participant added to this discussion the very reason why there is a need for peers. "The reason why we do this peer intervention is the fact that is has a rippling effect. Just by the fact that I knew this guy from this day on and I can see improvement in his life. Therefore I possibly can get on that journey also."

One of the managers spoke about the perception of the role of the peer and that is, indeed, very important. The issue associated with this was explained: *"And I think we underclaim the importance of the role the peers play. And how it brings funding to the table. And our job, in terms of making sure they're flourishing. The ideal situation is that a peer doesn't end up always a peer."*

COMMUNITY HEALTH WORKERS

COSUP included substance use as part of WBOT programme. Four questions about substance use was added to the triage on AITA Health. Community health workers were trained on doing the triage and basic referral and support. The data and experience from this will inform how substance use will be incorporated in the new WBOT/COPC project of CoT.

> *"most people treat homeless drug addicts like "garbage" and not like human beings – but not Martha Nukeria, a street jewellery vendor who took Van Staden as her son from the day she met him, at a time when he roamed the streets. And it was her warm embrace that would one day change his life for the better, away from the drug lines and needles."*
>
> *https://citizen.co.za/news/features-news/1895107/how-this-woman-saved-a-stinking-white-40-year-old-drug-addict/*

Sustainability of COSUP

Sustainability is a crucial issue to ensure that the gains made by COSUP is retained, researched and documented for the benefit of not only Tshwane but the whole country and society. COSUP is successfully implementing a harm reduction and demand reduction programme at scale in City of Tshwane. This is a major strategic movement away from the current interventions, which is mainly inpatient time-limited rehab and abstinence-based treatment in high threshold programmes. These programmes only reach people who are well motivated or coerced, and do not address the here-and-now medical issues for people who are actively using.

COSUP is completely different in that it:

1. addresses a wide range of existing health issues as well as prevents many more;
2. brings a group of people who normally only present when the situation is dire into the health system far earlier;
3. addresses broader community benefit – instead of just addressing drug use, it addresses the lived environment by delivering wellness services in the community;
4. provides employment and peer integration, and increases hope and belief in the ability to change; and
5. provides integrated care that can be used to address other emerging issues.

COSUP is designed to be integrated into both the community, the existing NGO sector and the primary health system. This is not fully realised yet, but once this happens, COSUP will be positioned to address other community issues and will serve as an intervention delivery system as well as a data collection system second to none.

The implementation of COSUP is complex and difficult. It is like building an aeroplane while flying it. SOPs and Norms and Standards are developed and implemented but are not yet tested in terms of efficiency, cost effectiveness, risks and impact.

Integration with the existing public health care AND social development system is partial and is hampered by the:

1. complexity of the interventions;
2. weaknesses and overloading in the health system;
3. uncertainty about the use of OST in the public health system;
4. uncertainty in the implementation of COPC, which is a core element of COSUP; and
5. lack of knowledge on the part of staff in clinics/hospitals on harm reduction, and stigma related to PWUD.

It is only in the last month that efforts to create an integrated health platform in Tshwane are gaining momentum. A Service Level Agreement between UP Family Medicine and GDOH Tshwane District that includes COSUP is being drafted at the moment. This will prepare the ground for better integration of COSUP into the existing services.

The new National Drug Masterplan is still in the drafting phase. This means that the uncertainties around the implementation of OST, NSP and management of co-morbidities (HIV, HCV) still persist. It is unrealistic to expect to have most of the questions above answered in the next year.

We hereby present three options with the advantages, risks and requirements for success.

Options:

1. Full integration with existing health services of CoT and GDOH before the end of the contract.

This is the approach that was taken when COSUP was designed and it is described as such in the SLA.

1.1 Advantages:

1.1.1 This is the best long-term sustainability solution; that substance use becomes an integral part of all the existing health services. This should be the ultimate goal.

1.1.2 This will change the responsibility from the CoT to GDOH.

1.1.3 This will put the health services of GDOH and CoT under significant pressure to make a success of an integrated health platform that includes COSUP.

1.2 Risks:

1.2.1 The major risk is that if this is done before COSUP is well established, researched and documented, the programme may lose momentum, be diluted and may disappear.

1.2.2 If health services are not well prepared, they may be overwhelmed, and this may have a negative impact on the quality of service.

1.2.3 If COSUP staff is not adequately accommodated in the health services, a lot of capability and capacity will be lost.

1.2.4 Unsuccessful integration may lead to disruption and interruption of care which can harm patients.

1.3 Requirements for success:

1.3.1 Full agreement for integration of services from CoT and GDOH health departments.

1.3.2 Immediate successful implementation of an Integrated Health Care Platform in Tshwane that includes COSUP.
1.3.3 Budget allocation within the health services for COSUP.
1.3.4 Creation of posts and absorption of COSUP staff within the health services.
1.3.5 Timing and speed of implementation will be crucial to ensure that there is no disruption of services.
1.3.6 Extensive training of existing health service managers and clinical staff.
1.3.7 Maintaining and funding of the COSUP research work.

2. Put out the service delivery, M&E, research and education on tender and appoint service providers.

If the processes, norms and standards, and requirements for service delivery, research, education and integration can be well described, this can be put out on tender.

2.1 Advantages:
2.1.1. This will make it possible to follow the normal procedures of outsourcing of services.

2.2. Risks:
2.2.1. This will create COSUP as a vertical programme with limited chances of integration into the normal health services.
2.2.2. This will put the approach and spirit of COSUP at risk. If an independent service provider does not have the skills, knowledge and culture, the service may revert to the historic approach.
2.2.3. If COSUP trained staff is not accommodated, critical capability and capacity will be lost.
2.2.4. Unsuccessful or delayed implementation may lead to disruption and interruption of care which can harm patients.
2.2.5. A new service provider will incur significant set-up costs.

2.3. Requirements for success
2.3.1. The specification, norms and standards need to be described in extreme detail to ensure that service delivery is in line with the values and culture of COSUP
2.3.2. The programme has to include service delivery, education, community engagement and research.
2.3.3. The work will have to be done very quickly to keep to timelines and have a service provider in place before the end of the contract.

3. Extend the existing contract for another three years

In the SLA, Section 4.1 (p. 7), it is stated that the contract can be extended if agreed by both parties. A new budget and deliverables must be agreed on and then COSUP can continue for another period of three years.

3.1. Advantages:

3.1.1. This will make it possible to consolidate the gains that were made thus far and provide the time to complete the development of norms and standards for implementation and create a more mature model.
3.1.2. Research and cost analysis can be continued and done on a more mature model of implementation.
3.1.3. The model of integration within the health system is at a very early stage at the moment. This will provide the time to develop the integrated model and compare the integrated site with the more separated COSUP sites' processes and outcomes.
3.1.4. This will provide time for more certainty around the National Drug Master Plan, changes in guidelines and possible changes in legislation, and will provide time to ensure that the COSUP model fits into new policies and legislation. This refers mostly to OST and NSP programmes.
3.1.5. Staff capability and capacity will be retained.
3.1.6. No new set-up costs will be required.

3.2. Risks

3.2.1. If integration is not done purposefully, COSUP may still develop as a vertical programme.

3.3. Requirements for success:

3.3.1. Agreement to be reached about the changes in budgets and deliverables.
3.3.2. Implementation of the existing SLA needs to be excellent.
3.3.3. Agreement with GDOH about collaboration needs to be finalised.

It is important that decisions about the way forward is taken timely as the implications of the decisions require different priorities of action.

Signature of Project Manager/Owner	**Name & Surname:**	**Date:**
	Prof Jannie Hugo	8 June 2018

Addenda

ADDENDUM A – COSUP SITES, DROP IN CENTRES AND NPO PARTNERS

COSUP Sites

	Site Name	Address	Contact Number	Operating Hours
1	Sediba Hope Community Clinic – Sunnyside	50 Vos Street, Sunnyside	082 858 2454	Mon – Thu (08:00–15:30)
2	Sediba Hope Community Clinic – Bosman Street	173 Bosman Street, Pretoria CBD	064 048 1915 / 082 858 4304	Mon – Thu (08:00–15:30)
3	Daspoort Poli Clinic	1049 c/o Market and Camp Street, Pretoria West	012 379 3453 / 082 857 0922	Mon – Thu (08:00–15:30)
4	Ikageng – Mamelodi	Ikageng Hall, 144 Molokolo Circle	012 842 3515 / 082 858 2553	Mon – Thurs (08:00–15:30)
5	Lusaka – Mamelodi	Lusaka, c/o Millenyane & Ratshwene Street	012 842 3515 / 082 858 2553	Mon & Tue (08:00–15:30)
6	Nellmapius – Mamelodi	Nellmapius Skills Centre, 200 Love Drive	012 842 3515 / 082 858 2553	Wed (08:00–15:30)
7	Mamelodi West – Mamelodi	Mamelodi West Community Hall, 51 Tsweu Street	012 842 3515 / 082 858 2553	Thu (08:00–15:30)
8	Eersterust Community Health Centre	C/o Ps Fourie Drive & Hans Coverdale Road East, Eersterust	082 941 6038	Mon – Thu (08:00–15:30)
9	Laudium Community Health Centre	405 Bengal Street, Laudium	081 725 2462	Mon & Wed (08:00–15:30)
10	Olievenhoutbosch	Olievenhoutbosch Ext 23, c/o Imbovane and Imbongolo Street	066 472 5741	Mon – Thu (08:00–15:30)
11	AttMed – Atteridgeville	85 Komane Street, Atteridgeville	012 373 6446 / 082 858 2450	Mon – Thu (08:00–15:30)
12	M17 – Soshanguve	Dream Team Foundation, M17 Road, Soshanguve South	082 858 2563 / 066 300 8338	Mon – Thu (08:00–15:30)
13	Block DD – Soshanguve	Heavens Defence Force, Tlholosang Street, Block DD	082 858 2563 / 066 300 8338	Tue & Thu (08:00–15:30)
14	Block V – Soshanguve	Elim Tabernacle Church, Inkanyezi Street, Block V	082 858 2563 / 066 300 8338	Mon – Thu (08:00–15:30)
15	Stand No. 1812 – Soshanguve	Thulasizwe Primary School, Stand No. 1812	082 858 2563 / 066 300 8338	Mon & Wed (08:30–15:30)
16	OUT Well-being – Hatfield	1081 Pretorius Street, Hatfield	012 430 3272	Mon – Thu (08:30–15:30)

17	Reliable House – Hatfield	5002 Arcadia Street	012 430 3272	Tue & Thu (12:00–14:00)

COSUP Drop In Centres

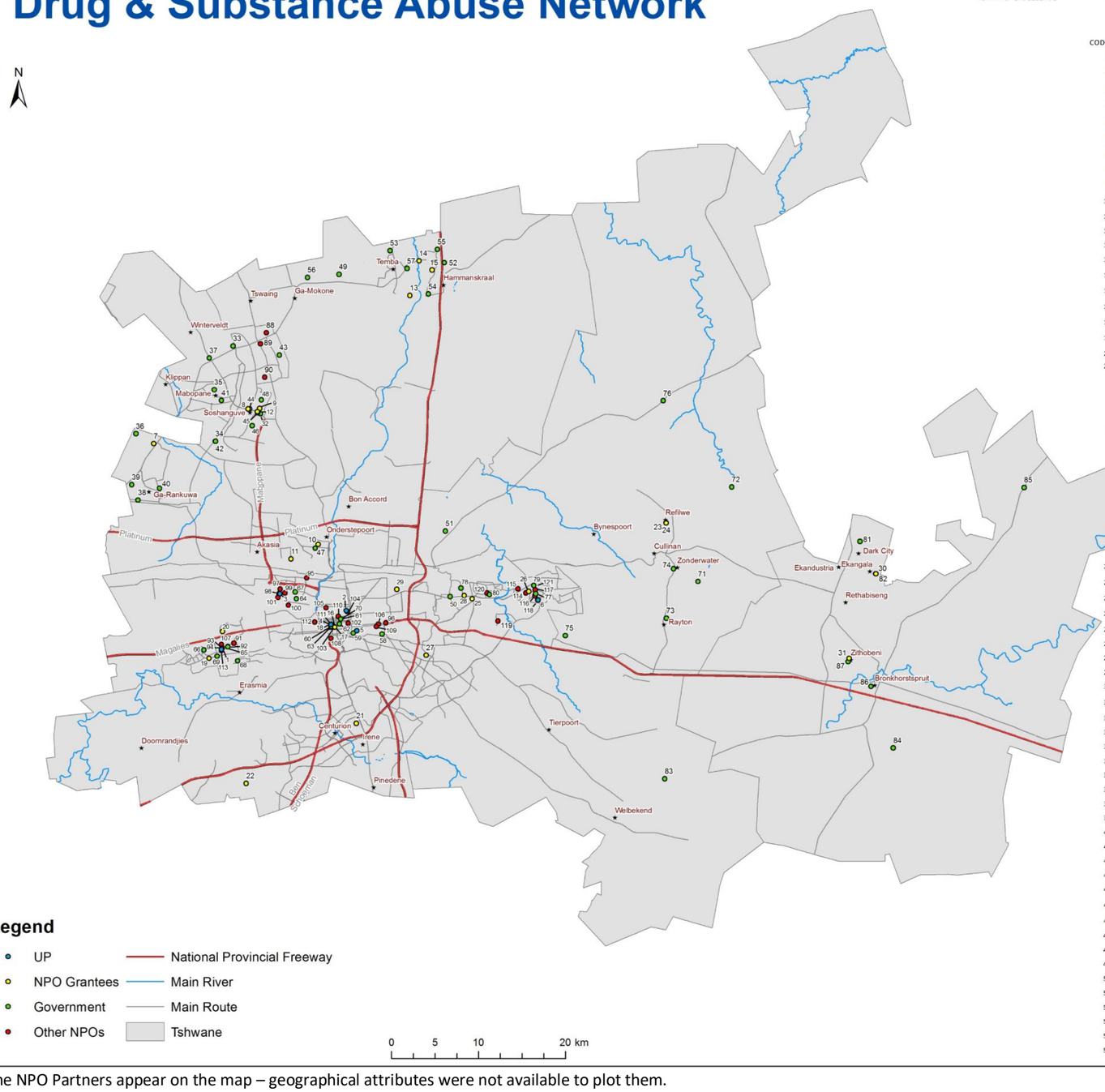
	Drop In Centre Name	Date Established	Operating Hours	Address	List of Activities
1	Daspoort	March/April 2018	Mon – Fri 08:00–15:00	1049 c/o Market and Camp Street, Pretoria West	▪ NSP ▪ Food Security ▪ Sanitary Services ▪ Clothes and Basic Essentials Bank ▪ Counselling Services ▪ Referrals ▪ Related Services
2	Harmless	December 2015	Wednesdays 08:30–15:30	1081 Pretorius Street, Hatfield	▪ NSP ▪ Shower Facility ▪ Food ▪ Access to laptops ▪ Clinical Associates and Social Workers
3	Bethesda	N/A	Mon – Thu 08:00–14:30	50 Vos Street, Sunnyside	▪ Group Sessions ▪ Health Education ▪ Fellowship ▪ Spiritual Counselling by Pastors ▪ Health Facilities
4	TLF Akanani	1997	08:30–15:30	C/o Jeff Masemola & Thabo Sehume Street (Inside Burgerspark)	▪ Psycho-social support ▪ Food ▪ Toiletries ▪ Referrals ▪ ID Documents
5	TLF The Potter's House	1993	08:30–16:30	288 Burgerspark Lane, Pretoria Central	▪ Shower Facility ▪ Psycho-social support
6	TLF Lerato House	1997	08:30–16:00	283 Struben Street, Pretoria	▪ Shower Facility ▪ Psycho-social support ▪ Food ▪ Toiletries ▪ Referrals
7	TLF Thusanang	2011	08:30–15:30	320 Leyds Street, Arcadia	▪ Shower Facility ▪ Psycho-social support ▪ Food ▪ Toiletries

					▪ Referrals
8	Eersterust	October 2017	Wednesdays 09:00–12:00	C/o St Joseph Street and Hans Coverdale Road, Eersterust	▪ Group Therapy ▪ Play Therapy ▪ Discussion groups ▪ Games ▪ Outreach ▪ Soccer Games ▪ Food ▪ Spiritual Day Devotions

NPO Partners

1. Hope for the Hopeless
2. Afrika Entle
3. Botho Socio Development
4. Performance Improvement Child & Youth Care Centre
5. SANCA Pretoria – Castle Carey Clinic
6. SANCA Soshanguve
7. Angels of Glory
8. SANCA Hammanskraal
9. Tshedimosetso Community Development
10. C3
11. NICRO
12. PEN
13. Rearabilwe Community Development Project
14. Sediba Hope Medical Centre
15. Sithuthukisa Bonke Crisis Centre
16. Counselling@
17. Olieven Development Association
18. Region 5 Drug Abuse Centre
19. SANCA Thusong – Refilwe
20. Concerned Tshwane Liquor Traders
21. Lesedi ke Bokamoso
22. SA Youth Movement
23. SANCA Thusong – Eersterust
24. Stabilis
25. Kungwini Peer Educators
26. SANCA Thusong – Bronkhorstspruit
27. Elim Terbanacle Church
28. Father Simangaliso Mkhatshwa Centre of Excellence
29. Heavens Defence Force
30. Atteridgeville Soccer Legends
31. Atteridgeville/Soulsville Sports & Recreation
32. Betlehem
33. Child Welfare Tshwane
34. Children on the Move
35. CMR
36. Crime & Drugs Free
37. Eleos
38. Eleos (ECD)
39. Eljada House
40. HTS Tuine Hercules
41. HTS Tuine Booysens
42. Kopano Manyano
43. Lesedi Bophelo Transformation Centre
44. Oasis
45. Ondersteunings Road
46. OUT Well-being
47. Pheli Le Kae
48. PopUp
49. Procare
50. Tshwane Leadership Foundation
51. WITS Reproductive Health Institute
52. Youth for Survival
53. Zanempilo Home Based Care
54. Brightening Young Stars Corners
55. Christ Ministries Church
56. Concerned Parents
57. Entokozweni Youth Development
58. Future Families
59. Grace of God
60. Life Line
61. SEDA Construction Incubator
62. Setchaba Art Projects
63. Stanza Bopape Community Development Centre
64. JRS
65. Mamelodi Community Learning Centre

City of Tshwane
Drug & Substance Abuse Network



CODE	ORGANISATION	ADDRESS	TELEPHONE
1	AttMed - COSUP	85 Komane Street	012 273 6446
2	COSUP, Family Medicine Department, Faculty of Medicine	7th Floor, HW Snyman North building Perk Street	012 356 3301
3	Daspoort Polikliniek - COSUP	1049 corner Market & Camp Street	012 319 2303
4	Sediba Hope Community Clinic - COSUP	173 Bosman Street	012 534 3333
5	Sediba Hope Community Clinic - COSUP	50 Vos Street	012 534 3333
6	Itsoseng Mamelodi - COSUP	corner Solomon Mahlangu & Hinterland Street	012 842 3515
7	Hope for the Hopeless	1767 phase 25 Casandra park zone 2	083 353 4473
8	Afrika Entle	Corner Lechibini Street and Boxoxele Drive	072 084 0564
9	Botho Socio Development	1812 Block H Soshanguve	012 797 2135
10	Performance Improvement Child & Youth Care Centre	542 Wonderboom Street	082 743 3700
11	SANCA Pretoria - Castle Carey	196 Waterbok Street	012 542 1121
12	SANCA Soshanguve	1658 Gaga Street	012 542 1121
13	Angels of Glory	4357 LLU Building, Temba Street	012 717 2201
14	SANCA Hammanskraal	NWDC Building, 14 Third Street	012 542 1121
15	Tshedimosetso Community Development	984A Marokolong	072 383 2382
16	C3	173 Bosman Street	076 441 1358
17	NICRO	544 Van Erkom Building, 217 Pretorius Street	082 541 0498
18	PEN	173 Bosman Street	012 323 1106
19	Rearabilwe Community Development Project	62 Maunde Street	012 375 9706
20	Sithuthukisa Bonke Crisis Centre	167 Mafa Crescent	012 770 1700
21	Counselling @	108 Saffier Road	082 550 0167
22	Olieven Development Association	1557 Leoka Street	012 770 1759
23	Region 5 Drug Abuse Centre	1768 Tshepong Centre, Zwane Street	073 321 8799
24	SANCA Thusong - Refilwe	Tshepong Centre, Zwane Street	082 846 6452
25	Concerned Tshwane Liquor Traders	356 Zasm Street	078 670 1896
26	Lesedi ke Bokamoso	14636 Apple Place	060 861 6931
27	SA Youth Movement	Stand 226, 66 Glenwood Road	012 348 1214
28	SANCA Thusong - Eersterust	505 Charles Leyds Street	012 806 7535
29	Stabilis	1229 HaarHoff Street	012 333 7702
30	Kungwini Peer Educators	1326 Section 7 Ekangala	071 461 2947
31	SANCA Thusong - Bronkhorstspruit	Stand 625, Zithobeni	013 937 0622
32	SAPS Soshanguve Police Station	R80 Commissioner Street	012 730 1300
33	Soshanguve Block JJ Clinic	7082 Rivoningo Street	012 713 2002
34	Soshanguve Block TT Clinic	625 Block TT Soshanguve	012 791 8027
35	Boekenhout Clinic	Stand 705-6 Block A Mabopane	012 702 1495
36	Ga-Rankuwa View Clinic	15 Kgaka Street	012 700 8957
37	Kgabo CHC	Kgabo Stand, 1480 Bushvald Road	071 679 0008
38	Phedisong 1 Clinic	22 Pilane Street	072 257 4102
39	Phedisong 4 CHC	5808 Lenyai Street	012 703 2993
40	Phedisong 6 Clinic	Zone 6 Ga-Rankuwa	012 700 3551
41	Tlamelong Clinic	2734 Block B Mabopane	012 725 7907
42	Block TT Clinic	Stand 625 Block TT Soshanguve	012 791 8027
43	Block X Clinic	Block-X Soshanguve	082 850 7831
44	Boikhutso Clinic	1266 Block T Soshanguve	012 790 0091
45	KT Motubatse Community Health Clinic	20941 Ext. 4 Soshanguve - K	012 791 9100
46	Maria Rantho Clinic	3180 Block BB Soshanguve	012 797 2857
47	Pretoria North Clinic	376 Jack Hindon Street	012 565 6667
48	Soshanguve Clinic 2	1850 Meriti Street	012 797 2714
49	Dilopye Clinic		083 288 6934
50	Eersterust Clinic & T.B	214 Willie Swart Ave	083 288 6942
51	Kameeldrift Clinic	44 Nieshout Road	083 288 6897
52	Kekana Gardens Clinic		082 319 1820
53	Kekanastad Clinic	Lehwelereng section Majaneng	083 288 6730
54	Mandisa Shiceka Clinic	60 Mandisa Street	012 711 3906
55	Ramotse Clinic		012 719 2011
56	Refentse Clinic	3197 Tambo 2 Hammanskraal Ave	012 715 5178
57	Temba CHC	2475 Roma Street	083 288 6897
58	SAPS Brooklyn Police	119 Duxbury Road	072 286 5610
59	SAPS Sunnyside Police	466 Leyds Street	072 214 0029
60	SAPS Central police	137 Pretorius Street	012 353 4535
61	City Of Tshwane DSA Unit	Sammy Marks Building, Madiba Street	
62	City of Tshwane MMC Health Office	Sammy Marks Building, Madiba Street	
63	Department of Social Development	HSRC Building, 134 Pretorius Street	012 312 7500
64	SAPS Hercules	Gustav Adolf Street	012 377 4120
65	Atteridgeville Clinic	1A Mareka Street	073 787 8547
66	Bophelong Clinic	66 Masopha Street	012 375 5955
67	Hercules Clinic	corner Ribbens Street & Taljaard Street	012 565 6667
68	Laudium CHC	405 Bengal Street	012 374 9973
69	Saulsville Clinic	Tsele Street	012 375 5955
70	Skinner Clinic	Gate 8 Tswane District Hospital, Dr Savage Road	012 354 1654
71	Dr Fabian and Florence Rebeiro Treatment Centre	Zonderwater Road	012 734 1027
72	Onverwaght Clinic		
73	Rayton Clinic	corner Montrose Street & Oakley Street	012 734 4274
74	Refilwe Clinic	1169 Masina Drive	012 732 0671
75	Ubuntu Clinic	Newlands, Pretoria	
76	De Wagensdrift Clinic		
77	SAPS Mamelodi East	Marishane Street	012 815 7006
78	Eersterust CHC	Corner PS Fourie Drive & Hans Coverdale Road	012 806 1300
79	Stanza Bopape Health and Community Development Centre	Stand 2, Shilovhane Street	073 537 2826
80	Mamelodi West Clinic	Pride Of Mamelodi, 6889 Ntshabeleng Street	071 897 1385
81	Dark City Community Health Clinic	1174 Section F Ekangala	012 935 7027
82	Ekangala Community Health Clinic	1227 Section D Ekangala	
83	Kanana Clinic	Bronkhorstspruit	
84	Rethabiseng Clinic	310 Rethabiseng Location	013 935 7046
85	Sokhulumi Clinic		
86	Bronkhorspruit Clinic	54 Market Street	013 932 1720
87	Zithobeni Clinic	624 Kabini Street	013 937 0146
88	Elim Terbanacle Church	Block V Soshanguve	
89	Father Simangaliso Mkhatshwa Centre Of Excellence	Soutpan Road	081 537 8958
90	Heavens Defence Force	926 Tlhalosang Street	072 464 7045
91	Atteridgeville Soccer Legends	52 Selkhukhune Street	079 394 5223
92	Atteridgeville/Soulsville Sports & Recreation	01 Mareka Street	
93	Child Welfare Tshwane	52 Komane Street	012 373 8131
94	Children on the Move	corner Komane Street & Mngadi Street	078 236 0673
95	CMR	492 Deneyssen Lane	012 379 5860
96	Crime & Drugs Free	1250 Pretorius Street	082 971 2407
97	Eleos	1066 Wilhem Street	012 397 5346
98	Eleos (ECD)	1067 Market Street	012 397 5346
99	Eljada House	949 Boekenhuiskloof Street	012 377 0303
100	HTS Tuine	344 Tuin Street	012 379 6181
101	HTS Tuine	0115 Commercial Street	012 379 6181
102	JRS	485 Madiba Street	083 547 8203
103	Kopano Manyano	177 Church Square, F.W. Nkomo Street	012 755 9598
104	Oasis	corner Steve Biko Rd & Dr Savage Road	
105	Ondersteunings Road	55 Malherbe Street	012 325 2320
106	OUT Well-being	1081 Pretorius Street	012 430 3272
107	Pheli Le Kae	06 Ratshoeuntane Atteridgeville	076 059 5150
108	PopUp	3 Skietpoort Ave	012 003 2008
109	Procare	1035 Arcadia Street	086 177 6227
110	Tshwane Leadership Foundation	36 Margareta Street	012 320 2123
111	WITS Reproductive Health Institute	173 Bosman Street	012 323 1106
112	Youth for Survival	181 Vom Hagen Street	012 326 1236
113	Zanempilo Home Based Care	1770 Komane Street	012 373 4196
114	Brightening Young Stars Corners	Shumishanang Primary School, 19555 Letswalo Street	079 819 3900
115	Entokozweni Youth Development	191 Mahlare Street	
116	Future Families	6222 Mogaladi Street	082 804 2766
117	Grace of God	80 Sebaka-Borena Street	073 058 4212
118	Life Line	corner Solomon Mahlangu & Hinterland Street	012 804 1853
119	SEDA Construction Incubator	200 Love Drive Street	072 120 4664
120	Setchaba Art Projects	23 corner Monoa Street & Mphaki Street	076 481 5862
121	Stanza Bopape Community Development Centre	Stand 2 Shilovhane Street	012 815 8008

Not all the NPO Partners appear on the map – geographical attributes were not available to plot them.

STANDARD OPERATIONAL PROCEDURE – TSHWANE COMMUNITY ORIENTED SUBSTANCE USE PROGRAMME (COSUP)

Date: 16 Nov. 17
Rev. 07

CONTENTS

Revision	0	1	2	3	4	5	6	7	8	9	10

1 INTRODUCTION

This document is to ensure that the correct procedure is followed when assessing and managing clients who are using COSUP services. It seeks to establish consistency in approach, whilst acknowledging jurisdictional responsibility for health care and legislative requirements relating to controlled substances.

This document is intended for managers and clinical leaders responsible for the organization of specific health care services at each site and all health care workers managing clients at COSUP sites.

1.1 PURPOSE

1.1.1 To achieve

- efficiency,
- quality output,
- uniformity of performance, and
- consistency.

1.1.2 To ensure

- safety,
- competency of the COSUP staff,
- compliance with standards and protocols, and
- co-ordination and integration of COSUP with other resources.

1.1.3 To serve as

- day-to-day implementation tool,
- ready reference on COSUP, and
- guideline for Monitoring and Evaluation.

1.2 SCOPE

Applies to any staff involved in the assessment, management, referral, including prescribing and dispensing of opioid substitution therapy for opioid dependent service users. This includes: Peer Educators, Community Health Workers (CHWs), Social Workers, Nurses, Clinical Associates (CAs), Medical Doctors, Pharmacists, and other allied health care workers.

1.3 GLOSSARY

TERM	DESCRIPTION
Acceptability	Social, psychological, and ethical acceptability of how the project provides services, including OST, from the perspective of clients, their families/support structures, and other stakeholders.
Action Research	A research methodology.
Aita	A mobile enabled community care management solution used by Community Health Workers (CHWs) to record, manage, and report all health care service information.
Community member	A person who possesses characteristics of a group of people who share a common identity and/or behaviour(s).
Client	An individual who accesses or benefits from a service provided by the demonstration project.
Cravings	The desire for more of a substance to experience the euphoric (or other) effects, as well as the desire to avoid symptoms of withdrawal.
Empowerment	Evaluation of empowerment will consider dimensions related to changes in OST beneficiary's power. Assessment of four dimensions of power: power to, power over, power within and power with.
Ethnographic observation	Close observation of a particular group of people or activities in order to better understand their customs, social structure and habits.
Feasibility	Broadly related to the relevant resources required for management and OST provision and the value of the outcomes. Elements relating to technical feasibility (relating to selection, provision, monitoring and safety of OST provision); economic feasibility (to broadly assess the costs and benefits in economic terms); legal feasibility (to assess the implementation in relation to existing policy and legislative framework), and operational and schedule feasibility (i.e. whether the project met the set aims and objectives as per work plan and budget).
Focus group	Facilitated formal discussions with individuals who consent to participate in a group or individual discussion (session). Discussions are guided by a standard format that helps the facilitator focus on the clients' experiences and perceptions of the project.
High threshold	High threshold services have a more onerous set of selection criteria. Typically, they have an expectation of abstinence and the participation in psychosocial programmes, with possible termination of treatment should the criteria not be met.
Illicit/illegal drug use	The use of substances that are obtained or possessed illegally; these may include scheduled drugs that usually would be obtained from a pharmacy with a prescription.
Key Populations	UNAIDS defines 'key populations' as those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response (i.e. key populations are key to the epidemic and the response). In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs and their sex partners, sex workers and their clients, and inmates are at higher risk of exposure to HIV than other people.
Low Threshold	Low threshold services have few selection criteria and aim to make services as easy to access as possible.

Needle and syringe programme	The term 'needle and syringe programme', otherwise known as NSP, is increasingly replacing the term 'needle exchange programme'. Emphasis on needle exchange has been identified as a potential barrier to accessing injecting equipment, whereas focusing on distribution and encouraging needle and syringe return has been found to be more acceptable among people who inject drugs. Both terms refer to programmes aimed at increasing the availability of sterile injecting equipment.
Nyaope	A local name for heroin. Can be of varying quality.
Opioid Substitution Therapy	The medical procedure of replacing an illegal opioid drug such as heroin with a longer acting but less euphoric opioid, usually methadone or buprenorphine, taken under medical supervision. The driving principle behind OST is that an opiate-dependent person will be more able to regain a normal life and schedule while being treated with a substance that stops him/her from experiencing withdrawal symptoms and drug cravings, but doesn't provide strong euphoria.
OST prescriber	A medical doctor that is trained to assess, initiate, and monitor a person on OST and who writes out the OST prescription.
OST psychosocial service provider	A social worker, therapist or other person trained to provide psychosocial support for people receiving OST.
OST supplier	Pharmacy/pharmacist that is registered to dispense OST.
OUT Well-being	A civil society organisation that is delivering health and HIV prevention services to PWID in Tshwane.
Peer educator	Peer education is an intervention using individuals from a target group to provide IEC or information to their peers. Social or demographic characteristics determine peers such as age or education, or by risk-taking behaviour (e.g. injecting drug use or sex work). Peers are trained, and can often convey information effectively to hard-to-reach populations. In this demonstration project, peers are either currently using, recovering/recovered from drugs or are non-users who are extremely knowledgeable about the PWID community and/or drug use.
People who inject drugs (PWID) People who use drugs (PWUD)	The terms 'people who inject drugs' (PWID) and 'people who use drugs' (PWUD) are preferable to 'injecting drug users' (IDU), as they place emphasis on the person. This term PWID refers to people who regularly inject drugs either intravenously, intramuscularly, subcutaneously or by some other route. PWUD refers to people who ingest drugs by other means, such as smoking, snorting, or swallowing.
Psychosocial Support	Psychosocial support refers to a range of interventions that addresses the ongoing emotional, social, and spiritual needs of an individual.
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may become infected with HIV.
Self-efficacy	Personal capability to perform or complete a specific action.
SF-12	This generic preference-weighted health outcomes assessment tool has been developed to assess quality of life and enable comparability of outcomes across a range of interventions for a range of conditions, and is validated for the South African context.
Site	For the purposes of this protocol, 'site' refers to the location(s) where services for PWUD and PWID will be provided from.
Step Up Project	A demonstration project run by TBHIV Care Association and OUT Well-being delivering services to injecting drug users in Cape Town, Tshwane, and eThekwini.
Triangulation	The analysis and use of data from three or more sources obtained by different

	methods. In theory, findings can be corroborated, and the weakness or bias of any of the methods or data sources can be compensated for by the strengths of another, thereby increasing the validity and reliability of the result.
Wellbeing	Personalised assessment of one's mental, physical and social status.
Whoonga	Whoonga is a local street name for heroin. Typically, this is of lower quality and smoked.

1.4 LEGISLATIVE & STANDARDS CONTEXT

DOCUMENT	LOCATION
Prevention of and Treatment for Substance Abuse Act, 2008 (Act No.70 of 2008)	
Medicine and Related Substance Control Act, 2002 (as amended) (Act No. 59 of 2002)	
Heath Act, 1977 (Act No. 63 of 1977)	
Health Professional Act, 1974 (Act No. 56 of 1974)	
Mental Health Care Act, 2002 (Act No. 17 of 2002)	
SAAMS Guidelines for the Management of Opioid Use Disorders	

2 POLICY

2.1 PRINCIPLES

The services provided by the drug use assistance site, including Opioid Substitution Therapy (OST), are informed by the following guiding principles:

- Shared responsibility and teamwork.
- Peer supported services.
- Non-judgemental, empathic person-centred services for all.
- Empowerment, respect, and autonomy.
- Holistic care per individual needs.
- All staff, including reception and administration staff who interact with the clients, should be trained in the basics of customer service.

2.1.1 Harm Reduction

Services are all based on a harm reduction approach that seeks to mitigate the potential risks and harms related to drug use with no prerequisite for abstinence. Services are based on best available evidence and best practice guidelines.

2.1.2 Low Threshold

This is a low threshold programme, thus many barriers to entry and retention should be removed, with consideration for safety. Psychosocial and similar services are voluntary.

2.2 ROLES & RESPONSIBILITIES

Tshwane COSUP is conducted as a multidisciplinary team approach with planned services at predetermined sites. The team consists of the Family Physician or General Practitioner, Clinical Associate, Professional Nurse Counsellor, Social Worker, Community Health Workers, Peer Liaison/Educators and other allied health care workers supported by Team Leaders.

The following roles and responsibilities have been identified for this programme:

POSITION	RESPONSIBILITIES
Peer Liaison/Educator	• First point of contact. • Make clients feel comfortable. • Encourage and guide through process and manage expectations. • Mini-Triage: Assess clients and see why they are here and where they need to go. Be familiar with referral pathways and redirect appropriately. • Provision of COSUP IEC handouts and other relevant reading materials. • Assist clinical staff and family members with communication, translation, and interpretation of situations. • Obtain a signed informed consent.

	• Complete a screening consent process and assess eligibility.
	• Complete ASSIST 3.0.
	• Identify high-risk behaviours and prioritise:
	  ▪ Overdose.
	  ▪ Injecting.
	  ▪ life-threatening wounds.
	In such cases liaise with Clinical Associate to prioritise immediate medical assessment.
	• Distribute harm reduction materials and keep records.
	• Deliver behavioural interventions.
	• Assist with groups and conduct peer support groups at the centre and other locations and facilitate Community Advisory Groups (CAGS).
	• Referral pathways and redirection if client is at the wrong place.
	• Schedule appointments and assist with follow-ups and locating PWUD who are lost to follow-up, in consultation with other team members.
	• Assist with administration where necessary.
	• Provide feedback to project teams on community issues and suggest improvements.
	• Identify an emergency and administer basic first aid.
	• Be equipped and trained to be able to deliver naloxone in case of overdose.

Community Health Worker	• Assist peers with their duties. • Complete ASSIST 3.0. • DOT and document. • Assist with administration. • Help with screening for medical conditions, e.g. Screen for TB and collection of sputum, STI, etc. • Help with HCT. • Home visits. • Community Outreach. • Link between COSUP and WBOT.

Intake Officer
- Can be: Social Worker, Clinical Associate, Counsellor, Psychologist
	• Assessment role:
	  ▪ Conduct individual and contextual assessment.
	  ▪ Take comprehensive psycho-social history.
	  ▪ Complete ASSIST 3.0.
	  ▪ Quality of life baseline (SF-12).
	  ▪ Prioritise services.
	  ▪ Refer for clinical assessment.
	  ▪ Assign case manager.
	  ▪ Refer to outside services where appropriate.
	• Keep all records up to date.
	• Report to team on numbers, issues, etc. at weekly clinical meeting.

Case Managers	• Case management role:

- Can be: Social Worker, Auxiliary SW, Counsellor Also, Clinical Associates can perform this role where they are available	▪ Establish rapport with clients. ▪ Work collaboratively with clients where they wish to engage. ▪ Keep up to date with progress. ▪ Help clients develop personal development plans. ▪ Track referrals. ▪ Enter information into Synaxon. ▪ Feedback to clinicians. ▪ Update staff on issues. ▪ Regular follow-ups as per research protocols.
PNC or Nurse	• Provide daily doses as per doctor's prescription. • Observe for discomfort, withdrawal symptoms or intoxication and refer to the doctor or Clinical Associate. • Document procedures for medication supply chain management, daily observed therapy and take-home doses as appropriate. • Screen for infectious diseases. • Assess adherence to treatment as appropriate. • Assess participation in psychosocial support services. • Refer for other services as needed.
Clinical Associate	• Baseline assessment including: ▪ An assessment of substance use, medical and related history will be conducted using the Addiction Severity Index (ASI) Lite Version 2. • Medical examination as needed/informed by history. • Complete a screening consent process (if not done by the peer already) and assess eligibility. • Complete ASSIST 3.0. • Perform client specific special investigations that may be needed AND are consented to (viz. ECG and blood sampling [ALT] and HIV testing [testing for viral hepatitis B and C may be offered], including drug urinalysis where applicable). • Can also do mental health screening where a mental health practitioner is not available on site. • Assess for OST. • Discuss OST contract with client and obtain an informed consent for OST. • OST report, documentation, including Synaxon. • OST administration, supply chain management in liaison with the Family Physician or Medical Officer. • OST adherence management. • Management of referrals. • Engagement with WBOT. • Can also perform many of the duties of the PNC should a PNC not be available • Lead Team Meetings in liaison with the supporting doctor.
Family Physician	• Attend to clinically significant events and medical emergencies. • Perform initiation visit tasks which include:

	▪ Review of laboratory results. ▪ Provide additional counselling around COSUP or OST. • Discuss treatment contract for OST if eligible. • Prescribe and initiate the client onto methadone or buprenorphine at an appropriate dose in accordance with good clinical practice. • See or communicate with the client twice per week during the initiation phase i.e. until stable dose is reached. • Identify health and non-health problems. • Provide harm reduction support and brief interventions. • Manage co-morbidities. • Refer clients who need specialists' services. • Conduct weekly clinical meetings with staff.
Group Facilitators - Can be Occupational Therapists, Social Worker, Counsellors, Lay Counsellors, Peers	• Groups: ▪ Conduct groups. ▪ Help peers learn to facilitate groups. • Prepare groups. • Feedback on materials.
Social Worker, Counsellor, Psychologist (in some cases PNC and CA)	• Ensure Confidentiality Agreement. • Individual sessions: ▪ Brief problem solving. ▪ Community reinforcement approach. • Brief interventions. • Home visits where indicated.
Social Worker	• Counselling clients and family members. • Working together with multidisciplinary teams to formulate individualised development plans and treatment plans. • Assess and enrol clients with substance, mental and emotional challenges into the programme. • Organise and conduct groups to address psycho-social needs and/or skills training. • Referral to other service providers for further assistance. • Provide after care support to the individual and/or family and monitor the basic functioning of the client. • Assessment to determine skills and assist with skills development programmes to be self-sufficient. • Administrative duties such as report writing, statistics, referrals, and networking, attending meetings, supervision. • Engagement with continuous professional development in subject field. • Complete ASSIST 3.0. • Provide harm reduction support and brief intervention. • Statutory roles, such as: ▪ Grant applications.

	▪ ID documents. ▪ Accommodation. ▪ Employment. ▪ Family issues, such child safety.

3 PROCEDURES

3.1 COSUP OVERVIEW

STAGE	ACTIONS	DOCUMENTS
Recruitment	Person is referred or walks in. Person is made to feel welcome. COSUP information is provided. Consent is signed.	IEC_OST COSUP_PAT013_ OST Consent
Screening	Peer or CHW outlines project and activities. Peer assesses for eligibility, including ASSIST 3.0. Road to Linked Care Booklet is given.	ASSIST 3.0 Road to Linked Care Booklet Med010
Baseline assessment	CA provides additional information and questions are answered. CA conducts baseline assessment procedures (including ASI assessment). CA conducts investigations as indicated.	Health Screen ASI Synaxon system SF-12 Med010
Initiation	Results of investigations discussed with CA. Doctor reviews assessment, lab results and discusses project with clients. Questions are answered, consent and treatment contracts are signed with doctor or Clinical Associate. The doctor will prescribe the appropriate dose. The first dose will be given.	Tx Contract Synaxon system
Dose adjustment	The PNC or CA will provide daily observed doses, and in consultation with the doctor dosages will be adjusted as per the SAAMS guidelines over the next 14 days. Should the clients be experiencing discomfort, withdrawal symptoms or appear intoxicated, they will be referred to the doctor. Doctor to see clients twice per week during initiation period i.e. until stable dose is reached.	Recorded on Synaxon and dose recorded in Road to Linked Care Booklet on each change
Stable dose	Once clients are comfortable on their doses, showing no objective or subjective withdrawals for a period of 7 days they will move to the maintenance phase.	
Maintenance	The clients will receive daily observed doses for at least 2 months unless there is a pharmacist or a reliable support system to observe the daily dose or unless otherwise suggested at the discretion of the prescribing physician. Take home dosing: • Client must have been on stable dose for 12 weeks. • Maximum prescription for 7 days. • Must come in person each week to collect. • Client needs good support structure and must attend with a	Standard records

	person who will supervise dose and meet PNC. • After 6 months scripts to be fortnightly; after 12 months scripts to be monthly.	
Monitoring visits	3, 6, 12 and 18 months' post baseline. Quality of life, infectious disease and participation in psychosocial interventions assessment.	SF-12 ASI
Voluntary termination	The clients must be down titrated per the SAAMS guidelines. The clients must have the risks explained and sign an indemnity form. Clients to be offered an exit interview.	Indemnity form
Involuntary termination	The clients must be down titrated per the SAAMS guidelines. Risks explained, and clinical notes made outlining the discussion and reason for the termination. Clients to be offered an exit interview.	Client information sheet
NOTES		
Missed doses	If the clients skip 3 days, they must see the doctor who will re-initiate on a lower dose as per the SAAMS guidelines.	
Drop-outs	Attempts will be made to find clients who miss more than 2 appointments. Clients will be given the opportunity of re-joining the project	
Illicit drug use	Illicit drug use will not be grounds to terminate participation in the programme unless there are indications that this may lead to drug poisoning. Dose may need to be increased.	

3.2 HEALTH SCREENING & HISTORY

Health screening is conducted using the appropriate tools at each stage. These include:

TOOL (CLINICAL OR RESEARCH)	DESCRIPTION	WHEN WHERE	WHO
Aita Screening (C&R)	Standard substance use screening done on hand-held in the home.	Home during visits	CHW
ASSIST 3.0 (C&R)	Both screening and brief intervention tool.	Screening at site	PF, CA, SW, PNC
MED010 (C&R)	Full assessment across domains.	As part of full assessment	CA, MD, PNC
Health Screen Tool	Basic health data		CA, PNC
SF-12 (R)	Quality of life measure to determine programme impact.	As per protocol	CA
Addiction Severity Index (R)	Tool to measure progress regarding drug use and risks and harms.	As per protocol	CA

3.3 INCLUSION & EXCLUSION CRITERIA

Each case should be assessed on individual merits and according to the SAAMS guidelines and project research protocol. In some cases, additional examinations may be required. COSUP has a low threshold for admission.

General criteria for methadone are:

3.3.1 Inclusion criteria

- More than 12 months' history of heroin/nyaope use (unless clinically indicated) and scored as High-Risk opioid use (≥ 27) on the ASSIST 3.0.
- Understands project procedures.
- Agrees to be contacted for follow-up.
- Provides informed consent.
- Able to attend site daily during initiation phase.
- Has resided in the City of Tshwane for at least 12 months.
- Completes the pre-assessment and preparation procedures (including ASSIST 3.0 and COSUP Registration Form [COSUP_PAT015_Registration Form]).

3.3.2 Exclusion criteria
(evaluated on an individual basis)

- Negative urinalysis for opioids.
- History of heart disease for methadone.
- Acute alcohol use disorder.
- Acute benzodiazepine use disorder.
- Clinical diagnosis of schizophrenia or any other psychotic disorder.
- History of respiratory depression or other chronic respiratory condition, including asthma (unless recommended by assessing physician).
- Severe liver impairment.
- Severe head trauma or any other condition that causes increased intracranial pressure.

3.4 ASSESSING FOR INTOXICATION & WITHDRAWAL

3.4.1 Withdrawal

SIGNS AND SYMPTOM OF OPIOID WITHDRAWAL	
Dilation of pupils	Lacrimation
Anxiety	Rhinorrhoea
Muscle and bone ache	Abdominal cramps
Muscle cramps	Nausea
Sleep disturbance	Vomiting
Sweating	Diarrhoea
Hot and cold flushes	Palpitations
Piloerection	Rapid pulse
Yawning	Raised blood pressure

3.4.2 Intoxication

Intoxication with central nervous system depressants such as benzodiazepines and alcohol increases the risk for overdose in combination with methadone or buprenorphine.

SIGNS OF OPIOID OVERDOSE	SIGNS OF OPIOID INTOXICATION
Pinpoint pupils	Constriction of pupils
Loss of consciousness	Itching and scratching
Respiratory depression	Sedation and somnolence
Hypotension	Lowered blood pressure
Bradycardia	Slowed pulse
Pulmonary oedema	Hypoventilation

3.4.3 Intoxicated presentations

Client safety is the key consideration in responding to those who present for dosing while intoxicated due to opioids, alcohol, or other drugs. Clients should be made aware at the commencement of treatment that medication will be withheld in the event of intoxication ('nodding').

Clients should always be assessed by the person dispensing the dose (nurse or pharmacist) for signs of intoxication before the dose is given. Clients who appear intoxicated with CNS depressant drugs should not be dosed or given a takeaway dose of methadone or buprenorphine.

Clients can be asked to re-present later in the day (or the following day) for dosing. The prescribing doctor must be notified to determine the need for the client to be assessed by the prescriber prior to the next dose being administered.

Clients with a history of repeated presentations for dosing while intoxicated should be reviewed by the treating doctor and the treatment plan reconsidered.

Examine peripheral sites for evidence of previous injections documenting any related complications (e.g. infections). Injecting into the groin or neck are indications of high risk drug use which may benefit from specialist advice or referral.

3.5 INVESTIGATIONS

3.5.1 Special Investigations

Use of investigations should be based on clinical indications.

3.5.2 Urine drug screening

Urine screening is typically only done once, prior to OST initiation, where indicated. At this stage urine drug screening is useful to:

- confirm client history of opioid use,
- establish recent opioid use, and
- identify other substance use, not reported by the client, that may assist in the diagnosis and management of the client (e.g. Psychosis).

However, delays in obtaining results should not delay treatment initiation where the diagnosis can be clearly established. Clinicians should be aware of the potential for an adversarial relationship with the client if the purpose of urine drug screening is poorly communicated. (These are simple single/double dip drug tests that are easy to read and should not be done in a strict manner – they are simply to confirm heroin use or possible concurrent BNZ use.)

Staff performing tests should be competent in taking samples and, if appropriate, in reading and interpreting results. Steps should be taken to reduce opportunities to tamper with the specimens.

3.6 SUPERVISION

This is done to ensure safety of the client and to minimize the risk of toxicity. The level of supervision and the frequency of collection should be based on individual risk assessment of client needs. This is informed by the SAAMS guidelines.

3.7 MONITORING VISITS

- Date of OST initiation.
- Current methadone dosage.
- Date of last dosage change.
- Date of take-home dosing (if appropriate).
- Missed visit(s) in last month (number of days in total).
- Assessment of wellbeing (complete ASI and SF-12 assessment tools, as appropriate).
- Enquire about symptoms of toxicity.
- Enquire about symptoms of withdrawal.
- Enquire about heroin/nyaope/whoonga use since last visit.
- Enquire about injecting drugs.
- Sexually active (if so, partner(s) – number, sex, risk practices).
- STI symptoms.
- TB symptoms.
- HIV status.
- ART regimen and last viral load (if applicable).
- Participation in psychosocial support services (list type, duration/frequency).
- Current challenges with OST/life.
- Plans to address challenges.

3.8 RECORDS & REPORTING

Case records detailing client's clinical history and progress in treatment should be established and adequately maintained. There should be clear and concise notes, properly signed, named, and dated. A separate structured sheet for recording prescriptions must be kept. Client notes to be filed in accordance with the COSUP Compiled Client File Index (COSUP_PAT017_Compiled Patient File Index).

3.9 REFERRALS

- People with significant psychiatric co-morbidity, especially where psychotic features are present.
- Acute medical conditions.
- Chronic pain syndromes and pharmaceutical opioid dependence.
- Parenting and child protection.
- Difficulties attending dosing facilities.

- COSUP sites need to:
    - Discuss referral options with the client.
    - Engage referral partners (based on LISA) and establish pre-referral contact and post-referral feedback.
    - Use the COSUP referral form (COSUP_PAT001_Referral Note) and document/file feedback responses or letters.
    - Make sure every referred client has a Road to Linked Care Booklet.
    - Document referrals within COSUP.

4 REFERENCES

1. University of Pretoria Department of Family Medicine. Implementing Opioid Substitution Therapy using the COPC Approach. Research Protocol. Investigators: Prof. Jannie Hugo, Prof. Tessa Marcus, Shaun Shelly, Dr Lorinda Kroukamp, Dr Andrew Scheibe.
2. Kerr T, Wodac A, Elliott R, et al. Opioid Substitution and HIV/AIDS Treatment and Prevention. The Lancet. 2004 Nov 27;364(9449):1918-1919.
3. Shoptaw S, Fuller E R, Yang X, et al. Smoking Cessation in Methadone Maintenance. Addiction. 2002 Oct 1;97(10):1317-1328. doi: 10.1046/j.1360-0443.2002.00221.x
4. Rao R, Mittal A. Standard Operating Procedure. Opioid Overdose Prevention and Management for Injecting Drug Users. United Nations Office on Drugs and Crime, Regional Office for South Asia, 2012.
5. Northern Ireland Primary and Secondary Care Opioid Substitute Treatment Guidelines. Health and Social Care. 2013.
6. Gowing L, Ali R, Dunlop A, et al. National Guidelines for Medication-Assisted Treatment of Opioid Dependence. 2014. Online: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/AD14DA97D8EE00E8CA257CD1001E0E5D/$File/National_Guidelines_2014.pdf
7. WHO, UNODC, UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012. Online: http://www.who.int/hiv/pub/idu/targets_universal_access/en/

CLINICAL GOVERNANCE[9]

COSUP

[9] Adapted from: Harris S, Taylor S. Clinical Governance in Drug Treatment: A Good Practice Guide for Providers and Commissioners. London: National Treatment Agency; 2009. Available from: www.emcdda.europa.eu/attachements.cfm/att_231393_EN_UK37_clinicalgovernance.pdf

1. INTRODUCTION

Clinical governance refers to 'the clinical leadership and accountability, as well as the organisation's culture, systems and working practices that ensure that quality assurance, quality improvement and patient safety are central components of all activities of the health care organisation.'[10] It is a process made up of a large number of elements. For many of these there are a range of criteria or recognised standards of good practice that can be used in audit and benchmarking.[11]

Clinical governance is relevant to all individuals and organisations providing and commissioning treatment for substance users, even where their interventions might not be considered as 'clinical'.

2. KEY POINTS

Clinical governance is constituted of a wide range of components that, together, contribute to safe, effective, and high-quality service provision.

The core domains of Standards for Better Health (SfBH) effectively cover all these components and are used in this document.

2.1 SAFETY

- Deaths and other adverse events

All incidents are to be telephonically communicated immediately to the clinical manager of the project. An incident report form (ANNEXURE 1 – Incident Report) is to be completed and sent to the clinical and project manager within 24 hours of the incident.

- Medicines safety, safe prescribing and handling of medicines, appropriate prescribing, dispensing accuracy, on-site storage and communication with pharmacists

All medication (OST) is kept safely in a locked cabinet with restricted access. (See OST SOP for detailed information.)

[10] South Africa. Department of Health. Handbook for District Clinical Specialist Teams (DCST). Pretoria: National Department of Health; 2014.

[11] Harris S, Taylor S. Clinical Governance in Drug Treatment: A Good Practice Guide for Providers and Commissioners. London: National Treatment Agency; 2009.

- Hazardous waste disposal

All hazardous waste is removed by The Waste Group (ANNEXURE 2 – Medical Waste Removal Request). The clinical associate at each site completes the waste removal form. This is then sent to a contact person at the University of Pretoria. The disposal company removes the waste approximately a week after the request has been logged.

- Risks to children from drug-using parents

Each site has a social worker that works with clients and their families. In the event of risk to children, the social worker will take appropriate action.

- Blood-borne viruses – preventing and responding to needle-stick and other injuries

All staff have on-site access to personal protective equipment (e.g. gloves) to prevent and reduce injuries. In the case of accidental exposure to HIV, post-exposure prophylaxis (PEP) is immediately available. Protocols have been created to initiate treatment, report and further manage the incident (ANNEXURE 3 – IOD Protocol).

- Staff safety

The service delivery platforms are regularly evaluated and improved where possible, e.g. adding burglar bars onto the temporary structures at various sites and fencing properties that are exposed. Staff are also encouraged not to perform outreach alone but rather to work in pairs/groups.

- Safety notices

Facilities have been provided with signage that states that 'no methadone is stored on site'. The sign is depicted in three languages (English, isiZulu, Sesotho).

2.2 CLINICAL AND COST EFFECTIVENESS

The SAAMS guidelines have been used for clinical guidance. Pharmaceutical protocols and training from Equity have also assisted in creating the clinical framework.

- Clinical supervision and leadership

Each site is overseen by a family physician/medical doctor. The doctor sees each new client that is to be initiated on OST, after the client has been seen by the team. The doctor will review the client and confirm that the client is fit for OST and decide which OST to prescribe. The doctor also ensures that all relevant documentation has been completed. The doctor may also sit in on consultations to assess the quality of consultations and offer advice where necessary.

The project also has a clinical manager who is a family physician. The clinical manager is responsible for overseeing all clinical aspects of the project. He/she is also available for clinical questions and decision-making.

A team meeting with all clinical staff is held bi-monthly. The meeting is facilitated by the clinical manager/project manager. These meetings are used to iron out any issues and also to facilitate group discussions and case studies. Patient confidentiality is always maintained. Talking about clinical work in a supportive environment can fulfil several different functions, which combine to fulfil the overall function of discussion and reflection on maintaining and enhancing the quality of service provision. These meetings have the following advantages:

- They help staff to generate ideas.
- They enable staff to check that their own ways of working are consistent with approaches within the service/profession, and to gain validation for the work they are doing.
- They provide the opportunity for advice and guidance, and potential understanding from a broader range of theoretical perspectives.
- They provide an opportunity for staff to explore their existing knowledge, identify gaps, and be challenged to extend their knowledge and develop new approaches to practice.

- Continuing professional development

There is regular training on OST and harm reduction as well as updates. Staff members who work on-site with clients are sent for Basic Life Support training. Training on opioid overdose management is also arranged for clinical staff. Staff members are encouraged to study further and take part in research. The doctor at each site also assists in mentorship and on-the-job training of staff. It is also the medical doctor's role to identify gaps in clinical knowledge and address these – either through formal or informal training. The doctors are also encouraged to study further and boost

their knowledge through self-study and discussions amongst themselves. COSUP also performs biannual peer reviews to assist in identifying gaps in clinical knowledge. Each group of professionals is governed by a professional board and staff are encouraged to keep their knowledge updated and in line with their board recommendations.

- Clinical audit and review

Regular clinical audits need to be performed by the doctor that oversees each site. These need to be performed on a small scale at each visit and more extensively once every three months at each site. This is to ensure that the patients are being examined and managed according to the clinical guidelines and/or SOP. The biannual peer reviews also assist in identifying gaps.

A multidisciplinary team should be instituted to review sites and their quality of work. This should be done quarterly or, at least, biannually.

- Cooperation between health and social care

All clients are seen by a social worker. Social workers employed by the project are encouraged to familiarise themselves with existing social structures within the communities they are working in. Collaboration is an important element of success.

2.3 GOVERNANCE

- Processes and culture to support staff to do their jobs openly and effectively

Staff members are encouraged to attend debriefing sessions with a psychologist arranged by the project. This allows staff to express some of the impact of therapeutic work on themselves, in a place where emotions can be contained and processed. It also provides the opportunity for staff to explore the possible impact of personal issues in their own lives on their therapeutic work with clients.

- Challenging discrimination and promoting equality

All staff members are to be treated equally. It is illegal to discriminate against people on grounds of sex, race, disability, sexual orientation, religion or belief.

2.4 PATIENT FOCUS

- Consent for treatment and information sharing

All clients complete an informed consent form, both for participating in research and therefore information sharing, as well as for OST (ANNEXURES 4, 5 and 6).

- Complaints

Clients are encouraged to voice any dissatisfaction they may have. If complaints are received, the site team is to work with the patient to manage these. If no solution is reached, the matter can be escalated and reported to the overseeing family physician and/or to the project manager.

- Working in partnership with other organisations

Each site is encouraged to perform a Local Institute Support Analysis (LISA) (ANNEXURE 7 – LISA). The LISA enables the site to gather information about all the organizations within the community. Partnership working with other organisations/health facilities to meet a client's full range of needs is critical to delivering effective support for recovery and reintegration for all clients. It is also vital for specific client groups, including:

- Young people – Youth Forums
- Pregnant women – Local clinics for antenatal care
- Mental health problems – Mental health clinics
- Criminal justice system – developing a working relationship with SAPS
- Physical health problems – Local clinics and hospitals

2.5 ACCESSIBLE AND RESPONSIVE CARE

COSUP encourages the involvement of clients and staff in designing, planning, delivering and improving services, and prompt and equitable access to services. Community Advisory Groups (CAGs) are groups run by users/peer educators whereby clients can voice their needs, plan activities and be active participants in their care plans. COSUP services are available to all members of the community. Many satellite sites have been created to ensure that all parts of the community can be reached.

2.6 PUBLIC HEALTH

Harm reduction measures can make a significant impact on public health.

- Needle exchange programmes are run at some COSUP sites. This prevents the spread of HIV and Hepatitis, and also assists with hazardous waste management. Users are encouraged to bring in used needles in exchange for clean ones. This will reduce the number of used needles lying around in the streets.

- Safe and clean injecting practices are also encouraged for those users who are not yet ready to stop using drugs.

3. THE COMPONENTS OF CLINICAL GOVERNANCE

3.1 LINES OF RESPONSIBILITY AND ACCOUNTABILITY

- Individual professional responsibilities – duty of care to patients, professional codes of conduct and registration requirements.
- 'Duty of care' responsibilities of all caring organisations.
- Employers' responsibilities to employees and vice versa.

3.2 QUALITY IMPROVEMENT ACTIVITIES (SECTION 2.2)

A comprehensive programme of quality improvement activities includes:

- Clinical audit

All clinical professional groups (doctors, clinical associates and social workers) can be expected to participate in clinical audits as part of their professional responsibilities for clinical governance.

- Continuing professional development

Continuing professional development (CPD) is essential for a skilled workforce that can adapt to the changing needs of service users and to developments in treatment.

- Identification of learning needs.
- Drawing up a personal development plan.
- Undertaking CPD in line with the personal development plan.

- Evidence-based practice

Evidence-based medicine has been defined as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients … integrating clinical expertise with the best available external clinical evidence from systematic research'.[12] All programme and clinical decisions are based on evidence and these are researched and reviewed when necessary. COSUP as a whole is developed from evidence-based information; this includes

[12] Harris S, Taylor S. Clinical Governance in Drug Treatment: A Good Practice Guide for Providers and Commissioners. London: National Treatment Agency; 2009.

Screening, Brief Interventions, Referral and Treatment (SBIRT); Opioid Substitution Therapy (OST); and Needle and Syringe Programmes (NSP).

- Research and development

The principles of research governance are:

- The research should aim to answer a research question that has not yet been answered.
- Design should be sufficiently robust and sample size adequate in order to draw a reliable conclusion.
- Adequate resources to undertake research should be ensured in advance.
- Plans for dissemination of findings should be in place prior to undertaking research.

All of these are addressed in the COSUP Research Plan.

- Effective monitoring of clinical care

High quality systems for clinical record keeping and the collection of relevant information are essential components of the effective delivery of high quality care, both for the management of a particular individual and for the overall quality of care delivery.

3.3 POLICIES AIMED AT MANAGING RISKS (SECTION 2.1)

Critical policies for managing risks in drug treatment include:

• Child protection.
• Safe prescribing and handling of medicines.
• Blood-borne viruses.
• Staff safety.
• Investigate reports and incidents.
• Act on risks identified and give feedback to staff.

3.4 PROCEDURES FOR IDENTIFYING AND REMEDYING POOR PERFORMANCE

It is important to avoid a culture of inappropriate blame: poor performance should usually be seen as a failure in one or more systems and as an opportunity for learning and improving.

The mechanisms for identifying and remedying poor performance:

Identifying poor performance

Poor performance may be identified by:

• Investigating the causes of serious untoward incidents and near misses.

• A whistle-blowing policy that allows colleagues to report poor performance.

• Client complaints, whether informal or formal.

• Effective supervision and appraisal against specified standards of performance.

• Audit or inspection findings.

Remedying poor performance

Depending on the seriousness of the poor performance, its impact on client safety and whether and how previous efforts have failed, remedying individual poor performance may involve an escalating scale of actions at different levels.

The situation may be resolved at ground (on-site) level, then may be escalated to clinical and project manager. If there is no resolution/improvement, the matter may be escalated to the Head of Department at the University of Pretoria, Department of Family Medicine.

Any actions should aim to:

1. first, neutralise the situation, preventing any further poor performance from impacting on client care;
2. next, investigate the nature and causes of the poor performance;
3. then, rectify the poor performance by addressing training needs, personal problems, inappropriate policies and procedures, etc. as appropriate; and
4. finally, when satisfied that individuals concerned are able to perform to the required standard and that any system issues have been resolved, restart, if possible.

4. ROLES, RESPONSIBILITIES AND ASSURANCE IN CLINICAL GOVERNANCE

4.1 STAFF

All staff delivering treatment interventions have a general responsibility to engage in clinical governance. Staff with professional clinical responsibilities have mandatory registration with their professional bodies. Through these they must adhere to particular professional codes which require them to engage in key clinical governance activities that help to promote and maintain high quality clinical care. These include requirements to:

- adhere to good practice guidelines and protocols;
- maintain skills and knowledge through continuing professional development;
- report serious adverse events (SAEs) and report in SAE reviews; and
- participate in clinical audit.

Reception and administration staff must:

- maintain data quality and ensure data collection;
- ensure clear and timely communication;
- enable service user access to information and treatment; and
- facilitate service user feedback and complaints.

4.2 TEAMS

Collaborative and open teamwork is essential for good clinical practice, and this is especially important for management of drug use where multidisciplinary teamwork is the cornerstone of effective treatment.

Teams that deliver high quality care:

- ensure that the interests of service users are always the focus of their actions;
- understand each other's roles and responsibilities and ensure appropriate designation of tasks;
- share information and knowledge on a 'need-to-know' basis where this is in the interests of the service user;
- support each other to deliver the best possible care;

- monitor and audit their practice and are not afraid to challenge poor practice, without blaming individuals; and
- work together to learn lessons and change practice to improve the quality of service.

5. SERVICE USERS AND CARERS

Service users and carers have a number of vital roles in clinical governance.

There are effectively three aspects to service user involvement in clinical governance:

5.1 PATIENT FOCUS (SECTION 2.4)

- Being treated well in treatment.
- Being involved in the planning and delivery of their own treatment.

5.2 ACCESSIBLE AND RESPONSIVE CARE (SECTION 2.5)

- Being involved in the monitoring, development, design and planning of local services.

5.3 AS SERVICE PROVIDERS

Themselves, including peer support and advocacy.

- Rights and responsibilities – Roles in 5.1 and 5.2 are often combined and expressed in the rights of service users, but service users also have responsibilities, including observing service rules and keeping to the terms of their care or treatment plan. These responsibilities cannot be directly controlled, and performance cannot be managed by the service in the way that rights can, but paying attention to patient focus and providing accessible and responsive care may help service users meet their responsibilities. It is good practice for carers to be involved in the planning and delivery of an individual's treatment where the service user agrees, and in the design and planning of services more generally.

Annexures

ANNEXURE 1 – INCIDENT REPORT

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

INCIDENT REPORT

Incident Category:	**Safety**		**Health**		**Property Damage**		**Non-conformance**		**Equipment Reliability**		
Operation:	**COSUP**					**Date:**					
Location:						**Incident Number:**					
Type of Event:											
Consequence	**Actual**	**Minor**		**Moderate**		**High**		**Major**		**Extreme**	
	Potential	**Minor**		**Moderate**		**High**		**Major**		**Extreme**	
Brief Description of Incident:											
Immediate Remedial Actions:											

For Further Information	Name:	
	Email:	

COSUP

MEDICAL WASTE REMOVAL REQUEST

Medical Waste Removal Request (MWRR) for medical and pharmaceutical waste

Generator Details				Waste Management Details
Company Name	University of Pretoria	Account Number		
Contact Person		Department		
Cell Number		Campus, Building Name, Room No:		
Tel Number				
Fax Number				
Email Address				
*Booking can only be made once this form has been completed in full.				
Date booking made (Completed by Client):		Booking Reference number (Completed by booking clerk)		Service date: (Completed by booking clerk):

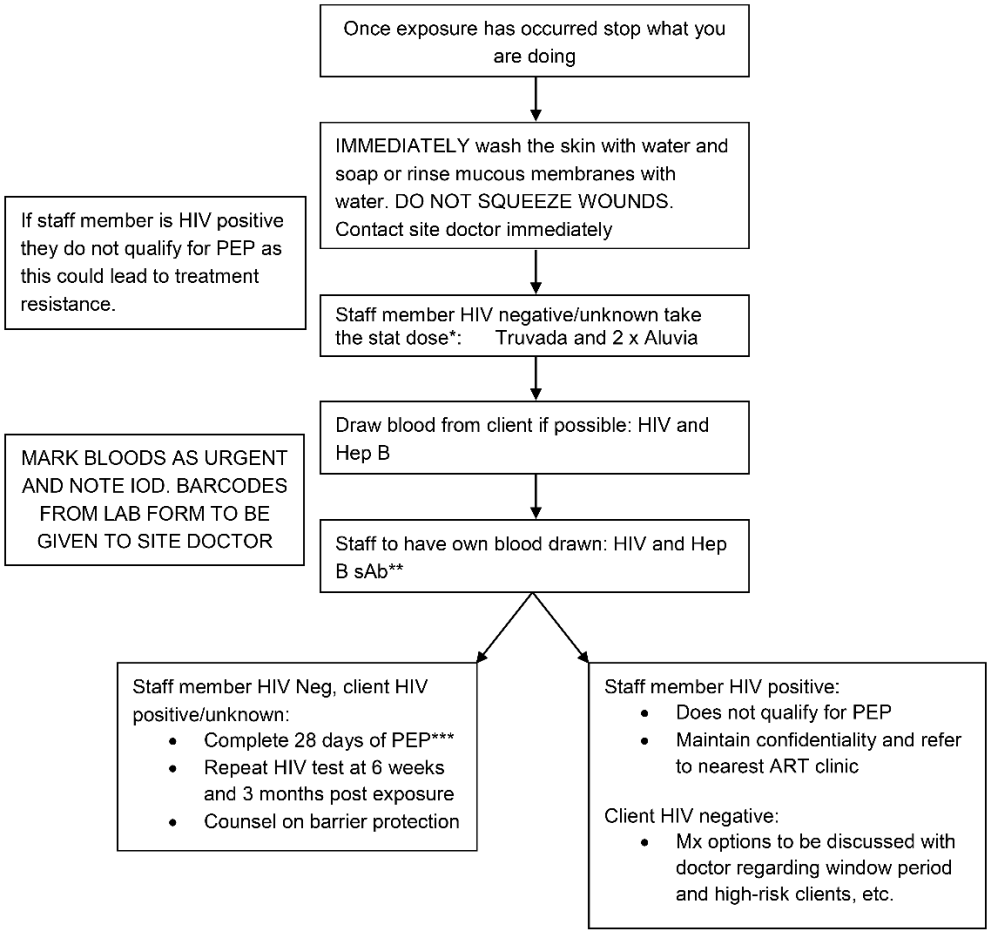
Item No.	Product Name, Container Capacity and Type	Number of Containers	PLEASE TICK ✓			Estimated Quantity
			EXCHANGE	REMOVE	PLACEMENT	

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

HIV EXPOSURE INCIDENT PROTOCOL



*STAT doses to be kept on site – can only be taken once doctor contacted.

**Bloods to be drawn at TDH (IOD and first medical report forms need to be taken to TDH in order to open a file and have bloods drawn). Northern Team to contact Dr Nzaumvila regarding blood tests (IOD and first medical report forms still needed in order to open a file and have bloods drawn).

***Prescriptions for continuation of PEP to be taken to Riviera Pharmacy. Please note UP personnel number on prescription. Prescription will be issued once HIV test confirmed negative.

All completed IOD forms to be taken to Mr Lesego Sehume to be forwarded to occupational health.

ANNEXURE 4 – OST CONSENT

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

OPOID SUBSTITUTION THERAPY (OST) AGREEMENT

This agreement has been prepared to both inform you about OST, as well as to document to the rules/obligations contained in this agreement.

Acknowledgement

I acknowledge that:

A. Methadone is an opioid (opioids are drugs like heroin, cocaine, morphine, pethidine, etc.), and that I may develop a physical dependence on this medication. Sudden decrease in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.
B. I am already physically dependent on at least one form of opioid and I'm unable to discontinue the use of opioids.
C. I have tried, to the best of my ability, other possible treatments for opioid dependence and these attempts have been unsuccessful.
D. Taking any mood-altering substance with methadone can be potentially dangerous. There have been reported deaths caused by the combination of methadone with alcohol, opioids, cocaine, barbiturates, and/or tranquilizers.
E. I may voluntarily withdraw from the OST programme at any time.
F. It is important to inform my physician/dentist who is prescribing an opioid, that I am taking methadone. I understand that a failure to do so is considered double doctoring, which is a criminal offence.
G. Regarding pregnancy, I understand that there can be effects on the developing foetus caused by methadone and that specialized care will be required to reduce any harm to my foetus if I am or become pregnant while on methadone.
H. It is unsafe to drive a motor vehicle or operate machinery during the stabilization period after starting methadone and during dose adjustments.
I. Poppy seeds and certain over-the-counter medication may result in a positive drug urine screen.
J. I have been informed that the most common side effects of methadone are sweating, constipation, decreased sexual function, drowsiness, increased weight, water retention and other side effects listed in the registered package insert.
K. Methadone treatment will be discontinued or tapered off if the physician/clinical associate determines that it has become medically unsuitable (i.e. the treatment is not effective or I develop a medical condition that could be made worse by methadone administration).

Behaviour while in our practice/site

I understand that the following behaviour is not acceptable in the clinic and may results in the termination of treatment:

A. Any violence or threatened violence directed towards the staff or other patients.
B. Disruptive behaviour in the clinic or the surrounding vicinity of the clinic.
C. Any illegal activity, which includes selling or distribution of any kind of illicit drug in the clinic or the surrounding vicinity of the clinic.
D. Any behaviour that disturbs the peace of the clinic or the surrounding vicinity of the clinic.

I agree to maintain positive, respectful behaviour towards other programme patients and staff at all times when in the clinic. Threats, racist or sexist remarks, physical violence, theft of property, vandalism or mischief, the possession of weapons, and selling or buying illicit substances while on clinic property are extremely serious programme violations and may result in the termination of my treatment.

Obligations of being on this programme:

A. I agree to take only one dose of methadone a day, and to have the ingestion of my dose witnessed on those days that I don't have carries (take home methadone).
B. It is important to inform any prescribing physician or dentist who may treat me for medical or psychiatric conditions that I am receiving methadone, in order that my treatment can be tailored to prevent potentially dangerous interactions with methadone. I will bring any prescriptions and/or methadone bottles that I receive from other doctors to my appointments.
C. I agree to provide a supervised urine sample for a drug screen when I receive a prescription for methadone.
D. Failure to provide a urine sample may result in my record being marked as a sample assumed to contain drugs and that this could reduce my level of carries.
E. I understand that tampering with my urine sample in any way is a serious violation of the programme and it may affect my future status in the programme.
F. I understand that counselling is highly recommended while I am in the programme.
G. I agree to keep all my appointments. Repeatedly missing appointments may result in the reduction of my carry status and could interfere with the doctor-patient relationship. The physician is not obligated to give a methadone prescription without an assessment.

I understand that I will not be given a dose of methadone if I:

A. Appear to be intoxicated or under the influence of some other substance. I may be asked to see a physician. For the sake of my own physical safety, I may be asked to wait before receiving my dose or refused a dose for that day.
B. Arrive late, after the clinic/pharmacy hours.
C. Exhibit threatening or disruptive behaviour towards any staff member or another patient.
D. Do not show proper identification before receiving methadone, if asked for identification.
E. Miss more than three doses of methadone in a row.

Regarding carries (take-home methadone doses):

A. Methadone is a potent medication. **A single dose taken by a person not used to taking opioids can be fatal, especially if taken by a child.** For this reason, I agree to store take-home dose(s) in a locked cupboard, in a location where it is unlikely to be stolen or accidentally taken by another person.
B. I agree that the number of carries I receive will be decided by the physician/clinical associate, with input from therapists, nurses and pharmacy staff, as I progress in my treatment.
C. I agree not to give, lend or sell my carries to anyone.
D. I agree that I will consume the methadone on the dates specified on the medication label and in the appropriate manner – that is, a full dose is taken within 24 hours.
E. I agree to return all empty methadone bottles on my appointment back at the site/clinic after receiving take-home dose(s)/carries.

Consents:

- I allow the methadone prescribing physician to speak to other doctors/clinical associates or healthcare professionals about my care.
- I allow the clinic's pharmacist and nursing staff to speak to pharmacists or other healthcare providers to verify my recent methadone dose(s), which I receive at another pharmacy or institution.

Confidentiality:

Everything that you tell the clinic staff is confidential, although it is important to realize that under exceptional circumstances we may be obliged to report something you tell us to the appropriate authority. This can occur under the following conditions:

- If we suspect that a child is at risk of emotional or physical harm or neglect, it is the law that we report this information.
- If you become suicidal, homicidal, or are unable to take care of yourself due to a psychiatric condition, you might be held against your will to be assessed by a psychiatrist.
- If you reveal to the staff that you intend to harm another person, we will be obliged to protect that person by notifying the appropriate authority.
- If a court subpoenas your chart, we must release it in accordance with the subpoena.
- If it is suspected that you are unable to drive an automobile due to a medical condition (which includes intoxication from alcohol or drugs), we are obliged to notify the SAPS of this.
- Certain infections must be reported to the local public health department, e.g. tuberculosis.

I agree to respect the confidentiality of other patients in the programme.

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that I may be asked to leave the OST programme. I have had an opportunity to discuss and review this agreement with my attending physician/clinical associate and my questions (if any) have been answered to my satisfaction.

_____	_____	_____
Date (dd/mm/yyyy)	Client's Name	Client's Signature
_____	_____	_____
Date (dd/mm/yyyy)	Staff's Name	Staff's Signature

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

APPENDIX 5: INFORMED CONSENT – IMPLEMENTING COMMUNITY ORIENTED SUBSTANCE USE PROGRAMME (COSUP)

EVALUATION CONSENT FORM

Title of Project: Implementing Community Oriented Substance Use Programme (COSUP)
The COSUP project and evaluation (study) has been described to me in a language that I understand. My questions about the project and the evaluation have been answered. I understand what my participation will involve and I agree to participate by my own choice and of my own free will.
I understand that my personal and contact details will only be used by the health workers providing COSUP and related services to me. I understand that information for the evaluation will not include my personal or contact details. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I provide consent for my data to be used.

Participant name: _____

Participant signature: _____

Participant Enrolment Code: _____

Date:

Staff member name: _____

Staff member signature: _____

Date:

ANNEXURE 6 – COUNSELLING INFORMED CONSENT

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

INFORMED CONSENT

COUNSELLING AGREEMENT FORM
As a Counselee, I understand the following:

1. The contact I have with the service provider is professional in nature.
2. In some cases, co-workers may see me.
3. All counselling is confidential. The confidentiality includes the supervisors of the service provider.
4. If a translator's services are required, he/she will also be bound by this confidentiality agreement.
5. The progress of the counselling process is determined NOT ONLY BY THE SERVICE PROVIDER, but depends on the co-operation and commitment of the counselee.
6. As counselee, I will endeavour to have realistic expectations of the tempo of progress and the end results of the counselling.
7. I will meet with the service provider for 6 sessions, usually for a period of 50 minutes, at a venue agreed upon by both parties.
8. After 6 sessions, we will reassess the situation. At that time, a new decision will be made concerning the course of action for me. This may include: referral to a professional counsellor, continuation of my counselling with the service provider or termination of the counselling sessions.
9. That the counselling process is a relationship between the service provider and counselee in a paraprofessional manner and cannot be seen as a process of giving legal advice. This paraprofessional is not a forensic practitioner. Counselling services will be free of charge.
10. Out of courtesy to my counsellor, I will give at least 24 hours prior notice of cancelling an appointment.

I have reviewed the above conditions with the counsellor and agree to abide by them.

COUNSELLEE NAME (PRINTED)	**DATE**
COUNSELLEE SIGNATURE	**IF UNDER 18, PARENT OR GUARDIAN SIGNATURE**
COUNSELLOR	**DATE**

I hereby grant permission for my counselling sessions to be recorded for supervisory purposes only.

COUNSELLOR	**DATE**

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

Confidentiality and privileged communication remain of all counselees. However, if it comes to light that an individual intends to take harmful, dangerous or criminal action against another human being, or oneself, it is the counsellor's duty to warn appropriate individuals of such intentions. Counsellors are mandated to report any 'reasonably suspected child abuse' (physical or sexual).

I have read the above and understand the counsellor's social and ethical responsibility to warn when harmful, dangerous or criminal action is strongly indicated. I further understand the counsellor's legal responsibility to notify the proper authorities in cases of 'reasonably suspected child abuse'.

COUNSELLEE NAME (PRINTED)

COUNSELLEE SIGNATURE **DATE**

CONSELLOR **DATE**

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

PERMISSION TO DISCUSSS SESSIONS

I, _____ (full names and surname), hereby give permission to _____ (counsellor name and surname) that the counselling sessions may be discussed during research or supervision sessions. I understand that the sessions will be held in the strictest of confidence and information will not be made known to any other person who is not directly involved in the research or supervision sessions.

Exceptions to the above are the following:

_____

_____ _____

Signature **Date**

TOESTEMMING OM BERADINGSESSIES TE BESPREEK

Ek, _____ (volle naam en van), gee hiermee toestemming aan _____ (berader naam en van) om die inhoud van die beradingsessies tydens navorsings- of supervisiesessies te bespreek. Ek verstaan dat die inhoud van die sessies as vertroulik hanteer sal word en dat die inligting aan geen persoon wat nie direk by die navorsings- of administrasiesessies betrokke is, bekend gemaak sal word nie.

Uitsonderings ten opsigte van die bogemelde is die volgende:

_____

_____ _____

Handtekening **Datum**

ANNEXURE 7 – LISA

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

COSUP/COPC LOCAL INSTITUTIONAL SUPPORT ASSESSMENT

We all want to live in a healthy community. We believe that it is possible if we work together with all the organisations that are active here as well as with the individuals and families we serve. Our vision is _____

I have come to find out more about your organisation and if you would be interested in working with us in Community Oriented Primary Care (COPC)/Community Oriented Substance Use Programme (COSUP). COPC is an approach that brings service providers and service users to work together, using the best available information and resources, for better health and wellbeing in the community.

I would like to ask you some questions about your organisation. The information you give me will be shared with other community partners. It may also be used for research purposes, although your organisation's name will only be mentioned in publications and reports with your permission.

1. Name of your organisation:	**9. Your organisation's sources of funding** (you can have more than one source): ☐ Government ☐ Private company/ies ☐ Donor/s (local) ☐ Donor/s (international) ☐ Community ☐ Self-funding ☐ Charity ☐ Personal out of own pocket
2. Physical address:	
3. Person in charge:	
4. Contact number/s:	
5. Email address/web address:	**10. Name of funder/s:** (1) (2) (3)
6. Date of establishment:	
7. Registration number:	**11. Who are your main partners** (people/ organisations you actively work with): (1) Name of organisation Name of contact person Contact number (2) Name of organisation Name of contact person Contact number
8. Type of organisation: ☐ Government National ☐ Government Provincial ☐ Government Local ☐ Private ☐ Not for profit NGO ☐ Community based organisation ☐ Faith based organisation	

(3) Name of organisation Name of contact person Contact number	**(2) Lifestyle Support** ☐ Aftercare/education ☐ Violence and abuse ☐ Substance/alcohol abuse ☐ Water/sanitation ☐ Sports/dance/recreation ☐ Infection and hazard prevention ☐ Family health promotion & education ☐ Teen pregnancy ☐ Family planning/safe sex ☐ Food and diet ☐ Other _____
12. Number of people working in your organisation (located in or working in this community/my sector of the community): Full time: Part time: Volunteers:	
13. Main purpose of your organisation:	
14. Target population for your services: Who Where How many currently supported _____ individuals/families daily/weekly/monthly	**(3) Access to Care** ☐ Grant support ☐ Child headed households ☐ Oral and dental care ☐ Immunization ☐ Mental/physical disability ☐ Home based care ☐ Health/disability support groups ☐ Other _____
15. Do you provide any of these services? **(1) Prevention and Treatment Support** ☐ TB ☐ HIV/AIDS ☐ Pre/postnatal care ☐ Heart/stroke ☐ Diabetes ☐ Infant feeding/child nutrition ☐ Physical disability ☐ Mental disability ☐ Other _____	**16. Can we contact you in the near future to plan a shared approach to community health?** ☐ Yes ☐ No

STANDARD OPERATIONAL PROCEDURE – OPIOID SUBSTITUTION THERAPY (OST)

1. INTRODUCTION

This document is to ensure that the correct procedure is followed when assessing and managing clients who are using Opioid Substitution Therapy (OST) within the COSUP programme. It also outlines the regulations that follow with regards to OST which is a Schedule 6 medication. This SOP follows on the general SOP for COSUP. It seeks to establish consistency in approach, whilst acknowledging jurisdictional responsibility for health care and legislative requirements relating to controlled substances.

This document is intended for managers and clinical leaders responsible for the organization of specific health care services at each site and all health care workers managing clients at COSUP sites.

OST is the medical procedure of replacing an illegal opioid drug such as heroin with a longer acting but less euphoric opioid, usually **methadone** or **buprenorphine**, taken under medical supervision. The driving principle behind OST is that an opiate-dependent person will be more likely to regain a normal life and schedule while being treated with a substance that stops him/her from experiencing withdrawal symptoms and drug cravings but doesn't provide strong euphoria.

2. COMPLIANCE ON MEDICATION

The following are notes and commentary on compliance of regulations as pertaining to Schedule 6 medications, specifically methadone and buprenorphine.

2.1 GENERAL

Methadone and buprenorphine are Schedule 6 medications.

- The prescription can only be for 30 days, maximum, with no repeats.
- The prescription is valid for a period of 30 days.
- The dispensing pharmacist or doctor with dispensing licence must keep a Schedule 6 Register (see Section 3.6 on OST Supplier).

Licensed medications are:

- Equity methadone in 60ml and 500ml at 2mg/ml in liquid form.
- Suboxone and Subutex in 2mg and 8mg sublingual tablets.

Neither product is on the EDL for maintenance purposes.

- They cannot be used for longer than 14 days in a state hospital.
- This does not apply to private practice, where they can both be prescribed for maintenance, in accordance with Schedule 6 Regulations.

Any medical doctor can prescribe methadone and buprenorphine. There are no legal requirements describing supervised dosing or consumption.

2.2 METHADONE AND BUPRENORPHINE IN THE PUBLIC SECTOR

- Inpatient:
  - Doctor may prescribe and state pharmacist may dispense for short-term detoxification (as in Stikland Hospital's Opioid Detoxification Unit).
    - This is widely recognised as sub-optimal.
    - Detox can increase risk of overdose post-detox.

- Outpatient:
  - Doctor may prescribe for maintenance.
  - Patient can fill prescription at local pharmacy at own cost.

- Medications can be bought by other parties and supplied for maintenance purposes.

2.3 METHADONE AND BUPRENORPHINE IN THE PRIVATE SECTOR

- Doctor consults with and assesses a patient.
- Doctor then writes script for Methadone or Buprenorphine:
  - Can be for up to 30 days.
  - Guidelines suggest supervised initiation dose.
  - In reality, the initial dose is seldom supervised.
- Patient goes to pharmacy.
- Methadone is dispensed by pharmacy according to script.
  - Methadone is dispensed.
  - Labelled as per regulations.
  - Pharmacy keeps Schedule 6 Register.
- At this stage patient can take the methadone home.

3. COSUP PROCESSES

- COSUP COULD LEGALLY, ACCORDING TO REGULATIONS:
  - Give the prescription to the client.
  - Client goes to pharmacy and fills script.
  - Client takes home a 30-day supply.
  - Client returns 30 days later to COSUP for check-in and new script.

- COSUP PREFERS TO FOLLOW A MORE CONSERVATIVE APPROACH:
  - Each client undergoes a thorough evaluation by trained members of the staff.

- Each client is seen by a social worker, clinical associate and a doctor.
- Once the decision to begin OST is jointly made, the following processes are followed:

3.1 INITIATION OF CLIENTS ON OST

Please refer to COSUP general SOP (COSUP_SOP001_TSHWANE COSUP) for procedures. Initiation on OST will follow after all initial evaluations have taken place and a joint decision between the client and clinician has been made to initiate OST.

- The client needs to sign an OST consent form after discussing and understanding the form in detail (ANNEXURE 1 – OST Consent).
- An OST readiness form needs to be completed. This form acts as a control measure and check-list to ensure that clients are fit to be started on treatment (ANNEXURE 2 – OST Readiness).
- A COSUP approved qualified medical doctor will medically evaluate if the client is fit for OST.
- A prescription is then written by the abovementioned doctor if the client is medically fit.
- If the client/family is able to afford the OST, the prescription is given to a responsible family member where possible.
- The client/family brings the medication back to the site for safe-keeping and directly observed treatment (DOT).
- If the client cannot afford OST, motivation for funding is requested after a social and financial evaluation is conducted by the team.
- Clients are advised not to use opioids for at least 12 hours before initiation and the dangers of using OST and opioids together are emphasized.
- Clients are evaluated for signs of intoxication before the first dose is given to reduce the incidence of overdose.
- The dosage and tapering up of medication depends on which medication is used.

3.2 METHADONE

- The initial dose should be 10–30 mg methadone per day for the first three days.[1]
- The principle is: start low, go slow, aim high.[1]

- The standard initial dose is 20 mg (10 ml) once daily.[1] The initial dose can be increased upon clinical judgment by the prescribing doctor. Higher initiation doses are usually limited to those who inject large amounts of heroin daily.
- The client comes in daily for DOT and review of symptoms.
- Clinical criteria for dosage increases: The physician will consider increasing the patient's methadone dose if the patient experiences withdrawal or cravings. Persistent opioid cravings or opioid use may indicate the need for a dose increase, even in the absence of reported withdrawal symptoms.[1]
- Doses should not be increased by more than 5–10 mg every three to four days.
- For most patients, the optimal dose is between 50 and 120 mg.[1]
- Drug craving alone is not an adequate reason to increase the dose above 120 mg. The physician should consider requesting a second opinion if the patient continues to request additional dose increases above 120 mg.[1]

3.3 BUPRENORPHINE (SUBOXONE)[2]

- Titrated to clinical effect.
- Administer at least 12–24 hours after last opioid use and/or observed withdrawal symptoms.
- Initiate at 2–4 mg.
- The principle is: start low, go fast, aim high.
- Increase every two hours by 2 mg (under supervision).
- Up to 8 mg MAX on Day 1, up to 16 mg MAX on Day 2.
- To reach dose of 12–24 mg at the end of Week 1.
- Maximum dose: 32 mg (hardly ever reached).
- Monitor daily if possible, at least three times per week.

3.4 MAINTENACE ON OST

Once clients are initiated on treatment they should be monitored daily (where possible) for at least the first two weeks. This will give clinicians an indication of how well the medication is working and whether a dosage adjustment is needed. The maintenance is determined on an individual basis.

3.5 ORDERING OF OST

Clients/family who are self-funded will receive a prescription for purchasing OST.

- Prescription is taken to pharmacy. As far as is possible the prescription is given to a responsible family member to obtain the medication
- Methadone is dispensed, labelled as per regulations and pharmacy keeps a Schedule 6 Register.
- Pharmacist supplies 30 days of methadone.
- Legally the methadone is now dispensed.
- ALL OBLIGATIONS UNDER LAW & REGULATIONS ARE NOW ENDED.
- Labelled unopened methadone gets taken back to the site.

Clients who cannot afford OST:

- The clinical associate/social worker treating the client will complete a form 'MOTIVATION FOR FUNDED OST' (ANNEXURE 3).
- This form is reviewed by the medical doctor on site and then sent to a COSUP approved staff member (medical professional) for approval.
- If the motivation for funding is approved, a prescription is then sent to the approver, who then forwards the prescription to the OST supplier.
- The medication is then either delivered to the site and the original prescription collected or the clinical associate takes the original script to the OST supplier and collects the medication.
- The OST supplier has an approved list of staff members who they may dispense the OST to.
- Methadone is dispensed, labelled as per regulations and the pharmacy keeps a Schedule 6 Register.
- Pharmacist supplies 30 days of methadone.
- Legally the methadone is now dispensed.
- ALL OBLIGATIONS UNDER LAW & REGULATIONS ARE NOW ENDED.

Once the medication is received, the clients are assigned an OST monitoring form (ANNEXURE 4) where all usage of the OST is documented.

3.6 OST SUPPLIER

- Pharmacy/pharmacist that is registered to dispense OST.
- The OST suppliers used for the purposes of this project are: PharmaValu (Sunnyside); Riviera Pharmacy, Medirite Shoprite (Atteridgeville) and Dischem (Soshanguve). These are all registered pharmacies and are licensed to supply OST. The project may also approach other pharmacies to assist with supply of OST. This will be related to cost of OST as well as geographical location.
- The OST supplier keeps the Schedule 6 Register and enters all OST dispensed.

3.7 STORAGE OF OST

- In order to limit the quantity of unmonitored methadone in the public domain, Schedule 6 medication for OST (self-funded and COSUP funded) is stored by the project on behalf of the patient once dispensed by the pharmacy until it is confirmed that take-home doses are appropriate.
- Control of Schedule 6 medicines or substances are of such nature that only persons authorised in terms of the Medicine Act (section 22A) have access to these substances.
- CONTROL OF SCHEDULE 6 MEDICINES OR SUBSTANCES[3]

  a) Schedule 6 medicines or substances must be stored in designated places under lock and key at all times.
    - All OST is kept locked safely in cupboards/cabinets.

  b) The key must be in personal possession of an authorised person responsible for the control of Schedule 6 medicines or substances.
    - Only authorised staff members have access the keys to where the OST is stored.

  c) A register of Schedule 6 medicines or substances must be kept and shall be balanced so as to show clearly the quantity of every Schedule 6 medicine or substance remaining in stock as on the last day of March, June, September and December of each year and such balancing shall be completed within 14 days following each said dates.
    - The register is kept by the OST supplier.
- At sites where storage is not possible, medication will be kept at the pharmacy supplying the medication.

3.8 DOT, DECANTING AND MONITORING

- DOT – Directly observed treatment is the procedure used (where possible) to administer and monitor clients on treatment. Ideally, the client will come in daily (or as frequently as possible) and they will be given a daily dose by a trained staff member.

As the medication has already been dispensed by the pharmacy to a named individual, DOT cannot be considered as dispensing.

- DOT is monitored on the OST Monitoring Form (ANNEXURE 4). The daily dose is documented.
- Decanting is the process whereby a specific quantity of medicine (OST) is transferred into another container to be used for a specified period of time. This is done over weekends/public holidays and when clients cannot come in to DOT. The amount that is decanted is also documented on the OST monitoring form. Clients/family members are given a home chart where they document their doses.
- Both DOT and decanting are to be strictly done from the medicine container or blister pack that has been prescribed specifically for that client. (See Section 3.10 on Emergency OST for exception.)

3.9 MANAGEMENT OF UNUSED OST

If clients have defaulted their treatment and have not been on treatment for more than one month, the following should be done:

- All unused leftover medication must be returned to the University of Pretoria, Department of Family Medicine.
- Unused medication is to be returned to the pharmacy for adequate discarding.

3.10 EMERGENCY OST

In the event of an emergency, the situation will BE managed on a case by case basis. A request for emergency OST can be made and approved by the clinical/project manager.

4. REFERENCES

1. Equity Methadone Make the Choice. Pretoria: Equity Pharmaceuticals; 2009.
2. Warren NJ. Suboxone [package insert]. Reckitt Benckiser Pharmaceuticals Inc; 2010.
3. Office of the Registrar, ed. Good Pharmacy Practice of South Africa. 4th ed. Arcadia: The South African Pharmacy Council; 2010.

Annexures

ANNEXURE 1 – OST CONSENT

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

OPOID SUBSTITUTION THERAPY (OST) AGREEMENT

This agreement has been prepared to both inform you about OST, as well as to document to the rules/obligations contained in this agreement.

Acknowledgement

I acknowledge that:

A. Methadone is an opioid (opioids are drugs like heroin, cocaine, morphine, pethidine, etc.), and that I may develop a physical dependence on this medication. Sudden decrease in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.
B. I am already physically dependent on at least one form of opioid and I'm unable to discontinue the use of opioids.
C. I have tried, to the best of my ability, other possible treatments for opioid dependence and these attempts have been unsuccessful.
D. Taking any mood-altering substance with methadone can be potentially dangerous. There have been reported deaths caused by the combination of methadone with alcohol, opioids, cocaine, barbiturates, and/or tranquilizers.
E. I may voluntarily withdraw from the OST programme at any time.
F. It is important to inform my physician/dentist who is prescribing an opioid, that I am taking methadone. I understand that a failure to do so is considered double doctoring, which is a criminal offence.
G. Regarding pregnancy, I understand that there can be effects on the developing foetus caused by methadone and that specialized care will be required to reduce any harm to my foetus if I am or become pregnant while on methadone.
H. It is unsafe to drive a motor vehicle or operate machinery during the stabilization period after starting methadone and during dose adjustments.
I. Poppy seeds and certain over-the-counter medication may result in a positive drug urine screen.
J. I have been informed that the most common side effects of methadone are sweating, constipation, decreased sexual function, drowsiness, increased weight, water retention and other side effects listed in the registered package insert.
K. Methadone treatment will be discontinued or tapered off if the physician/clinical associate determines that it has become medically unsuitable (i.e. the treatment is not effective or I develop a medical condition that could be made worse by methadone administration).

Behaviour while in our practice/site

I understand that the following behaviour is not acceptable in the clinic and may results in the termination of treatment:

A. Any violence or threatened violence directed towards the staff or other patients.
B. Disruptive behaviour in the clinic or the surrounding vicinity of the clinic.
C. Any illegal activity, which includes selling or distribution of any kind of illicit drug in the clinic or the surrounding vicinity of the clinic.
D. Any behaviour that disturbs the peace of the clinic or the surrounding vicinity of the clinic.

I agree to maintain positive, respectful behaviour towards other programme patients and staff at all times when in the clinic. Threats, racist or sexist remarks, physical violence, theft of property, vandalism or mischief, the possession of weapons, and selling or buying illicit substances while on clinic property are extremely serious programme violations and may result in the termination of my treatment.

Obligations of being on this programme:

A. I agree to take only one dose of methadone a day, and to have the ingestion of my dose witnessed on those days that I don't have carries (take home methadone).
B. It is important to inform any prescribing physician or dentist who may treat me for medical or psychiatric conditions that I am receiving methadone, in order that my treatment can be tailored to prevent potentially dangerous interactions with methadone. I will bring any prescriptions and/or methadone bottles that I receive from other doctors to my appointments.
C. I agree to provide a supervised urine sample for a drug screen when I receive a prescription for methadone.
D. Failure to provide a urine sample may result in my record being marked as a sample assumed to contain drugs and that this could reduce my level of carries.
E. I understand that tampering with my urine sample in any way is a serious violation of the programme and it may affect my future status in the programme.
F. I understand that counselling is highly recommended while I am in the programme.
G. I agree to keep all my appointments. Repeatedly missing appointments may result in the reduction of my carry status and could interfere with the doctor-patient relationship. The physician is not obligated to give a methadone prescription without an assessment.

I understand that I will not be given a dose of methadone if I:

A. Appear to be intoxicated or under the influence of some other substance. I may be asked to see a physician. For the sake of my own physical safety, I may be asked to wait before receiving my dose or refused a dose for that day.
B. Arrive late, after the clinic/pharmacy hours.
C. Exhibit threatening or disruptive behaviour towards any staff member or another patient.
D. Do not show proper identification before receiving methadone, if asked for identification.
E. Miss more than three doses of methadone in a row.

Regarding carries (take-home methadone doses):

A. Methadone is a potent medication. **A single dose taken by a person not used to taking opioids can be fatal, especially if taken by a child.** For this reason, I agree to store take-home dose(s) in a locked cupboard, in a location where it is unlikely to be stolen or accidentally taken by another person.
B. I agree that the number of carries I receive will be decided by the physician/clinical associate, with input from therapists, nurses and pharmacy staff, as I progress in my treatment.
C. I agree not to give, lend or sell my carries to anyone.
D. I agree that I will consume the methadone on the dates specified on the medication label and in the appropriate manner – that is, a full dose is taken within 24 hours.
E. I agree to return all empty methadone bottles on my appointment back at the site/clinic after receiving take-home dose(s)/carries.

Consents:

- I allow the methadone prescribing physician to speak to other doctors/clinical associates or healthcare professionals about my care.
- I allow the clinic's pharmacist and nursing staff to speak to pharmacists or other healthcare providers to verify my recent methadone dose(s), which I receive at another pharmacy or institution.

Confidentiality:

Everything that you tell the clinic staff is confidential, although it is important to realize that under exceptional circumstances we may be obliged to report something you tell us to the appropriate authority. This can occur under the following conditions:

- If we suspect that a child is at risk of emotional or physical harm or neglect, it is the law that we report this information.
- If you become suicidal, homicidal, or are unable to take care of yourself due to a psychiatric condition, you might be held against your will to be assessed by a psychiatrist.
- If you reveal to the staff that you intend to harm another person, we will be obliged to protect that person by notifying the appropriate authority.
- If a court subpoenas your chart, we must release it in accordance with the subpoena.
- If it is suspected that you are unable to drive an automobile due to a medical condition (which includes intoxication from alcohol or drugs), we are obliged to notify the SAPS of this.
- Certain infections must be reported to the local public health department, e.g. tuberculosis.

I agree to respect the confidentiality of other patients in the programme.

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that I may be asked to leave the OST programme. I have had an opportunity to discuss and review this agreement with my attending physician/clinical associate and my questions (if any) have been answered to my satisfaction.

Date (dd/mm/yyyy)	Client's Name	Client's Signature
Date (dd/mm/yyyy)	Staff's Name	Staff's Signature

ANNEXURE 2 – OST READINESS

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

OST READINESS

Date:	Site:
Client Name:	COPC number:

Please answer the following questions about the client:

			Comments
> 12 months of heroin/nyaope use or <12 months but high risk	Yes	No	
High-Risk opioid use (≥ 27) on the ASSIST 3.0	Yes	No	
Understands project procedures and protocols	Yes	No	
Agrees to be contacted for follow-up	Yes	No	
Provided informed consent	Yes	No	
Able to attend site daily during initiation phase	Yes	No	
Has resided in the City of Tshwane for at least 12 months	Yes	No	
History of heart disease	Yes	No	
Acute alcohol use disorder	Yes	No	
Acute benzodiazepine use disorder	Yes	No	
Clinical diagnosis of schizophrenia or any other psychotic disorder	Yes	No	
History of respiratory depression or other chronic respiratory condition	Yes	No	
Severe liver impairment	Yes	No	
Severe head trauma or any other condition that causes increased intracranial pressure	Yes	No	
HIV/TB Screening done?	Yes	No	
Client on treatment for HIV/TB?	Yes	No	
Other Contra-indications to OST	Yes	No	

Have the following been completed:

Task			Comment
ASSIST	Yes	No	
Consent forms	Yes	No	
Admission booklet	Yes	No	
Medical evaluation	Yes	No	
Individual development plan	Yes	No	
Psychosocial evaluation	Yes	No	

Client Ready for OST?

Yes	No	Postpone

OST selected:

Methadone	Suboxone

Completed by:

_____ (Name and Qualification)

_____ (Signature)

ANNEXURE 3 – MOTIVATION FOR FUNDED OST

COSUP

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CITY OF TSHWANE
IGNITING EXCELLENCE

MOTIVATION FOR COSUP FUNDED OST (FIRST REPORT)

Date:	Site:
Client Name:	COPC Number:
Date of Birth:	COSUP Enrolment date:
Address:	ASSIST Score:
Contact Number:	Number of visits:

History: (include previous rehabs, use of OST and interventions at COSUP)

Medical history and current medication:

Socio-economic history: (employment, education, finances, family support)

Reasons for sponsorship:

Compiled by:

_____ (Name and qualification)

_____ (Signature)

Approved:	Yes	No
Name and Qualification:		
Signature:		
Date:		

FUNDING TYPE: SELF ☐ / COSUP ☐ **MONITORING DONE AT: SITE ☐ / HOME ☐**

COSUP	OPOID SUBSTITUTION THERAPY MONITORING FORM	Name and Surname:

SITE: _____

OST DRUG: _____ **QUAINTITY:** _____ **DURATION:** _____

INITIATION DATE: ____/____/____ **INITIATION DOSE:** _____ **MAINTENANCE DOSE:** _____

WEEKS	MON	TUE	WED	THU	FRI	SAT	SUN	Who administered the dose	Week's comments (initial dose/dose adjustment/decanted dose)
/ /20_ _									
/ /20_ _									
/ /20_ _									
/ /20_ _									
/ /20_ _									
/ /20_ _									
/ /20_ _									
/ /20_ _									

- Indicate in the blocks the dose and mark with a tick (✓) if the client has received the prescribed dose or a cross (x) if dose missed.
- Put the date of the Monday of that week.

SITE ESTABLISHMENT:

Norms and Standards for establishing a community oriented substance use programme site.

Version 1.0

The ideal site

The ideal COSUP site is not something that can be described by a set of uniform interventions delivered by a consistent set of resources. Rather, the development of a COSUP site is guided by a set of proven principles that are applied so as to determine the priorities of each community according to their context. In order to guide the process and ensure alignment with the underlying theoretical and philosophical approach this document describes the principles that inform the COSUP approach and provides a menu of appropriate resources, effective interventions and a set of processes that are drawn from when establishing and developing a COSUP site.

AIM

The aim of COSUP is to minimise the health, social and economic impacts of substance use through the prevention, identification and resolution of substance use disorders in the City of Tshwane using a community oriented primary care (COPC) approach. Therefore, an ideal COSUP site is able to deliver appropriate, effective community based support for people who use drugs and their families.

PRIORITIES

The priorities, across the domains of substance use; community health, wellbeing and integration; education training and skills; and monitoring and research are:

1. **Substance use**
   - 1.1. To immediately address the life-threatening harms related to the use of drugs in the community.
   - 1.2. To address the health and medical needs of the PWUD community.
   - 1.3. To provide services and support to people who use drugs and their families to empower them to make conscious informed choices about their drug use and changes they want to make.
   - 1.4. To create an environment and ensure the availability of services that support people who use drugs and their families until such time as they are able to maintain their goals in respect of drug use.
   - 1.5. To prevent the transition from less to more harmful ways of using drugs and assist in the transition from more to less harmful ways and patterns of using drugs.
   - 1.6. To create an environment in the community that reduces the levels of substance use and the development of substance use disorders.
2. **Community health, wellbeing and integration**
   - 2.1. To ensure that the continuum of substance use is addressed using appropriate, informed and effective screening and interventions at all levels of the health services.
   - 2.2. To be accepted, trusted and supported by the local community, its leaders and structures, and to establish an effective means of engagement with communities.
   - 2.3. To empower communities, their leaders, service providers, the families and individuals, including people who use drugs, to play an active role in reducing the

negative impacts of the use of drugs and respond to the use of drugs in an appropriate and effective manner that does not increase drug-related harms.

2.4. To develop the skills of people who use drugs so that they are better able to cope with being dependent on drugs and so they are better equipped to contribute to their community and become self-sustaining.

3. Education, skills and training

3.1. To ensure that all services are delivered according to the principles and objectives of the programme.

3.2. To ensure that all levels of COSUP staff are able to transfer knowledge to appropriate outside stakeholders including service providers, service users and other community members.

3.3. To develop a self-sustaining body of information within the community through the empowerment of community-based and -led service providers, community leaders, religious and educational institutions, LDACS and other political and community structures.

4. Research, monitoring, and programme improvement

4.1. Ensure that implementation processes and services meet research standards in respect of document control, data collection and integrity without compromising the quality of care.

4.2. To ensure that the processes are informed by an action research approach to programme improvement using the stages: plan, act, observe and reflect.

4.3. To combine the processes of monitoring and improvement using a peer-review process that is operationalised.

4.4. To record and report on all aspects of the programme and its development from the start so as to 'make evidence' and develop a model that can be applied in multiple settings.

4.5. To create a body of evidence through the publishing of peer-reviewed articles and other appropriate channels.

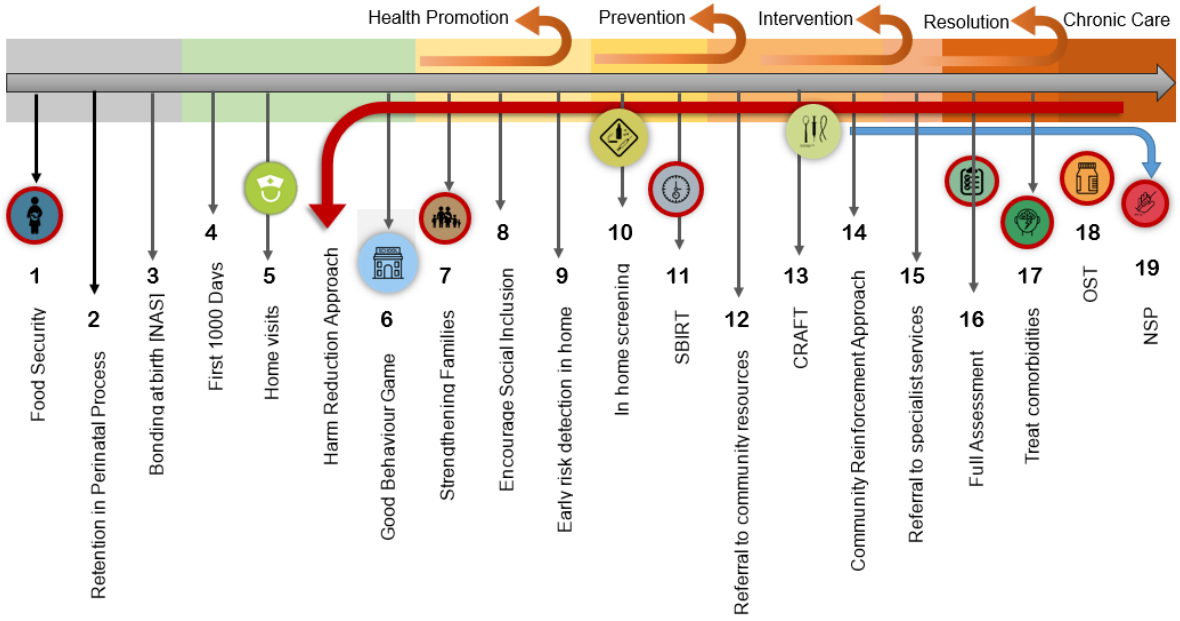


Figure 2: COSUP sites should aim for a continuum of care by filling gas and coordinating resources in the community

COSUP sites

HUMAN RESOURCES

COSUP makes use of multi-disciplinary teams. The programme is different in that it relies on active peer involvement as a means of being able to relate to and integrate with the community. It is a community and, specifically, peer informed clinician facilitated approach.

Staff at each site, depending on type and need, would be drawn from: peers, lay-counsellors, social and auxiliary social workers, psychologists, social workers, clinical associates, doctors, administrative assistants, specialist trainers and general workers.

SITE SERVICES

1. Community services
    1.1. Peer outreach
    1.2. Community engagement
    1.3. Training and education
    1.4. LDAC and other support
    1.5. Activities such as soccer, vegetable garden, social activities
2. Outreach services
    2.1. Needle services
    2.2. In-field wound care
    2.3. Behavioural interventions
    2.4. HCT
    2.5. Screening
    2.6. Brief interventions
    2.7. Harm reduction packs
    2.8. Hygiene packs
3. Site based clinical services
    3.1. Screening
    3.2. Assessment
    3.3. Brief interventions
    3.4. OST
    3.5. General health services
    3.6. HCT
    3.7. Reproductive health
    3.8. Wound care
    3.9. Psychosocial services
4. Psychosocial services
    4.1. Counselling
    4.2. Statutory social services
    4.3. Psychological interventions
    4.4. Peer facilitated groups
    4.5. Skills development
    4.6. Vocational training

DELIVERY OF SERVICES

There are a number of ways in which COSUP can address the priorities and achieve the objectives of the city. COSUP can be present in a number of ways:

Stand-alone full service

A standalone site provides services for people who use drugs in a community independently of the health services. A COSUP site is, however, integrated into the community structures and could be situated in a community centre, municipal building or a Wendy house on the grounds of a clinic. It could be in a clinic itself but provides services independently of the ward based outreach teams and is not integrated into the public health services and clinics with separation of duties, infrastructure and staff resources.

Role and services:

A full-service site will offer the majority of available COSUP services as is relevant to the context. In addition, the site would offer a potential base for satellite sites, provide a point from which community initiatives are run and provide a base for staff. Full clinical services operate from the site, including OST, needle and syringe services, and other health and medical services.

Resource requirements

- Secure space with security
- Clinical rooms and equipment
- Appropriate waiting spaces and reception
- Storage for medications and equipment
- Administrative infrastructure
    - IT equipment
    - Stationary and filing
    - Telephones
    - Furniture

Minimum staff

This would require a minimum of:
2 x peer
1 x clinical associate
1 x nurse
1 x social worker
0.5 x doctor
1 x reception and administrator

Integrated full-service site

An integrated site is a full-service site that is integrated into the community oriented primary care infrastructure and relies on WBOTs and their community health workers (CHWs) to collect information and deliver interventions in the community. They would be supported by peers.

Satellite site

A satellite site is a less-resourced site that may be used only on certain days or have limited operating hours. It can be located in any community building or clinic, and does not need the same resources as the full-service site. Satellite sites may be used for group sessions, wound care, clinics, counselling and DOTS.

Staff are likely to be made up of staff based at full-service sites and peers from the community.

WBOT driven service-only

Where there is a strong COPC system, services will be driven by the CHWs even if there is no full-service site in the community. CHWs will work with peers to conduct screening, brief interventions and referral to treatment as well as supply harm reduction commodities and provide information on effective ways of dealing with substance use.

Peer driven service-only

This is when there are critical harm reduction needs in a community. Peers will provide services on foot from within the community without any dedicated real estate to work from. They will conduct outreach and provide behavioural change interventions and psychosocial services in situ.

THE COSUP ENABLED COMMUNITY

The end goal is a COSUP enabled community. This does not need a dedicated COSUP presence because the COSUP approach and the harm reduction principles and philosophy have become part of the fabric of the community and the services that exist in the community. Peer facilitated groups are available; local NGOs are providing a wide range of inclusive activities for PWUD; the COPC model has integrated substance use interventions into the standard level of care; and clinics are welcoming, non-stigmatising service providers. The principles of high tech and high touch are operational; the data is analysed and substance use trends inform interventions. New 'epidemics' are identified and interventions are adapted accordingly.

The role of COSUP is not to provide sites and services in the community permanently, but to:

1. Train all people who come into contact with people who use drugs using a cascade model of training.
2. Monitor and add to service provider skills through peer review processes.
3. Collect and manage data and review outcomes and gaps that need attention.
4. Coordinate services and peer activities.
5. Facilitate communication, integration and coordinate community organisations and service providers.

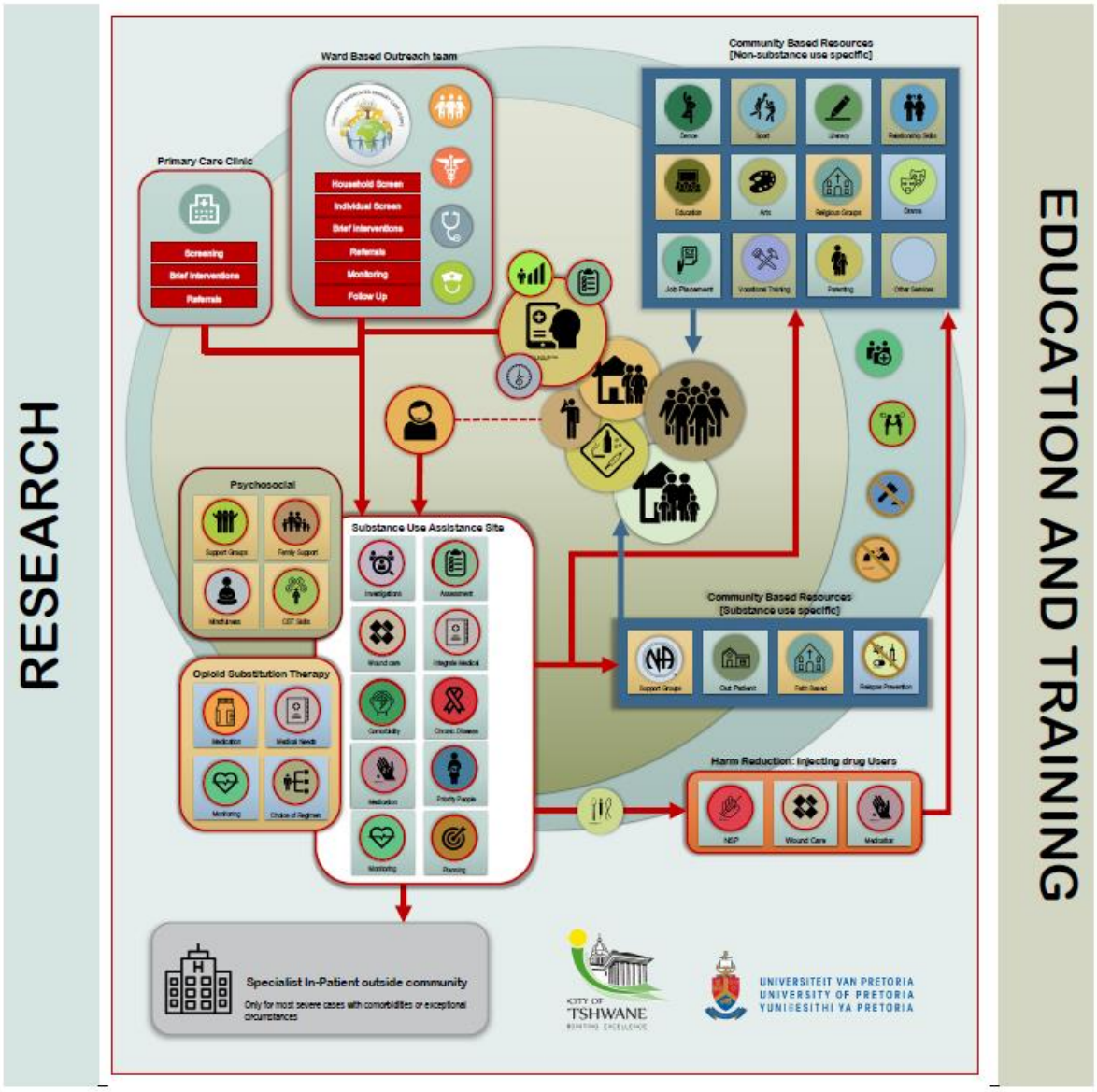


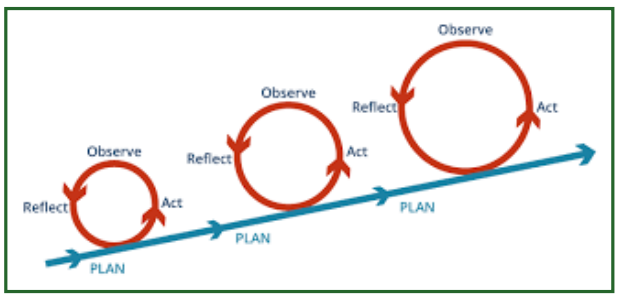
Figure 3: A representation of COSUP in a community with full services and COPC integration

Site development process

In order to establish a site, a number of activities need to happen, often simultaneously:

1. COMMUNITY
   1.1. Appoint and consult peers
   1.2. LISA Process
   1.3. Contact LDACS
   1.4. Establish CAGS – PWUD, community members, etc.
   1.5. CHW and WBOTs collect data using AitaHealth and do household screening to determine nature and extent of drug use in the community
   1.6. This informs a situational analysis

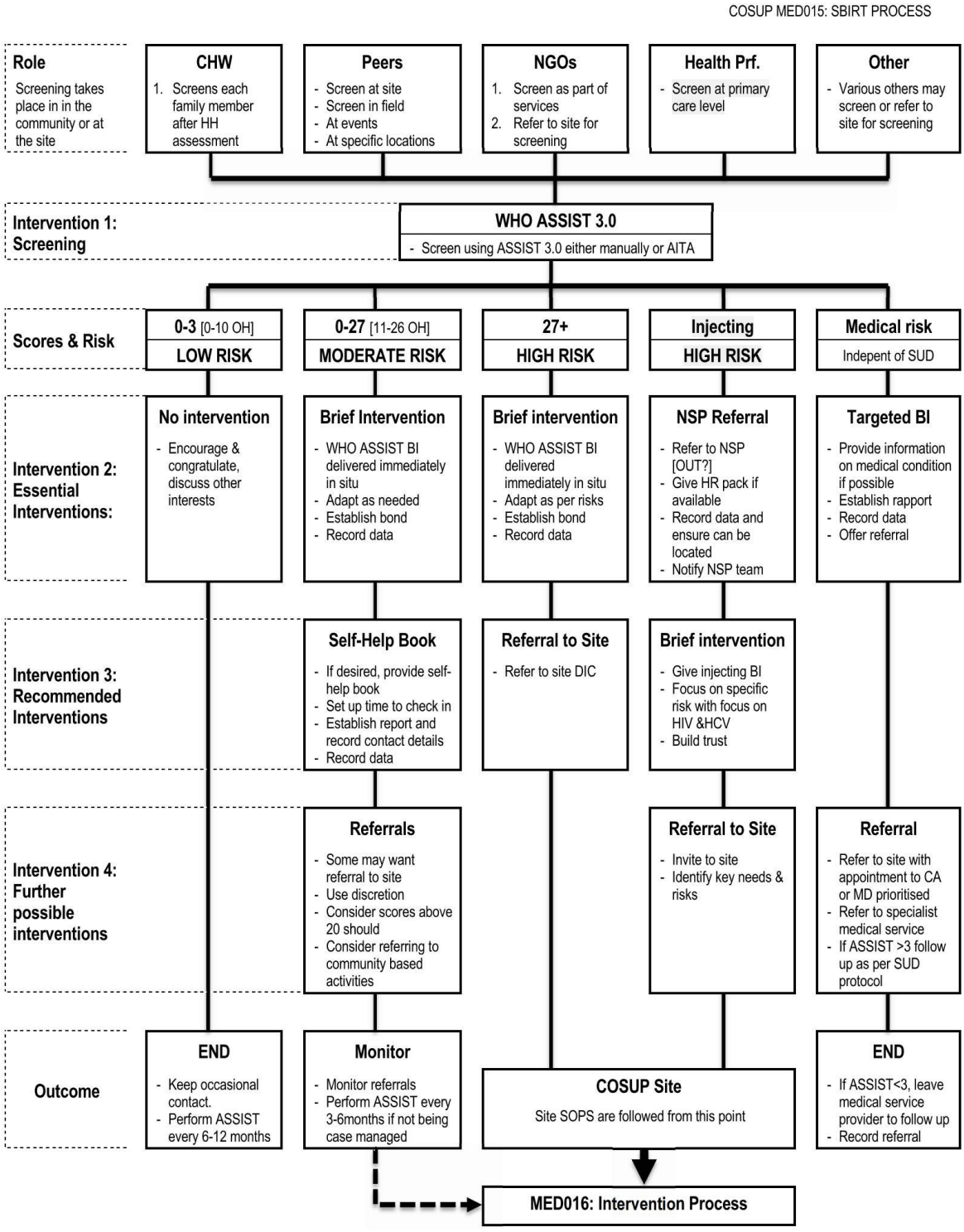
2. HEALTH
    2.1. Establish links with WBOTS, clinics, CHWs
    2.2. Determine priority needs based on drugs used and means of use
3. MAPPING
    3.1. Collate all information about community
    3.2. Map resources and determine gaps and priorities
4. STAFF
    4.1. Appoint all clinical and management staff
    4.2. Staff meet with peers, local health structures, community services to gain a clear understanding of area
5. EDUCATE
    5.1. Local services to align with COSUP approach
    5.2. Staff
    5.3. Peers
    5.4. Service users
    5.5. Families
    5.6. Community as a whole
6. IMPLEMENT
    6.1. Establish priority services
    6.2. Develop services according to gaps and available resources
    6.3. Create clear referral paths
    6.4. Hold organisations and partners accountable for services
7. MONITOR, EVALUATE and ADJUST
    7.1. Continuous monitoring and evaluation occurs through:
        7.1.1. Peer review process
        7.1.2. Monthly CAGS
        7.1.3. Monthly reporting on key performance indicators
    7.2. Evaluate performance and adjust as required
    7.3. Document all adjustments



CoT UP COPC integrated substance use programme: Domains of implementation

Domain	Engagement & Communication	Research & M&E	Sites/Treatment points	Household	Education	Skills & Development	Clinical	Project Management
Description	Engage with stakeholders and ensure communication is effective, messaging is consistent and buy-in secured.	Develop research protocols and co-ordinate research.	Site selection, planning & establishment of regions and sites	Integration with COPC programme using CHW, WBOTs	Education and training development	Vocational skills and training	Securing medications Developing clinical guidelines	Project coordination and continuity, including contracts, HR, finances
Resources	Clinical Associates Social workers Drug user network (DUG) Community advocates	Research team at UP M students?	Clinical Associates Social workers Site staff Students University departments	CHW WBOT members Community resources	Video team Findings website	Community resources		Finance and HR departments Department staff
Priorities	- Stakeholder analysis - Stakeholder workshops - Engagement with DSD, Health - Ensure CoT on board - Establish position statements	- Develop OST protocol - Develop main study protocol	- Identify potential sites - Establish regional clinical associates and social workers - LISA - Synaxon systems	- AitaHealth screening module - ASSIST - BI - Determine processes	- Develop educational materials - Develop education plan and processes - Train initial sites	- Still in planning - LISA data will inform	- Acquisition of meds - Determine processes and requirements for dispensing - Motivate for changes to EDL	- Appoint per area – CAs - Ensure budgets realigned - Determine outcome measures - Determine reporting processes and timelines - Appoint staff
Activities	- Workshop development - Schedule regular meetings and report backs - Establish and maintain links with stakeholders - Liaison with PWUD network - Advocacy - Ensure continuity of messaging	- Develop research components - Monitor and evaluate progress - Determine appropriate measures and tools - Ensure integrity of processes - Analysis of data	- On-going site development - Evaluate potential sites: OU&SADIBA - Determine processes & clinical guidelines - Build Synaxon modules - Engage with immediate community - Monitor and evaluate - Establish referral paths	- Integration with ward based teams - Training of WBOT & CHWs	- IEC Materials - Training presentations - Video animations - Coordinate knowledge base - Determine training resources needs - Web materials		- Continued negotiation with pharma-companies, MCC and other stakeholders	- Resource management - Financial controls - Procurement - Contractual arrangements
Outputs	- Regular stakeholder meetings - Stakeholder reports including infographics and updates - Press articles as appropriate	- Protocols - Procedures - Data - Research findings - Publications - Recommendations	- Operational sites - 7 by 2017 - 14 by 2018 - 20 by 2019	- Household data - Screening data - Prevalence data - Referrals to community resources - Brief interventions	- Educational Materials - Website links		- Generics available - EDL includes BMT and MMT	- Project delivered on time and in budget

SBIRT Process



Time frame	Day 1	< 3 days	As per risk < 7 days	< 10 days & as needed	<14 days - ongoing	Purpose	Purpose
Primary purpose	- Establish therapeutic bond - Manage risk - Screen	- Individual assessment - Context assessment - Refer - Retain	- Clinical assessment - OST assessment -	Establish development plan	Ensure personal goals are being met address changing needs.	Individual development Skills training	Appropriately disengage and encourage self-efficacy. Provide support
Interventions used	- Brief interventions - MI - IEC materials -	- Brief interventions - MI	BI Medical interventions Pharmacology	MET& MI BI	Problem solving CBT Comm Reinforcement Yalom groups	Competency based work	
External resources identified by LISA		**Interest groups & activities**	Medical referral to external /specialist services	PWUD friendly services	**Interest groups & activities**	Community based services	CHW assigned for follow-up
Processes that take place within the srug use drop in and resource centre	Induction by peer; register on system (Aita); basic assessment; Basic triage; Pathways book High risk Injecting	Non-problematic or mild low risk SUD Case manager assigned. Full individual & context assessment High Risk Medical or psychiatric	Medical & Psych Assessment	Service user & case manager set priorities & develop collaborative plan	Group therapy Social services Individual counselling	Stabilised: Able to partake in skills development & other programmes	Peer training in project Integrate into community Work placement
Harm reduction and medically assisted treatment	Needle & syringe programme	OST assessment by CA is initiated and dose stabilised by family physician. DOTS by CA or PNC	OST eligibility assessment	Initiation & dose stabilisation	DOTS and maintenance	Take home doses	Maintenance or down-titration
Who?	Peers with support peer leader, CA, Social workers	Social workers, lay counsellors, psych students	Clinical Associates Family physicians	Clinical associates? Social workers, lay counsellors	Social worker Lay counsellors Peers Psychologists	Social workers, occupational therapists, internal trainers	Community health workers Case manager
Forms	[to be filled in]						
Policies	[to be filled in]						

Aim:	To reduce the burden of alcohol and drug use on communities in Tshwane by creating an environment that enables the prevention, early detection and delivery of appropriate interventions using a COPC model.				
Intervention 1:	**Screening and brief assessment**				
Objective	Sub-objective	**Activities**	**Outputs and outcomes**	**Means of assessment**	**Indicator**
1. To establish the nature and associated risks of substance use and SUDs in the CoT. This aligns with project objective 4	1.1 To establish the prevalence and types of substances being used in the CoT	Screen all households for substance use, including alcohol, nicotine & illicit substances	Prevalence data quantifying numbers of PWUD and the types of drugs they are using giving a better understanding of drug use	Screen built into HHR	% of HH registered
	1.2 To establish the prevalence and types of substance use disorders, including opioid use disorders, in the CoT	Assess the presence and severity of SUDs among people who use drugs	Data describing the numbers of PWUD who meet the criteria of an SUD by drugs used and a measure of risk: Low, Moderate or High	WHO ASSIST 3.0	Number of individuals screened
	1.3 To identify at-risk individuals for monitoring and follow-up				
	1.4 To identify high-risk individuals for referral and follow-up				
	1.3 To establish the prevalence of injecting drug use and associated HIV risk	Assess for injecting drug use	Prevalence of injecting drug use and associated HIV risk	WHO ASSIST 3.0	Number of individuals screened
	1.4 To determine the epidemiology of substance use disorders, including spread, progression, resolution of SUDs	Continued screening and assessment integrated into the COPC programme over time	An accurate reflection of the prevalence of substance use and related risk profiles for the CoT	Screening and brief assessment tools	• Changes in ASSIST scores and related risks • Changes in types of substances used
Intervention 2:	**Brief interventions**				
2.a To deliver immediate evidence-based interventions to reduce risk of potential SUD harms and encourage an enabling family environment This aligns with project objectives 4, 6, 7, 8	2.1 To reduce the progression of substance use to substance use disorders	Deliver the ASSIST 3.0 Brief Interventions with the results of the ASSIST 3.0	Reduced risk of progression from substance use to developing a substance use disorder	Future ASSIST scores	• Number of Brief Interventions delivered to low risk individuals • Changes in ASSIST scores over time
	2.2 To reduce the risk of harms related to substance use disorders	Deliver immediate harm reduction brief interventions to substance users, including safer injecting practices where appropriate	Reduced drug-related harms including psychosis, overdose, transmission of infectious diseases and negative impact on health and relationships	Future health screens Risk profile	• Number of Brief Interventions delivered • Changes in risk profile • Changes in health status
	2.3 To empower family members impacted by substance use	Deliver brief family-based interventions for the affected family members	A home environment that encourages the resolution of substance use disorders and reduces conflict within the family	Feedback from family members	• Number of interventions delivered • Improvements reflected in feedback
2.b Deliver on-going brief interventions on a regular and on-going basis This aligns with project objectives 4, 6, 7, 8	2.1 To reduce the progression of substance use to substance use disorders	For people with ASSIST scores above the prescribed level, administer the ASSIST 3.0 and brief interventions every 3 months	Reduced risk of progression from substance use to developing a substance use disorder, reduction in substance use and less problematic substance use	Future ASSIST scores	• Number of Brief Interventions delivered to low risk individuals • Changes in ASSIST scores over time
	2.2 To reduce the risk of harms related to substance use disorders	Deliver on-going harm reduction brief interventions to substance users, including safer injecting practices where appropriate, and adapting these as needs change	Reduced drug-related harms including psychosis, overdose, transmission of infectious diseases and negative impact on health and relationships	Future health screens Risk profile	• Number of Brief Interventions delivered • Changes in risk profile • Changes in health status
	2.3 To empower family members impacted by substance use	Deliver brief family-based interventions for the affected family members	A home environment that encourages the resolution of substance use disorders and reduces conflict within the family	Feedback from family members	• Number of interventions delivered • Improvements reflected in feedback
Intervention 3:	**Referral for comprehensive assessment**				
3. To comprehensively assess the risks, health and other status, needs and treatment plan for people with SUDs This aligns with project objectives 4, 5,8	3.1 Determine comorbidities and establish health and related priorities, including HIV status, TB and chronic disorders	• Refer all high-risk individuals who wish to make changes to their substance use to the nearest support office for assessment • Discuss referral with moderate risk individuals and refer for assessment if desired • Appropriate staff conduct the full assessment of the individual, including referral for appropriate tests and special assessments • Re-assess individuals annually, unless earlier assessment is indicated by significant increases in ASSIST score or other issues identified by CHW	• A better understanding of the relationships between SUDs and comorbidities including HIV, TB and Hep • An understanding of the risk profiles and vulnerabilities of the individual and the community • An understanding of the correlations between QLM, crime, social exclusion, etc. and substance use disorders and their severity • An understanding of the perceived needs of people with SUDS	• Addiction Severity Index • SF-12 QLM • ASSESS 1.0 (in development) • Quantitative and qualitative data captured during the assessment process	• % of people with high risk fully assessed • % of people with moderate risk assessed • % screened for HIV, TB
	3.2 Determine specific risks and vulnerabilities				
	3.3 Establish current quality of life, socio-economic, employment, and educational status				
	3.4 Determine mental health and social issues and vulnerabilities that are contributing to levels of drug use				
	3.5 Determine level of criminal involvement and forensic history				
	3.6 Identify possible interests, protective factors, opportunities and relationships that can be developed to reduce the importance and role of drug use				
	3.6 Establish a treatment plan	• Collaboratively establish priorities focusing on the reduction of harm, improvement of health and expanding interests and social networks	A comprehensive plan of action tailored to the individual needs of the substance user	Audit of treatment plans according to M&E process	% of people with an SUD who establish an intervention plan

		• Determine objectives and time-frame for plan • Establish community based resources that can be utilised in the plan			
Intervention 4:	**Referral to services**				
Objective	Sub-objective	**Activities**	**Outputs and outcomes**	**Means of assessment**	**Indicator**
To link at-risk individuals and those with substance use disorders with appropriate interventions, activities and services This aligns with project objectives 4, 5, 6, 7, 8, 9 and 10	4.1 to capacitate families so they are able to effectively deal with substance use by other members and create an environment that encourages resolution of SUDs and minimises family conflict	• Identify or establish appropriate family resources and support groups • Train groups on interventions such as CRAFT that are evidence based and proven to be of benefit • Refer families to groups and other resources to assist them in providing appropriate support for those with SUDs	Intact families who do not exacerbate the harms and consequences of drug use and encourage the resolution of SUDs by establishing an enabling environment	• Feedback from the family over time • ASSIST scores from family members • ALM – SF12Q scores • ASI scores	• % of families referred who attend • Number of points of contact
	4.2 Encourage people who use drugs and those at risk to develop other interests and broaden their social networks	• Identify community based resources as per the LISA process • Refer to cultural, recreational and spiritual programmes	Greater social integration, wider interests and social networks	• ASSIST scores from family members • ALM – SF12Q scores • ASI scores	Number of people engaged in programmes
	4.3 Resolve or manage co-occurring health, social and psychiatric issues	• Refer to appropriate clinical services • Use CHW and COPC system to monitor retention, compliance and progress	Improved mental health, treatment compliance and access to services	• Clinical records	Number of people referred to care, retained in care and compliant on chronic medications or treatment compliant
	4.4 Empower individuals so they are better equipped to integrate into society and find purpose, employment and economic independence	• Identify community based skills development and literacy programmes as per the LISA process • Utilise UP resources and students to establish programmes where lacking • Refer to skills programmes	Social integration, community cohesion and increased levels of employment	• ASSIST scores from family members • QLM – SF12Q scores • ASI scores	Number referred and retained
	4.5 Assist those struggling with SUDs to access support groups and peer networks	• Refer individuals to mutual support groups including peer recovery groups and networks if choose to engage in these	Mutual support and reductions in drug use	• ASSIST scores from family members • QLM – SF12Q scores • ASI scores	Number of successful referrals
	4.6 To increase individual agency and help resolve psychological issues and develop effective coping skills	• Establish and train counsellors and upskill existing services and social workers in harm reduction, MI and MET • Refer appropriate individuals	Increased agency and reduced drug use with an increase in quality of life	• ASSIST scores from family members • QLM – SF12Q scores • ASI scores	• Number of counsellors trained • Number of people referred • Number of people completing sessions
	4.7 To assist those with severe SUDs and compounding factors or challenges to resolve their SUDs	• If there is a strong motivation for abstinence and current interventions are not working, refer individuals to rehabilitation centres	Guidelines for referrals and evaluation of appropriate programmes resulting in positive treatment outcomes	• ASSIST scores from family members • QLM – SF12Q scores • ASI scores	Number of successful referrals
Intervention 5:	**Opioid substitution therapy**				
Objective	Sub-objective	**Activities**	**Outputs and outcomes**	**Means of assessment**	**Indicator**
To retain heroin dependant individuals in treatment, reducing heroin use, HIV risk, criminal activity, mortality and improving health and quality of life This aligns with project objectives 4, 5, 6, 8, 9	5.1 To initiate and maintain individuals with a heroin use disorder on opioid substitution therapy	• Identify people with a heroin use disorder in the assessment process • Conduct the required tests • Educate those receiving OST prior to initiation • Initiate at the support office/clinic • Stabilise dose	People with SUD maintained on optimum OST doses resulting in lower levels of heroin use, less IV use, reduced criminal behaviour and improved health Improved understanding and perceptions of OST amongst those treated, their families and the community	• Compliance with medication from data collected • Retention in Tx from CHW data • Heroin use via self-report using ASSIST • QLM – SF12Q scores • ASI scores	• Number of people initiated • % Number of people retained • improvement in QoL
	5.2 To ensure compliance and minimise diversion	• DOTS established • CHW monitor compliance • Brief interventions	Increased compliance and retention in the programme with reduced heroin use and diversion	Clinical records and CHW reports	% of those in treatment skip less than x doses per month.

Intervention 6:	Harm reduction				
Objective	Sub-objective	**Activities**	**Outputs and outcomes**	**Means of assessment**	**Indicator**
To minimise the risk of harms to the individual and community related to drug use by people who use drugs and are not ready or unable to stop	6.1 To ensure access to appropriate health services and that they are retained in the primary health system	• Train and sensitise all HCW and clinical staff to use non-stigmatising language person-centred approaches with all people • Implement motivational approaches that respect the individual's autonomy	All staff are sensitized and respectful of Px needs and priorities, avoiding stigmatising language and assumptions, as a result PWUD feel comfortable to engage in health services and will seek assistance when they are ready to change patterns of drug use	• Training evaluation • Knowledge testing of CHW and clinical staff • Focus groups with PWUD and families	• received training • people visited more than once per year
	6.2 To increase the drug user's knowledge about the potential harms of drug use and have evidence-based strategies to avoid these	• Train and sensitise all HCW and clinical staff to use non-stigmatising language person-centred approaches with all people • Implement motivational approaches that respect the individual's autonomy • Deliver appropriate harm reduction information and ensure that drug users are able to apply the appropriate strategies e.g. drug-mixing	Drug users will be better informed of risk and be able to use drugs with less consequences to health and the community This reduces the costs and harms associated with drug use and decreases stigma, allowing users to be more integrated into the community	• Knowledge testing by HCW and researchers	• people have received IEC materials and harm reduction training

INDIVIDUAL COUNSELLING

According to need, clients may be assigned to an individual counsellor. Individual counselling then takes place on an as-needed and as-available basis. The individual counsellors may be a trauma specialist, pastoral counsellor, clinical or counselling psychologist, social worker, social auxiliary worker or specialist lay-counsellor depending on the individual need.

GROUPS

These groups are NOT designed to establish group consensus, but rather encourage the development of individual thinking and to celebrate and recognise the differences of opinion, drug use and personal goals.

The primary therapeutic modes are CBT, psycho-education and motivational enhancement therapy.

ADDENDUM F – MONITORING & EVALUATION: PEER REVIEW

During the reporting period, 6 sites were involved in a peer review process designed to support improvement in the quality of services and to fast track learning. COSUP sites were paired and reviewed each other.

The peer review field teams were made up of selected site team members (managers, social workers, clinicians, peer educators, community health workers, students), academics and a review team leader. They participated in a field assessment of their partner site.

The peer review followed a structured process using a purposively designed common standard 'benchmark for integrated learning' assessment tool. Sites were assessed against five defined benchmarks – namely, (1) approach; (2) the care process; (3) learning and skills development; (4) management; and (5) networking/partnerships. Site visits took place over two days. Specific feedback was given at each site on identified issues and concerns. A peer exchange seminar was held with all peer-reviewed sites to share learning and to discuss ways of refining the review process.

Amongst other things, the process helped the teams at COSUP sites realise the power of peer learning. They identified gaps in their knowledge and their practices. In particular, they learned that they need to deepen their understanding of harm reduction as an approach and a practice. And they need to improve their skills in dealing with multiple drug use as well as the complexity of comorbidities and the social determinants of harmful substance use. They also identified significant gaps in the system that were beyond their control, and that directly affected the impact of the programme. Key amongst these were homelessness and the referral system in hospitals, as well as the complexity of meeting predetermined outcome targets. They also helped identify solutions, including improved management and communication, as well as areas needing further development and specific training and support.

'Confirmation of Ownership rights to the materials, models, names, etc. associated with the project going forward'

As per SLA:

Clause 25. INTELLECTUAL PROPERTY

25.1 The Parties acknowledges and agree that ownership of any new Intellectual Property generated from the performance of this Agreement shall be determined and dealt with in accordance the South African Intellectual Property Rights from Publicly Financed Research and Development Act No. 51 of 2008.

25.2 Each party hereby grants to the other Party an irrevocable, perpetual, non-exclusive, royalty-free license to use and distribute, privately or publicly, such new Intellectual Property created under this Agreement for non-commercial purposes.

The effect hereof is in short that the University of Pretoria owns the Intellectual Property (IP) it had at the commencement of the contract.

Any new IP created during the contract is dealt with in terms of the Act 51 of 2008, which makes provision for the joint ownership where there is an agreement to the effect and joint contributions to the development of IP amongst others.

The Act makes provision for ownership by the financial contributor if the research was done on a full cost basis. There are, though, certain requirements for this, i.e. there needs to be specific mention in the SLA or an agreement in place which specifies that the project will be done on a 'full cost' basis. If this is not the case, then all IP developed belongs to UP. If it was specified, then all IP belongs to CoT.

Additionally, the parties grant each a royalty free perpetual licence to use the IP created for non-commercial purposes, irrespective of ownership of IP. This means that either party may use the IP created as long as it is not for commercial gain.

ADDENDUM H – FINANCE