

HALF- YEARLY PROGRESS REPORT ON THE FUNCTIONING OF TREATMENT-CUM-REHABILITATION CENTRES

INSTRUCTIONS

- ◆ This Progress Report is to be furnished by the Organizations receiving grant-in-aid under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse of the Ministry of Social Justice & Empowerment, Government of India.
- ◆ The Report is to be submitted to the Ministry of Social Justice & Empowerment on half-yearly basis – the first report (April to September) should be sent immediately after 30th September every year and the second report (October to March) immediately after 31st March every year.
- ◆ While filling up the report, the Organization should ensure that the figures supplied by them match the figures in the records maintained by them.
- ◆ No column should be left blank and if no information is available for some particular column, it may be clearly stated so.
- ◆ Normally, the first installment of a particular year would be considered after evaluation of the half-yearly report for the preceding half-year period ie. October to March of the previous financial year, and the second installment would be considered after evaluation of the half-yearly report for the period April to September of the same year.
- ◆ Organizations should ensure timely submission of their progress reports to enable the Ministry to process their grants-in-aid proposals in time.

PROFILE OF THE ORGANIZATION & CENTRE

1. (a) Name & address of the Organization: (Full Postal address with Tel Nos. and E-mail)	
(b) Name & address of the Centre (Full Postal address with Tel. Nos. and E-mail)	
(c) Contact Person for the centre: Name	
Designation	
Complete postal address	
Telephone/Fax number	
Mobile No.	

(d) E Mail Address	

2. Review Period (Please indicate whether the report is for April-September or October-March, 200____)	
3. Year of receiving first grant-in-aid from this Ministry	
4. Number, date, amount and the year for the last financial aid received	
5. No. of Beds for which the Organization is receiving grant-in-aid	
6. No. of beds actually in position (including temporary arrangements made during the review period)	

7. REGISTRATION

A. Please state the number of clients registered at the Center during the half-year under review.

For OPD	
For Indoor Treatment	
TOTAL	

B. Average age of clients registered at the Center during the Report period:

C. No. of female clients registered at the Center during the Report period :

8. DETAILS OF DRUGS ABUSED

Alcohol/Drug Abusers during the half-year under review at the Centre

Drug category	No. of Clients
Opium	
Heroin	
Morphine	
Buprenorphine	
Propoxyphene	

Brown Sugar	
Other opiates	
Cocaine	
Alcohol	
Cannabis	
Hallucinogens	
Amphetamines	
Barbiturates	
Minor Tranquilizers	
Sedatives/Hypnotics	
Multiple Drugs (in not in above categories)	
Volatile Solvents (Inhalants)	
Others (Please specify)	
TOTAL	

9. METHOD OF DRUG TAKING (Please state the number of clients)

ORAL	SMIFFING	INJECTING (IDU)	ANY OTHER

CLIENT'S DETAILS
(During the half-year under review)

10. SOURCE OF REFERRAL

Please state number of clients referred to the Centre by :

Self	Friends	Family	Social Worker	Private Doctor Hospital	Govt. hospital	Counselling & awareness center/De-addiction centers (NGOs)	Ex-clients or their family members	Law enforcement agencies	Any other

11. MARTIAL STATUS

Never Married	Married	Widow/widower	Divorced	Separated	Separated divorced due to drug use	Not known

12. EDUCATION

Illiterate	Literate (read & write)	Primary Education	Middle	Hr.Sec Equiv.	Graduate	Post Graduate	Prof. trained	Not known

13. EMPLOYMENT STATUS

Currently Unemployed	Never Employed	Part-time Employed	Full-time Employed	Self Employed	Student	House wife	Pensioner etc	Not Known

SERVICES

14. TREATMENT) – During the half year under review

Please state number of clients

OPD	Indoor	Total

15. DETAILS OF STAY (INDOOR) – During the half-year under review

Indicate the number of indoor clients treated for the following durations of stay at the Centre:

1-10 days	11-20 days	21-30 days	31-40 days	41-50 days	51-60 days	More than 60 days	Total

16. DROP OUTS – During the half-year under review

Please state the number of clients who dropped out of the Centre due to the following reasons:

Poverty	Lack of family support	Unable to cope with the treatment	Inadequate facilities	Personal/any other reasons	Legal	Total

17. COUNSELLING (for indoor clients)

Please state number of clients provided the following counselling services :-

A. GROUP COUNSELLING (During the half-year)

No. of clients	Average/time session	Total No. of sessions held

B. INDIVIDUAL COUNSELLING (During the half-year)

No. of clients	Average time/session	No. of sessions held

C. FAMILY COUNSELLING (During the half-year)

No. of families	Average time/session	No. of sessions held

18. CLIENTS REQUIRING ADDITIONAL TREATMENT (during the half-year under review)

Please state the number of clients suffering from the following ailments:

T.B.	HIV/ AIDS	Sexually transmitted diseases	Hepatitis A or Hepatitis B	Abscess	Any other infection

19. RECOVERY (during the half-year under review)

Please state number of clients in the following phases of recovery after receiving treatment Services at the centre:

Sober	Relapsed	Dropped Out	No News	Expired

FOLLOW UP ACTIVITIES

(During the half-year under review)

Details of follow up programmes taken up by the Centre:

20. Total number of letters sent/telephone calls made to ex-clients:

	Twice in a month	Once in a month	Quarterly	Total During the half-year
Letters /phone calls to ex-clients				

21. HOME VISITS (by counselors to homes of ex-clients during the half-year)–

No. of ex-clients visited	Total No. of visits undertaken

22. REHABILITATION PROGRAMMES GIVEN/ REFERRED BY THE CENTRE

Programmes	No.of clients
Out reach programmes, camps etc	
Self help groups	
Half way Homes	
Drop in centers	
Family assistance programme	
Vocational training services	
Educational support	
Work place support	
Any other services	

23. TRAINING PROGRAMMES

(a) Please indicate the details of the training Courses attended by your staff in **last two years**:

Name of the staff who attended training	Duration with dates	Organized by RRTC/NISD/Any Other	Name of the course

(b) Total no of staff trained in **last two years**

24. Please indicate the incidence of any other types of drug related morbidity during the period and causes thereof.

I certify that the above information is correct and is based on the records maintained at the centre.

Signature and Stamp of the authorized Signatory