



Republic Of Kenya

NATIONAL CAMPAIGN AGAINST DRUG ABUSE AUTHORITY

**NATIONAL STANDARDS FOR
TREATMENT AND REHABILITATION
OF
PERSONS WITH SUBSTANCE USE DISORDERS**

2010

This document was developed through the coordination and support of the National Campaign Against Drug Abuse (NACADA) Authority.

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FOREWORD

The National Campaign against Drug Abuse Authority's Vision is to create a healthy, secure and prosperous society free from alcohol and drug abuse. The Authority's goal is to contribute to the improvement of the overall health and social economic wellbeing of the people of Kenya through the significant reduction of the effects of drugs and substance abuse. In this regard, the Authority provides leadership for a multi-sectoral and multi-disciplinary response to the prevention, control and mitigation of drug and substance abuse in the country.

The NACADA Authority's responsibility in the fight against alcohol and drug abuse menace is extensive, and its core mandate entails:

- (a) Provide directly or in collaboration with other institutions, agencies or organizations facilities for coordination of public education against drug abuse;
- (b) Coordinate the implementation of the National Action Plan on curbing drug abuse by the public especially the youth and children;
- (c) Play an effective role in the development, setting up and expansion of rehabilitation centres for the rehabilitation of drug dependants;
- (d) Prepare and maintain a register of licensed persons to offer expert advice on treatment and prevention services in the field of drug abuse;
- (e) Liaise with relevant authorities in carrying out training or approving the training curriculum of trainers in the campaign against drug abuse;
- (f) Advise on the best practices and discipline of licensed drug rehabilitation operators;
- (g) Undertake research directly or in collaboration with other organizations or bodies in matters relating to control of drug abuse and chemical substances, as may be approved by the Board.

The field of treatment and rehabilitation of persons with substance use disorders in Kenya has, in the past, been done in an uncoordinated, unregulated manner and without any set standards and guidelines. This document, the National Standards for the Treatment and Rehabilitation of Persons with Substance Use Disorders, is the result of very extensive research and is informed by current local and international practices. It sets out the standards and practices for institutions and personnel working in the area of addiction rehabilitation.

The aim of this document is to regulate and guide the establishment of facilities that manage and treat persons with substance use disorders and to inculcate professionalism and ethics by setting minimum standard for those involved in the field of addiction treatment.

While it is not possible to capture every aspect of interest that should be regulated in such a document, the document has striven to encompass all the relevant areas. By its very nature, a document like this is organic, and NACADA Authority will

be alive to that reality. Future revisions will accommodate such omissions and also include lessons learnt in the interim period.

I am, however, persuaded that this document is a very important step in the fight against substance abuse in Kenya.

Jennifer Kimani (Mrs) - MBS
CEO – NACADA Authority

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EXECUTIVE SUMMARY

Treatment and rehabilitation centres in Kenya have grown exponentially in the recent past, particularly beginning in the year 2000. This is due to the fact that Alcohol and Drug abuse is a problem that is escalating in leaps and bounds (NACADA 2001, Masinde Muliro University, 2009).

The increase in demand for treatment and rehabilitation services has attracted many players including individuals, non-governmental organizations (NGOs), faith based organizations (FBOs), civil society, Private and Public institutions. Huge variations exist within these centres in terms of facilities, personnel competences, treatment options and costs.

It's in view of this that NACADAA has developed "standards for residential and non-residential treatment and rehabilitation facilities and programs for persons with substance use disorders". This will help bridge this gap.

These guidelines attempt to define minimum standards to be met within treatment and rehabilitation centres in Kenya. These include: rights and responsibilities of clients, levels of treatment, treatment centre management, and procedures for treatment centres management; thus, the standards will specifically, advise on the best practices and discipline of licenced rehabilitation operators, ensure professionalism in the treatment and rehabilitation of persons with substance use disorders, provide guidelines and minimum requirements for service providers to ensure that the rights of persons with substance use disorders and their families are protected, define the basic services and procedures that every treatment and rehabilitation facility should provide to clients, provide clear guidelines on intake, screening, assessment, placement, documentation, case management, treatment planning, discharge planning, and other core areas of treatment and rehabilitation, ensure clients seeking treatment and rehabilitation services get value for their money and are protected from exploitation, provide a basis for administrative and clinical supervision, monitoring and evaluation of treatment and rehabilitation procedures, services and facilities, establish a basis for resource mobilization and medical insurance coverage.

Hopefully, the huge knowledge gaps that exist in treatment and rehabilitation service provision in Kenya will be bridged for effective service delivery to our people and that operators will no longer be conducted in a policy vacuum, but in a realm of professionalism and result-orientedness.

PURPOSE OF THE STANDARDS

To establish a set of minimum standards for the regulation, guidance and monitoring of residential and non-residential treatment and rehabilitation facilities and programs for persons with substance use disorders in Kenya.

The specific objectives include the following:

- (i) To advise on the best practices and discipline of licensed rehabilitation operators.
- (ii) To ensure professionalism in the treatment and rehabilitation of persons with substance use disorders.
- (iii) To provide guidelines and minimum requirements for service providers to ensure that the rights of persons with SUDs and their families are protected.
- (iv) To define the basic services and procedures that every treatment and rehabilitation facility should provide to clients.
- (v) To provide clear guidelines on intake, screening, assessment, placement, documentation, case management, treatment planning, discharge planning, and other core areas of treatment and rehabilitation.
- (vi) To ensure clients seeking treatment and rehabilitation services get value for their money and the services rendered to them are cost-effective.
- (vii) To provide a basis for administrative and clinical supervision, monitoring and evaluation of treatment and rehabilitation procedures, services and facilities.
- (viii) To establish a basis for resource mobilisation and medical insurance coverage.

PRINCIPLES

Confidentiality: Clients' rights to appropriate confidentiality should be observed by the service providers at all times.

Accountability: Everyone who intervenes with clients and their families should be held accountable for the delivery of an appropriate, quality service.

Empowerment: The resourcefulness of clients and their families should be promoted by providing opportunities to use and build their own capacity and support networks and to act according to their own choices and sense of responsibility.

Participation: Clients and their families should be actively involved in all the stages of the intervention process.

Continuum of care: Clients and their families should have access to a range of differentiated services on a continuum of care, ensuring access to the least restrictive and most empowering environment and/or programme(s) appropriate to their individual developmental and therapeutic needs.

Continuity of care: The changing social, emotional, physical, cognitive and cultural needs of clients and their families should be recognized and addressed throughout the intervention process. Links with continuing support and resources, when necessary, should be encouraged after disengagement from the system.

Integration: Services to clients and their families should be holistic, intersectoral and delivered by an appropriate multi-disciplinary/trans-disciplinary team wherever possible.

Normalization: Clients with special needs and their families should be exposed to normative challenges, activities and opportunities, which promote participation and development.

Effective and efficient: Service provision to clients and their families should be rendered in the most effective and efficient way possible.

Rights of clients: The rights of clients should be protected.

Appropriateness: All services to clients and their families should be the most appropriate for the individual, the family and the community.

APPLICABLE LEGISLATION

Relevant Kenyan Laws

- Medical Practitioners and Dentists Board Act
- Mental Health Act, Chapter 248, Laws of Kenya of 1984
- Pharmacy and Poisons Act, Chapter 244, Laws of Kenya
- Public Health Act, Chapter 242, Laws of Kenya
- Narcotic Drugs and Psychotropic Substances Control Act, 1994
- Tobacco Control Act , 2007
- Food, Drugs and Chemical Substances Act, Chapter 254, Laws of Kenya
- Children’s Act, 2007
- Liquor Licensing Act, Chapter 121
- Chiefs Act, 128
- Chang’aa Prohibition Act, Chapter 70, Laws of kenya
- Sexual Offences Act, 2006
- Labour Relations Act, 2007
- The Employment Act, 2007
- The Occupational Safety and Health Act, 2007
- The Work Injury Benefits Act, 2007
- HIV/AIDS Prevention and Control Act, 2006
- Penal Code, Chapter 63, Laws of Kenya.

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DEFINITIONS OF TERMS

Specialists in the fields of addiction, treatment and recovery, like every field of study, have a language of their own. A brief examination of the most commonly used will remove ambiguities. They are listed alphabetically:

Abstinence Syndrome: The group of symptoms which occur when a dependent person abstains from the substance he or she is addicted to; see ‘withdrawal’.

Abuse: The misuse or overuse of a substance (using more than the norm); using a substance in a way different from the way it is generally used, either medically or socially; using any illegal substance (including alcohol if one is underage); continued use of a substance even though it is causing problems in one’s life.

Accreditation: The official authorization of a service by the public body legally entitled to confer that authorization by the laws of the country, based on a prescribed set of quality standards (WHO, 2003).

ACOA: See ‘Adult Children of Alcoholics’.

Acute care: Intensive treatment for an immediate and urgent problem.

Addiction: Loss of control and compulsive use of a mood or mind-altering chemical or chemicals, along with the inability to stop the use in spite of the fact that such use is causing problems in one’s life. It means having a physical and/or psychological dependence on a substance.

Addiction counsellor: A counsellor who has trained and demonstrated proficiency in core addiction counselling competencies and has been duly accredited and registered by a recognized training and registration body.

Admission: An administrative and clinical procedure by which a suitable applicant enters the centre. This occurs only after a pre-admission screening.

Administration (drug): The direct application of a prescribed drug, whether by injection, inhalation, ingestion or any other means.

Admission criteria: Criteria that define those applicants suitable for admission to the centre.

Adult Children of Alcoholics: Adults who grew up in an alcoholic home and were affected by the experience. There are those who believe that such individuals share specific behavioural traits, which frequently adversely affect their adult relationships.

Aftercare: also known as Continuing Care: Follow-up care that offers continuing on-going support to maintain sobriety/abstinence, personal growth and integration into the family/community.

AIDS: Stands for acquired immunodeficiency syndrome. When HIV infection becomes advanced it often is referred to as AIDS. It generally occurs when the CD4 count is below 200/ml and is characterized by the appearance of opportunistic infections. These are infections that take advantage of a weakened immune system.

Al-Anon: A Twelve-Step recovery program for family members and friends of alcoholics, including ACOA's.

Alateen: A Twelve-Step recovery program for adolescent children of alcoholics.

Alcoholic: A person with a disorder characterized by the excessive consumption of and dependence on alcoholic beverages, leading to physical and psychological harm a social and vocational impairment

Alcohol: (i) A colourless volatile flammable liquid, C_2H_5OH , synthesized or obtained by fermentation of sugars and starches and widely used, either pure or denatured, as a solvent and in drugs, cleaning solutions, explosives, and intoxicating beverages. (ii) A liquid substance capable of altering one's mood and mind. It is addictive. The abuse of this substance leads to alcoholism.

Alcoholics Anonymous (AA): The original Twelve-Step recovery program, begun in 1935 by two alcoholics to provide mutual help and support for people who have a desire to stop drinking.

Alcoholism: This is a primary, chronic illness with genetic, psychosocial, and/or environmental factors, influencing its development and manifestations. The disease is often progressive and fatal. (Some believe it is always progressive). The alcoholic has either continuous or periodic loss of control over drinking, is preoccupied with alcohol, uses it despite the damage it is doing, and has distorted thinking, most notably denial. The quantity of alcohol consumed is less important than the effect of the drinking on the individual's life and the lives of those around him or her.

Antabuse: A medication (disulfiram) which inhibits the metabolism of alcohol. The patient taking Antabuse becomes extremely ill upon taking even a small amount of alcohol.

Antiretroviral Therapy (ART): Stands for **antiretroviral therapy**. It is the treatment with a very potent drug "cocktail" to suppress the growth of HIV, the retrovirus responsible for AIDS. It is a combination of protease inhibitors taken with reverse transcriptase inhibitors.

ASAM: The American Society for Addiction Medicine, the professional organization of addiction medical specialists.

Assessment/Evaluation: The systematic identification of a patient's/client's condition and needs within a framework based on professionally accepted best-practice guidelines.

Barbiturate: A sedative-hypnotic substance (minor tranquillizer), acts as a depressant on the central nervous system.

Benzodiazepine: A sedative-hypnotic substance (minor tranquillizers) that acts as a depressant on the central nervous system. It is significantly dependence-inducing (e.g. Valium, Rohypnol).

Best practices: Evidence-based addiction treatment practices.

Big Book: This is the official handbook of AA (Alcoholics Anonymous).

Biopsychosocial (BPS) model: A model that has been developed to explain the complex interaction between the biological, psychological, and social aspects of addiction. It is the model most widely endorsed by treatment researchers because it can most adequately explain the intricate nature of addiction. The term “Biopsychosocial” comes from combining the individual factors that contribute to the model: biological, psychological (thoughts, feelings, behaviours), and social. Many clinicians and treatment providers (particularly those in traditional addiction treatment) use the same term to include a fourth factor, spirituality.

Blackout: A memory lapse while drinking; experienced by some alcoholics.

Centre: Substance dependency treatment facility.

Child: Any person under the age of 18 years.

Clients: People dependent on or addicted to a substance who have been admitted to the treatment centre.

Clinical record: Permanent medico-legal document of the patient’s history, assessment and treatment progress.

Clinical supervision: It consists of the practitioner meeting regularly with another (professional), not necessarily more senior, but normally with training in the skills of (supervision), to discuss casework and other professional issues in a structured way. The purpose is to assist the practitioner to learn from his or her experience and progress in expertise, as well as to ensure good service to the client.

Clinician: Either a medical or addiction professional who works in a clinic.

Cocaine Anonymous (CA): A Twelve-Step recovery program for those addicted to cocaine.

Co-dependency: A pattern of behaviour in which those who are in a close relationship with an alcoholic/addict become, in turn, dependent upon that person’s chemical dependency. The co-dependent builds his or her needs and life around the dependent person’s. The addict is addicted to the drug, but the co-dependent is addicted to the addict. The addict may also be co-dependent.

Cognitive behavioral therapy (CBT): Is a psychotherapeutic approach that aims to influence dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure. CBT can be seen as an umbrella term for a number of psychological techniques which share a theoretical basis in behaviorist learning theory and cognitive psychology. It is considered an evidence-based practice for addiction counselling.

Continuing Care: (Also referred to as **after-care**) Follow-up care which offers ongoing support to maintain sobriety/abstinence, personal growth and assists with reintegration into the community/family.

Co-morbid condition: A concurrent mental health condition that exists alongside substance-related disorders. The term “dual diagnosis” often applies here.

Core competencies: These are considered basic for knowledge, skills and attitudes in addiction counselling: screening, intake, orientation, assessment, treatment planning, counselling, case management, crisis intervention, client education, referral, report and record keeping and consultation. Addiction counsellors must demonstrate proficiency in the twelve core functions of substance abuse counselling.

Counselling: A therapeutic intervention which offers support and guidance and is undertaken by a relevantly trained accredited and professional staff member.

Critical incident: Any abnormal or unusual occurrence which threatens the safety or well being of clients and staff.

Cross-addiction: This occurs when an individual, who is addicted to one drug, substitutes another in the hope of avoiding dependence and then becomes dependent on this drug as well. This can happen with drugs that are very different, such as alcohol and amphetamines.

Denial: The self-deception which prevents alcoholics/addicts from admitting to themselves or to others the destructive nature of their drug use.

Diagnostic and Statistical Manual of Mental Disorders (DSM): Is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders.

Discharge criteria: Criteria that define a patient's/client's suitability for release from the treatment centre.

Disease model of addiction: Holds that addiction is a disease, coming about as a result of either the impairment of neurochemical or behavioural processes, or a combination of the two.

Drug: Broadly speaking, is any substance that, when absorbed into the body of a living organism, alters normal bodily function. In pharmacology, a drug is a chemical substance used in the treatment, cure, prevention, or diagnosis of disease or used to otherwise enhance physical or mental well-being. In reference to chemical abuse and dependency, a drug refers either to alcohol or other psychoactive substances such as marijuana and heroin (illicit or illegal drugs).

Drug dependency: A physical and/or psychological need for a mood-altering substance. Physical dependency is frequently associated with the development of tolerance (you need more to get the same effect) and the presence of symptoms when the drug is withdrawn. Not everyone who becomes physically dependent loses control and becomes addicted. Some people become psychologically dependent and can lose control without having a physical addiction.

Drug detoxification (often shortened to "detox"): A collective of interventions directed at controlling acute drug intoxication and drug withdrawal. It refers to a purging from the body of the substances to which a patient is addicted and acutely under the influence. The process of detoxification aims at lessening the physical

effects caused by the addictive substances.

There are three steps to drug detoxification:

1. *Evaluation:* Upon beginning drug detoxification, a patient is first tested to see which specific substances are presently circulating in their bloodstream and the amount. Clinicians also evaluate the patient for potential co-occurring disorders, dual diagnosis, and mental/behavioral issues.
2. *Stabilization:* In this stage, the patient is guided through the process of detoxification. This may be done with or without the use of medications but for the most part the former is more common. The patient is told what to expect during treatment and the recovery process.
3. *Guiding Patient into Treatment:* The last step of the detoxification process is to ready the patient for the actual recovery process. As drug detoxification only deals with the physical dependency and addiction to drugs, it does not address the psychological aspects of drug addiction. This stage entails obtaining agreement from the patient to complete the process by enrolling in a drug rehabilitation program.

Drug screen: A urine test or any other mode of testing used to detect if a person has been abusing drugs.

Enabler: A significant other of a substance abuser who provides either implicit or explicit support of substance-abusing or dysfunctional behaviour.

Enabling: Refers to any behaviour direct or indirect, no matter how well meaning, that allows the alcoholic/addict to continue drinking or using.

Evidence based practices: Refers to a decision-making process which integrates the best available research, clinician expertise, and client characteristics.

Family Interaction Model: Alcoholism, like drug addiction and schizophrenia, is best seen as a form of family interaction in which one person is assigned the role of the alcoholic while others play the complementary roles, such as the martyred wife, the neglected children, the disgraced parents, and so forth. As this deadly game is played by mutual consent, any attempt to remove the key factor, the alcoholic, is bound to create difficulties for the other family members, who will attempt to restore their former game.

Flashback: The re-experience of an event from the past, usually accompanied by a state of fear, terror, or horror. It is often used to describe the recurrence of a hallucination or other drug-related experience when no drug has been used.

Half-life: The time it takes for half the concentration of a chemical substance in a person's body to clear from his or her blood. The longer the half-life, the longer the effects of the drug linger.

Harm reduction/ harm minimization: Refers to a range of pragmatic public health policies designed to reduce the harmful consequences associated with drug use and

other high risk activities, e.g., training on the proper cleaning of needles before others use the needle, needle exchange.

Heroin: A white, odourless, bitter crystalline compound, $C_{17}H_{17}NO(C_2H_3O_2)_2$, that is derived from morphine and is a highly addictive narcotic. Also called diacetylmorphine.

Hepatitis: Injury to the liver characterized by the presence of inflammatory cells in the tissue of the organ.

HIV/AIDS: Human Immunodeficiency Virus is a lent virus (a member of the retrovirus family) which can lead to *Acquired Immunodeficiency Syndrome* (AIDS), a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections.

Indicators: Measures that summarize information about a specific aspect of service delivery. Indicators are usually quantifiable and can be used to measure change in a system (e.g. a staff/patient ratio). Norms can therefore be distinguished from indicators in the sense that indicators describe existing levels of care whereas norms recommend a level of care.

Informed consent: Consent for a procedure/treatment provided by a person who is deemed capable of making such a decision based on his/her mental state; intellectual, linguistic or educational abilities; freedom from coercion or age-related maturity and current relevant legislation.

Inpatient:(residential client): Client who resides in a residential treatment centre for treatment.

Intervention: A carefully planned meeting at which an alcoholic/addict is confronted by family members, friends, and professionals in an effort to break through denial and start subject on the road to recovery.

Levels of Care: After a client has been assessed for his/her degree of severity of drug abuse or dependency he/she is assigned to an appropriate stage of treatment:

1. Level 1: If the client abuses alcohol and/or drugs hazardously or harmfully he/she can be given a brief intervention by a counselor or trained health personnel.
2. Level 2: Here, a dependent client can be assigned to non-residential services, such as day outpatient or intensive day outpatient.
3. Level 3: Here, a dependent client can be assigned to a residential/inpatient services. This can either be a clinically managed residential services or a medically managed residential services.
4. Level 4: This constitutes continuing or aftercare services.

Marijuana: Marijuana (marihuana), *Cannabis sativa*, also known as Indian hemp, is a member of the Cannabaceae or hemp family.

Mental health practitioner: Professional staff member such as a psychiatrist, registered medical practitioner, a nurse, an occupational therapist, a psychologist or social worker who is trained to provide prescribed mental health care, treatment and rehabilitation services.

Methadone: A potent synthetic narcotic drug, $C_{21}H_{27}NO$ which is less addictive than morphine or heroin and is used as a substitute for these drugs in addiction treatment programs. It may also be used for chronic pain management.

Mind-altering drug: Any substance that affects mood or thinking.

Minnesota Model: One of the best-established treatment modes. It is based on the philosophy that addiction is a disease but continuous, life-long abstinence is possible. Programs usually include counselling aimed at behaviour modification, group therapy, 12-Step meetings, and intensive education on the nature and causes of addiction, the importance of peer support and sharing, and principles of long-term recovery and relapse prevention.

Moral Model of Addiction: States that addictions are the result of human weakness, and are defects of character.

Motivational interviewing (MI): A counselling approach in part developed by clinical psychologists Professor William R Miller, Ph.D. and Professor Stephen Rollnick, Ph.D. It is a client-centered, semi-directive method of engaging intrinsic motivation to change behaviour by developing discrepancy and exploring and resolving ambivalence within the client. It is considered an evidence-based counselling method for addiction counselling.

Multidisciplinary team: A therapeutic or team of health and social development professional and accredited addiction counsellors (if members of the centre's staffing body) who provide treatment at the centre. See section on 'minimum staff components of this team of facilities'.

Mutual-help groups: Any group of non-professionals who meet to help one another deal with a problem, either over the short term (such as a support group for women who experience miscarriage) or the long term (such as Alcoholics Anonymous or Narcotics Anonymous).

Naltrexone: It is an opioid receptor antagonist used primarily in the management of alcohol dependence and opioid dependence.

Narcotics: A class of depressant drugs derived from opium or compounds related to opium.

Narcotics Anonymous (NA): A 12-Step program for people addicted to drugs other than alcohol or tobacco.

Norms: Recommended quantitative levels of service provision usually linked to indicators (e.g. recommended patient/staff ratio).

Opioids: Substance derived from opium poppy or produced synthetically (e.g. heroin, Methadone, Pethidine, Morphine and Codeine).

Outpatient/Non Residential Client: The addict or alcoholic resides at home or in another supportive environment. Outpatient treatment can be available several times a week or once a week, with the services lasting approximately three hours per day.

Parents: A person's biological or adoptive parents, as well as legal guardians.

Pharmacotherapy: Individualized treatment and therapy using prescribed drugs.

Philosophy of treatment: The approach to addiction counselling adopted by the treatment centre, such as AA Twelve Step or Therapeutic Community.

Policy: A definite course or method of action selected by the treatment centre from among alternatives and in the light of given conditions to guide and, usually, to determine present and future decisions.

Post Acute Withdrawal Syndrome (PAWS) (also sometimes referred to as "Post Withdrawal Syndrome" or "Protracted Withdrawal Syndrome"): is a set of persistent impairments that occur after withdrawal from alcohol, opiates, benzodiazepines and other substances. Infants born to mothers who used substances of dependence during pregnancy may also experience a PAWS. PAWS affects many aspects of recovery and everyday life, including the ability to keep a job and interact with family and friends. Symptoms occur in three-quarters of persons in recovery from long-term use of alcohol, methamphetamine, or benzodiazepines and, to a lesser degree, other psychotropic drugs. Symptoms can include mood swings, cognitive impairment, and difficulty forming memories.

Primary counsellor: An individual, professional or accredited staff member especially assigned to clients, who is responsible for their assessment and ongoing management while at the centre. This could be any member of the interdisciplinary team, including a social worker, psychologist, and medical doctor.

Protocol: Document with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare.

Psychiatric nurse: A professional nurse (i.e. nursing officer) who has specialist mental health training registered/enrolled by the Nursing Council of Kenya.

Quality Assurance: Refers to planned and systematic processes that provide confidence in a service's suitability for its intended purpose.

Recovery: The ongoing process of overcoming physical and psychological dependence on mind-altering substances (including alcohol) and learning to live in a state of total abstinence, without the need or desire for those substances. In recovery, one's physical and mental state is modified so that chemical substances are unnecessary for happiness and fulfilment.

Rehabilitation: See 'Treatment'.

Relapse: The return by a person in recovery to the self-prescribed, non-medical use of any mind-altering drug (including alcohol) and risk of the consequent problems associated with such use. It is often preceded by negative thoughts, distorted perceptions, and even nonspecific physical symptoms.

Release planning: A structured therapeutic intervention that assists clients and their families/significant others in preparing for clients' release from the centre and

subsequent integration into family life and other social networks (e.g. community and work).

Residential/inpatient: Substance dependency/addiction treatment provided in a residential setting where clients reside or live in at the centre to obtain treatment.

Risk reduction: Interventions that reduce the risks associated with alcohol and drug misuse.

Screening: A brief assessment of the applicant's suitability for admission to the centre based on the centre's admission criteria and client need.

Self-help groups: See 'Mutual-help groups'.

Self-medication Model: This view, originating in the 1960s among psychoanalysts, assumes that people self-medicate to cope with life problems. A person in emotional pain will self-medicate to find relief, and this can eventually lead to addiction.

Significant others: Families and clients' families (including spouses, partners and dependents) and other significant non-family members who make up the support system (e.g. guardians, employees, and friends).

Slip: A brief return to drinking or drug-use behaviour.

Sobriety: A state of mental clarity reached through abstinence from alcohol and other drugs.

Social Learning Model: Drinking behaviors are learned as a part of socialization and then are reinforced.

Staff: People employed by or contracted to the centre. This does not refer to volunteers.

Standards: Qualitative statements that describe what constitutes acceptable or adequate performance or resources.

Stimulants: These drugs cause alertness and create energy. Amphetamines, for example, increase the dopamine signalling, stimulating its release or blocking its typical absorption.

Structured daily program: An organized programme of activities and treatment offered by the centre, which occurs during daily "office hours" based on clear therapeutic aims and objectives.

Substance: A chemical, psychoactive substance such as alcohol, tobacco and illicit/illegal, over-the-counter drugs and prescription drugs.

Substance dependence: A health condition which involves physical and/or psychological addiction to a psychoactive substance. The result of which is (i) a major disruption and distress in the person's life (and usually that of his/her family/caregiver) and functioning; (ii) a persistent desire or craving to take a substance (usually with unsuccessful efforts to reduce or stop); (iii) a great deal of time spent in trying to acquire the substance (including often high-risk and illegal activities); (iv) the continuation of the substance usage despite an awareness of the destruction and damages caused; (v) a marked increase in the amount of substance required to attain

the desired intoxication effect (i.e. diminished effect of the substance and increased tolerance); (vi) the presence of withdrawal symptoms if the substance is reduced or withdrawn; (vii) rapid progression into the dependent state on resumption of substance use after a period of abstinence. Substance dependency therefore affects a person's emotional, psychological, physical, interpersonal and spiritual life and lifestyle.

Substance Use Disorder (SUD): The disorder is characterized by a pattern of continued pathological use of a medication, non-medically indicated drug or toxin, that results in repeated adverse social consequences related to drug use, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems. Substance abuse is defined in terms of the social consequences of substance use. Substance dependence is defined in terms of physiological and behavioural symptoms. Some consider substance dependency as a brain disease.

Therapy: Treatment provided by professional staff.

Tolerance: A situation where higher doses of a drug or alcohol are needed to achieve the same effect as initially experienced.

Treatment: The clinical process by which the clients are assisted in abstaining from their drug abuse/dependency and in participating in rehabilitation to achieve their optimal level of functioning. This process is based on best practice health care principles. Treatment should be holistic and, as far as possible, address all the clients' (and their families' and significant others') needs, i.e. physical, psychological, social, vocational, spiritual, interpersonal and lifestyle needs.

Treatment centre: A licensed facility that specializes in the evaluation and treatment of drug addiction, alcoholism and associated disorders. This centre may provide residential treatment, partial hospitalization treatment or outpatient treatment services.

Treatment plan: Is a medical and clinical plan, designed by the physicians and clinicians of addiction and alcohol treatment programs, complete with goals and objectives focused on the addict or alcoholic achieving and maintaining long term abstinence.

Tuberculosis: (abbreviated as TB for *tubercle bacillus* or Tuberculosis) is a common and often deadly infectious disease caused by mycobacterium in humans, mainly *Mycobacterium tuberculosis*.

Treatment for substance abuse: A planned systematic program to help a person become abstinent and remain so, while improving his or her quality of life.

Twelve Steps: The steps taken by the founders of AA as they turned away from alcohol; used today by millions of people attempting to recover from addiction to a wide variety of substances and behaviours.

Twelve Traditions: The guidelines that govern the way Alcoholics Anonymous groups are run.

Volunteer: An individual offering services at the centre without formal employment or remuneration.

Withdrawal: What someone who is addicted to drugs or alcohol experiences when they abruptly discontinue the use of drugs or alcohol.

Withdrawal symptoms: The actual effects an addict or alcoholic experiences when they discontinue the use of drugs or alcohol. Examples would be: sweats, tremors, nausea, pain in the joints or bone, confusion, loss of concentration, diarrhoea or loss of appetite.

Withdrawal syndrome: Symptoms which develop when an individual who is physically addicted to alcohol or another drug abstains (intentionally or otherwise) and levels of the drug in the body begin to diminish.

LIST OF ABBREVIATIONS

AA	Alcoholic Anonymous
ASAM	American Society of Addiction Medicine
DSM-IV TR	Diagnostic and Statistical Manual of Mental Disorders, Volume IV. This is an internationally used standard diagnostic classification system developed by the American Psychiatric Association (1994).
ICD-10	<i>International Classification of Diseases</i> , Volume 10. An international disease classification system which includes physical and mental health conditions.
KCA	Kenya Counselling Association
KPA	Kenya Psychological Association
KPA (K)	Psychiatric Association of Kenya
NA	Narcotics Anonymous
NADAC	National Association of Alcohol and Drug Addiction Counsellors (UK)
NAADAC	National Association of Alcohol and Drug Addiction Counsellors (USA)
NACADAA	National Campaign Against Drug Abuse Authority
NDCS	National Strategy for the Prevention, control and mitigation of drug and substance abuse
NGO	Non-governmental organization
NIAAA	National Institute of Alcoholism and Alcohol Abuse (USA)
NIDA	National Institute of Drug Abuse (USA)
OT	Occupational Therapist
S & C	Standards and Criteria
SUD	Substance Use Disorders
TB	Tuberculosis
TC	Therapeutic community
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drug and Crime
USDHSS	United States Department of Health and Social Services
VCT	Voluntary Counselling and Testing for HIV/AIDS
WHO	World Health Organization

COMPONENTS OF STANDARDS

1. RIGHTS, RESPONSIBILITIES AND DUTIES

1.1 Standard statement

The rights of the clients are upheld by the treatment centre within an ethos of client dignity, appropriate treatment provision and respect for human rights.

1.2 Rights of clients: The constitutional rights of the clients are upheld and supported by the centre. Specific care is taken to ensure that clients are not deprived of their basic constitutional rights. This includes the following rights.

- (a) The right to personal liberty.
- (b) The right not to be treated or punished in a cruel, inhumane or degrading way.
- (c) The right not to be subjected to forced labour and to unfair labour practices.
- (d) The right to freedom of religion, belief and opinion.
- (e) The right to freedom of expression.
- (f) The right to equality, and equal protection and benefit before the law.

1.3 Responsibilities and duties of treatment centres: The centre shall establish policies and systems that ensure realization of clients rights. The policies and systems shall cover the following areas or aspects in regard to. (a) Dignified and humane treatment and care, effective communication in a language and manner that clients understand reasonable expectations in terms of the range of services offered and the quality of care provided. Access to locally available services.

- (b) The right to exercise choice and guide treatment through informed consent.
- (c) Freedom from discrimination in terms of inequitable access to treatment. privacy and appropriate confidentiality, appropriate treatment and medication, protection from psychological, physical and verbal abuse, adequate information about clients' clinical and treatment status and the range and options of treatments available. Prompt assistance, especially in emergency situations, safe treatment environments and adequate water, sanitation and waste disposal, protection from life-threatening diseases, freedom to express opinions and make complaints that will be investigated.

1.4 Rights documents: Clients' rights and responsibilities are clearly communicated to all clients, their families, significant others and staff from the onset of the clients' entry into the centre as may be deemed appropriate.

Staff and clients' rights and responsibilities should be documented and made accessible to clients, their families and significant others. These should form part of the clients' admission and orientation. Care is taken to ensure that the

rights and responsibilities are communicated in a manner appropriate to the clients' (and their families'/significant others') age, language and competencies. Clients should sign a contract upon entering the centre to ensure that they have indeed understood what has been explained to them.

1.5 Discrimination: Treatment facilities seek to ensure that no discrimination occurs on the basis of race, class, gender, ethnicity, colour, age, location, social status, language, sexual orientation, diagnosis, disability, clinical or forensic status in the quality of care and the type of service offered.

2. LEVELS OF SERVICE DELIVERY

The following are the levels of service delivery as described under treatment and rehabilitation:

LEVEL 1: Community Outreach Prevention and Early Intervention

This includes services described under ASAM Placement criteria, level 0.5 and Risk Reduction programs.

LEVEL 2: Non-Residential services

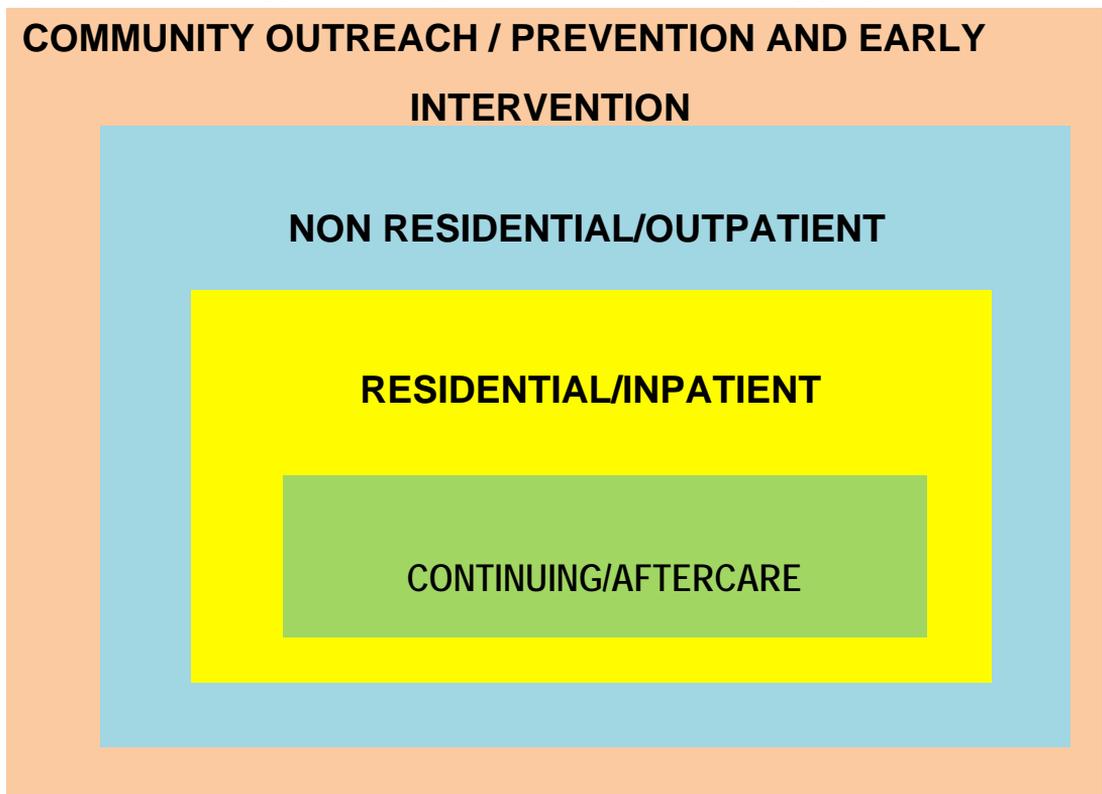
This includes outpatient and Intensive outpatient treatment/partial hospitalization services described in ASAM Level I and II services.

LEVEL 3: Residential/Inpatient services

Includes a range of services including residential, clinically managed residential and medically managed residential services. These are described in ASAM level III services. Medically managed intensive inpatient services described in ASAM Level IV services is also described in this level.

LEVEL 4: Continuing/Aftercare

Follow up outpatient services, halfway houses, transitional houses, community/significant others support, re-integration services and self help programmes



3. LEVEL 1: COMMUNITY OUTREACH, PREVENTION AND EARLY INTERVENTION

3.1 Standard: Community Outreach and Prevention

3.1.1 Standard statement

Individuals, families, groups, institutions/organisations and communities are sensitized about the dangers and manifestations of alcohol and drug abuse as well as the availability of treatment services. In addition to helping them maximise existing strengths, develop new capacities that will promote resilience.

3.1.2 Outcome

Target individuals are prevented from developing substance use disorders.

3.1.3 Program practice

Outreach workers demonstrate that measures are taken to:

- Strengthen vulnerable community members to develop resilience.
- Develop mechanisms and processes for identification and referral of individuals at risk.
- Promote prevention programmes aimed at preventing the initiation of alcohol and drug use/abuse and reducing and preventing the harmful effects of misuse.

Special programmes for early intervention:

- Education programme specifically for those selling substances.
- Education programme for professionals, e.g., Health workers and educators.
- Educational programmes specifically for parents/families/significant others.
- Prevention programme for drinking/drug use and driving.
- Education programmes for students, commercial sex workers, long distance truck drivers and other vulnerable groups.

3.1.4 Management actions

- Outreach workers have policies and procedures to ensure that measures are taken to attend the above program practice.
- Outreach workers receive training, support and developmental supervision that maximize their ability and capacity to implement the policies and procedures on outreach and prevention effectively.
- Resources are allocated in such a manner as to maximize the delivery of outreach and prevention services and programmes.

4. EARLY INTERVENTION

4.1 Standard: Risk reduction

4.1.1 Standard statement

Identify high risk individuals and groups based on a developed and intervene promptly to prevent them from becoming addicted to substances.

4.1.2 Outcome

Early identification and brief intervention to modify behaviour and minimize harm among substance abusers who are not yet dependent.

4.1.3 Early Intervention for Substance Use Disorders

Early intervention is: An approach that aims to reduce alcohol or drug-related harm through timely identification and tailored advice and support for those at risk of harm due to their hazardous or harmful use of alcohol or drugs.

A program, service or resource is “early intervention” if it:

- is aimed at reducing alcohol and/or drug related harm and encouraging moderation.
- is available for groups/individuals that are drinking or drugging in a hazardous manner.
- is easily accessible.
- has the capacity to identify those at high risk or due to their hazardous drinking or drugging.
- is a form of secondary prevention.
- is tailored for the groups/individuals that are drinking or drugging in a hazardous manner and are therefore at risk.

4.1.4 Screening and brief intervention (SBI) for alcohol and other substance use is a technique used by primary healthcare providers, VCT counselors, ART clinicians and counselors, and peer counselors to identify and intervene with people who use alcohol or drugs in a harmful or hazardous way, and may be at risk for substance use-related problems or injuries.

SCREENING and BRIEF INTERVENTION (SBI) targets individuals who use alcohol and other drugs who may not be abusive or dependent and could reduce their use through early intervention, generally in the healthcare setting.

4.1.5 Commonly Used Screening Tools: Alcohol: CAGE, AUDIT, AUDIT-C, MAST; Drugs: DAST; Alcohol, Smoking and Substances: NIDA-Modified ASSIST.

4.1.6 Brief intervention:

- short sessions.
- aimed at reducing alcohol and/or drug consumption.
- utilized with individuals.
- at any point on the continuum of alcohol use, abuse and dependence.

4.1.7 REFERRAL to TREATMENT (RT) provides a mechanism for providing a continuum of care to those individuals identified as having already moved beyond the at-risk threshold and may be in need of some level of substance use intervention or treatment.

5. LEVEL 2: OUTPATIENT/NON-RESIDENTIAL TREATMENT

5.1: Standard Outpatient Non-residential Treatment

5.1.1 Standard statement

Clients participate in a structured outpatient treatment and rehabilitation programme that effectively and safely addresses treatment goals and is supported by appropriate activities and routines.

5.1.2 Outcome

A formal outpatient treatment and rehabilitation programme that addresses clients' needs utilized.

5.1.3 Programme practice — Treatment and rehabilitation programme

Programme models/philosophy: A formal outpatient treatment and rehabilitation model and programme defined, regularly reviewed and updated in accordance with national and internationally accepted standards. The treatment and rehabilitation programme describes structured weekly and daily activities, individual and group counselling/therapy; and in a time-bound programme.

Programme content: The structured programme consists of:

- (a) Individual sessions, youth therapy and family therapy.
- (b) Life and social skills.
- (c) Psycho-educational groups.
- (d) Recreational and creative activities.
- (e) Spiritual counselling (optional).

Individual and group therapies may be psychotherapeutic; life skills (e.g., anxiety management, social skills training, problem solving and goal setting), self-help, and psycho-educational (e.g., drug information and relapse prevention).

Programme duration: The duration of the short term treatment programme is a minimum of six weekly sessions, while the long term is a minimum of 12 weekly sessions. The duration of treatment may also be set according to clients needs.

5.1.4 Management actions

Programme communication and participation: The treatment programme, daily activities and expectations are documented and communicated to clients, their families and significant others. Appropriate opportunities exist for clients to participate in decision making on the daily activities and other issues that affect the centre and clients' community. This can include orientation information, posters and regular staff and clients' meetings.

Policy and procedures: The centre has documented policies and procedures that it implements to regulate and guide daily activities at the centre.

Meals:

- (a) Clients can be provided with refreshments when necessary.
- (b) The centre should have proof of regular inspection and certification of the kitchen and food preparation area(s) by Public Health Officers from the Ministries of Local Government or Public Health and Sanitation.
- (c) Nutritionists from the Health Ministry should review menus and meal quality regularly.

Space: There are adequate and appropriate spaces in the centre and its grounds for treatment activities, relaxation, solitude, recreation and exercise.

Therapeutic amenities: The centre provides an acceptable environment that enhances the positive self-image of clients and preserves their human dignity. This covers the following:

- (a) Clean, well-ventilated, well-lit treatment and therapy area.
- (b) Adequate security against intruders, theft and crime, such as security personnel and/or perimeter fencing.
- (c) Toilets and showers/baths in good repair.
- (d) Sufficient bathrooms and toilet facilities: at least 1 toilet to every 8 clients and 1 bath and shower to every 12 service users.

The rest of the standards, policy and procedures are as described under the sections of the continuing/aftercare.

6. LEVEL 3: INPATIENT/RESIDENTIAL TREATMENT

6.1 Standard: Inpatient/residential treatment

6.1.1 Standard statement

Inpatient/residential treatment services are provided for person with substance use disorders.

6.1.2 Outcome

Individuals with substance use disorders are admitted, treated and discharged from inpatient/residential treatment centres.

6.1.3 Programme practice

- Substance-dependent persons admitted to inpatient/residential treatment centres fill in appropriate admission forms.
- The referral of substance-dependent children from borstal institutions and rehabilitation (approved) schools should be accompanied by relevant documentation from the Children's Department or Probation Office.
- Voluntary clients admitted to inpatient/residential treatment should be accompanied by a voluntary admissions form.

6.1.4 Management actions

- Copies of relevant legislation are provided to all service providers. These would include:
 1. Medical Practitioners and Dentists Board Act.
 2. Mental Health Act , Chapter 248 Laws of Kenya of 1984.
 3. Pharmacy and Poisons Act, Chapter, 244 Laws of Kenya.
 4. Public Health Act, Chapter 242, Laws of Kenya.
 5. Narcotic Drugs and Psychotropic Substances Control Act, 1994.
 6. Tobacco Control Act , 2007.
 7. Food, Drugs and Chemical Substances Act, Chapter 254, Laws of Kenya.
- Service providers are given appropriate training and support that maximizes their ability to implement the relevant legislation effectively.
- The centre has clear, documented admission criteria that guide the admission of the above-mentioned persons.

6.2 Standard: Client assessment

6.2.1 Standards statement

All clients receive a comprehensive, accurate, timely assessment of their physical, psychiatric and psychosocial functioning and a specified regular review of such functioning.

6.2.2 Outcome

The subjection of all clients to holistic assessment processes.

6.2.3 Programme practice

- **Assessment of competencies:** Assessments will be undertaken by professional staff with the relevant knowledge, skills and competencies. *A medical or psychiatric diagnosis should only be done by qualified medical clinicians.*
- **Intake assessment:** Intake assessment or screening is undertaken by a medical and addiction clinician within 24 hours, or, in the case of clients admitted with alcohol, benzodiazepine or opiate dependency, within 8 hours of admission. The assessment includes:
 - (a) Bio-data and brief personal history.
 - (b) Mental state examination, including intoxication status and needs.
 - (c) Provisional psychiatric history and diagnosis.
 - (d) Physical examination and history of medical conditions, including tests to facilitate evaluation.
 - (e) Brief history of substance abuse and past treatment, if any.
 - (f) Past and current use of medication, if any.
 - (g) Assessment of risk potential (i.e., for suicide and other forms of self-harm) and specifications for detoxification (if offered).
- **Comprehensive biopsychosocial spiritual assessment:** A comprehensive assessment is undertaken within 72 hours of admission by qualified and experienced professionals. The assessment includes:
 - (a) Psychiatric and physical assessment and diagnosis, with special reference to any co-morbid conditions.
 - (b) Comprehensive psychosocial, developmental and functional assessment including an evaluation of the client's social situation (e.g., family, employment, housing and legal situation) and vocational and developmental needs.
 - (c) Referral for a more in-depth psychological, social, psychometric or physical evaluation, as appropriate.
 - (d) Initial treatment goals and prognosis.
- **Psychiatric diagnosis:** Identified clients receive as part of the comprehensive assessment a psychiatric diagnosis, according to DSM-IV TR or ICD 10, made by an appropriately qualified and experienced professional staff member. All psychiatric diagnoses are provisional until they have been reviewed by the psychiatrist and the interdisciplinary team.

- **Specialist and team review:** The results of each client’s comprehensive assessment are reviewed by a primary counsellor/case manager and the centre’s multi-disciplinary/transdisciplinary team within 1 week of the client’s admission.
- **Documentation:** The assessments are recorded in the clients’ case records within 24 hours.
- **Assessment panel:** The results of the comprehensive assessment and the treatment plan are presented and discussed at case conferences. This occurs within the first ten days of admission.
- **Client feedback:** Clients receive feedback during the assessment process on the results of the process.
- **Review of progress:** A formal review of the clients’ treatment progress (including psychiatric status) is done weekly by the multidisciplinary team. The review is made available weekly by the primary counsellor/case manager and monthly by the multidisciplinary/Tran disciplinary team.

6.2.4 Management actions

Policy and procedures: Documented, up-to-date policies and procedures support monitor and regulate the assessment and review process. Clients may submit reasons to the supervisor for a change in primary counsellor/case manager should they be dissatisfied with therapeutic relationship or the counselling provided. The management ensures that clients are given this option, and attends to feedback from clients.

6.3 Individualized treatment planning (ITP)

6.3.1 Standards statement

All clients have a documented, individualized treatment plan that encourages their participation, motivation and recovery.

6.3.2 Outcome

Treatment plan: All clients have an individualized treatment plan/programme.

6.3.3 Programme practice

Informed consent and information: Informed consent is sought from all clients prior to the onset of any treatment. Clients are given the opportunity, as far as possible and appropriate, to make choices regarding their care and are provided with adequate information on the specific treatment (e.g., medication used) and risks, benefits and options of the treatment offered. For children and persons without a mental capacity to make decisions, their parents/guardians will be required to make informed consent on behalf of the clients.

See relevant legislation for the rights of children to provide informed consent.

- **Health promotion/prevention:** Treatment centres will seek to promote optimal client health and well-being and to prevent the onset and negative impact of health and mental health/substance-related problems among clients (and their families and significant others). The following is included:
 - (a) Information and practical support to maintain a healthy, alcohol and drug-free lifestyle (e.g., exercise, better nutrition, stress management).
 - (b) Information and practical support to prevent the onset and spread of HIV/AIDS and other sexually transmitted and infectious diseases (e.g., voluntary counselling and testing, risk reduction education regarding needle use).
 - (c) Access to reproductive health care and support of pregnant clients.
 - (d) Access to nutritional support and supplements for chronic alcohol-dependent clients.
- **Individual treatment selection:** Treatment is planned for clients according to the nature of their substance addiction/dependency and/or other psychiatric or psychological conditions (symptoms, severity and history), their personal preferences, strengths and characteristics, and their social needs and circumstances.
- **Care plan:** Based on the comprehensive assessment, a written individual treatment plan or provisional development treatment plan is developed in partnership with the client and recorded. The plan contains the following:
 - (a) Clear and concise statement of the client's current strengths and needs.
 - (b) Clear and concise statement of the client's presenting issues.
 - (c) Clear and concise statements of the short and long-term goals the client has undertaken to achieve.
 - (d) Type and frequency of therapeutic activities and treatment programme in which the client will be participating in order to achieve his/her stated goals.
 - (e) Staff responsible for the client's treatment and their individual counsellor.
 - (f) The client's responsibilities and commitment to the rehabilitation process.
 - (g) The plan is dated and signed by the individual counsellor and the client and a copy given to the client.
- **Participation:** Clients participate in the development and regular review of the treatment plan.
- **Core competencies:** Addiction counselling staff must have knowledge, skills and competencies to undertake the following:
 - (a) Screening to establish whether the client is appropriate for the programme.

- (b) Intake – Administrative and initial assessment procedures.
- (c) Orientation of the client.
- (d) Assessment – For the development of a treatment plan.
- (e) Treatment planning, including special needs planning (children and adolescents, the elderly, disabled).
- (f) Counselling (individual, group and family).
- (g) Individual case management/treatment.
- (h) Crisis intervention – Acute emotional or physical distress.
- (i) Client education.
- (j) Referral – If the patient’s/client’s needs are not being addressed by the programme.
- (k) Reports and record keeping.
- (l) Consultation with other professionals on client treatment services.

6.3.4 Management actions

- **Treatment standards:** Facilitate the provision of treatment that is safe, evidence-based and meets internationally accepted standards.

This includes any homeopathic or complementary therapies offered at the centre (e.g., aromatherapy and hypnotherapy). These therapies may only be used as prescribed by a medical doctor or psychiatrist. All alternative therapy practitioners should be officially registered and recognized by the appropriate statutory body.

- **Primary counsellor/case manager:** All clients are assigned a primary counsellor/case manager who is a professional addiction counsellor or psychologist. Basic requirements are that:
 - (a) The primary counsellor is responsible for assisting clients to identify and develop their treatment goals and tasks, to provide regular support and motivation, and liaise with families and significant others.
 - (b) The primary counsellor meets for a minimum of 60 minutes once a week with the client to review treatment progress and next course of action.
 - (c) The primary counsellor is reasonably accessible to clients for support and crisis intervention even outside of fixed counselling sessions.
 - (d) The centres stipulate the optimum and maximum case load for each primary counsellor (e.g., 20 clients). The ratio is 1:15 for those using TC model; 1:10 for Matrix model; and 1:7 for Minnesota model.

6.4 Standard: Pharmacotherapy and medical care

6.4.1 Standard statement

Medication and other medical care are provided in a timely, accessible and professional manner in accordance with statutory requirements and client safety.

6.4.2 Outcome

Medical coverage: Routine medical and mental health care is available through employed or contracted medical and mental health professionals.

6.4.3 Programme practice

- **Medical coverage:** Emergency medical and mental health care is available to clients 24 hours a day, 7 days a week.
- **Clinical/Case record:** A medication record will be kept in the clients' case records in accordance with statutory requirements and will include the following:
 - (a) Name of the medication,
 - (b) Method of administration,
 - (c) Dose and frequency of administration,
 - (d) Name, date and signature of prescribing doctor,
 - (e) Name, date and signature of person administering or dispensing drug.

Refer to the Pharmacy and Poisons Act, Cap 244 Laws of Kenya.

- **Medicine administration:** Medication is administered only by a registered professional nurse or medical practitioner according to the documented instructions of the attending doctor/psychiatrist. Self-administration of prescribed medication is observed by or is done under the supervision of such registered staff members. Medicine prescribed for one client shall not be administered to or allowed to be used on another client.
- **Medicine-related monitoring:** Clients are carefully monitored by professional staff to prevent and/or respond promptly to adverse effects of prescribed and non-prescribed medication. Adequate review of the clients' condition and treatment should take place to ensure prompt response to signs of adverse effects and side-effects.
- **Medicine storage and disposal:** Storage and disposal of medicines comply with current legislation.

All medicines should be kept in locked storage and all controlled substances in a locked box in a locked cabinet. Medicines that require refrigeration should be kept in a refrigerator separate from food and other items.
- **Emergency medicine and equipment:** Medicine and equipment for emergency use and first-aid are available and functioning, and staff is skilled and equipped to use/administer them.

- **Medicine records:** Records for medicines are accurately maintained according to statutory requirements.
- **Prescriptions:** Clients will undergo an initial intake assessment (i.e., face-to-face examination) by a medical clinician before any medicines are prescribed.
- **Medical waste storage and disposal:** The centres will store and dispose of medical waste (e.g., syringes and unused medicines) according to current statutory requirements. *All unused prescription drugs prescribed for residents should be destroyed by the person responsible for medicines, and such destruction should be witnessed and noted in the clients' case record.*

6.4.4 Management actions

- **Prescriptions:** Adequately skilled medical clinicians are available to evaluate the need for and to prescribe medication in accordance with statutory and centre regulations and policy/procedures.
- **Continuity of care:** No clients are prevented from continuing with appropriate treatment prescribed prior to admission.
- **Policy and procedures:** Documented, up-to-date policies and procedures are used to regulate pharmacotherapy and medical care. They include the following:
 - (a) Handling of prescription medicines and the use of over-the-counter medications.
 - (b) Intoxication and overdose.
 - (c) Detoxification and voluntary withdrawal.
 - (d) An up-to-date list of staff qualified and authorized to prescribe and administer drugs.
 - (e) Medicine administration, including timing, venues and supervision.
 - (f) Storage, control, accountability, inspection and documentation of medicines (according to statutory and professional requirements).
 - (g) Monitoring of adverse reactions and medication errors (pharmacovigilance).

The development of policies and procedures is the responsibility of the Ministry of Medical Services and not that of the treatment centres. Therefore the treatment centres shall apply the policies and procedures stipulated by the Ministry in charge of medical services or WHO recommended policies and procedures.

- **Treatment protocols:** Documented, up-to-date and scientifically based treatment protocols of established safety and efficacy are used to regulate, monitor and support clinical regimes, including the following:
 - (a) Polydrug usage and related complications.

- (b) Intoxication and overdose.
- (c) Detoxification regimes based on type of substance/s abused (including medicine dosage, administration and frequency of administration, client care and monitoring, and required equipment).
- (d) Assessment and management of HIV/AIDS, tuberculosis and hepatitis.
- (e) Emergency procedures.

It is not the treatment centre's responsibility to develop treatment protocols; rather, these protocols should be developed by the Ministry of Medical Services. Therefore the treatment centres shall apply the treatment protocols stipulated by the Ministry in charge of medical services or WHO recommended protocols.

- **Detoxification:** Detoxification (including voluntary withdrawal) occurs according to written policies and procedures. All components of care are available from centres that render detoxification services. Components of such policy include:
 - (a) Type and qualification of staff;
 - (b) Assessment and placement procedures;
 - (c) 24-hour professional nursing and easily accessible medical backup;
 - (d) Standardized, official, best-practice detoxification protocols;
 - (e) Client background information;
 - (f) Client participation and informed consent in detoxification decision-making process;
 - (g) A documented, individualized detoxification treatment plan (including referral if required) based on detoxification protocols, the clients' individual needs and preferences and the centre's capacities;
 - (h) A safe, quiet and comfortable space for the detoxification process;
 - (i) Adequate monitoring and supportive care;
 - (j) Pharmacotherapy (as per protocol for medicated detoxification) including adequate, individual-specific, prescribed medicines;
 - (k) Emergency care and equipment, including referral to hospital, if required;
 - (l) Feedback and support to family and significant others if appropriate.

6.5 Structured treatment programmes and daily activities

6.5.1 Standard statement

Clients participate in a structured treatment and rehabilitation programme that effectively and safely addresses treatment goals and is supported by

appropriate activities and routines.

6.5.2 Outcome

A formal treatment and rehabilitation programme that addresses clients' needs.

6.5.3 Programme practice.

Treatment and rehabilitation programme

- **Programme models/philosophy:** The management formulates a specific programme model and philosophy for their formal treatment and rehabilitation programme, and this is regularly reviewed and updated in accordance with WHO standards. The treatment and rehabilitation programme describes structured daily and weekly activities, individual and group sessions, stages or phases of treatment and related goals in a time-defined programme.
- **Programme content:** The structured programme consists of group counselling/therapies, opportunities for individual and family therapies/counselling and organized group activities such as sport, health education (e.g., HIV/AIDS), recreation and creative activities.

Individual and group therapies may be psychotherapeutic, life skills (e.g., anxiety management, social skills training, problem solving and goal setting), self-help (AA and NA), and psychoeducational (e.g., drug information and relapse prevention).

- **Programme duration:** The duration of the treatment programme offered by the centres should be defined by the management in accordance with the treatment model.

6.5.4 Management actions

- **Programme communication and participation:** The treatment programme, daily activities and expectations are documented and communicated to clients, families and significant others. Opportunities exist for clients to participate in decision making on the daily activities and other issues that affect the centre and client community.
- **Guidelines for daily activities :** The centre has documented guidelines that it implements to regulate and guide daily activities at the centre.
- **Client's and visitors' rules:**
- The centre has documented rules that it implements to regulate and guide client's and visitors' conduct at the centre. These may include:
 - (a) Client waking and sleeping times.
 - (b) Telephone use for private conversations.
 - (c) Visits from families and significant others, friends, religious leaders and legal counsel.

- (d) Visits and outings beyond the centre.
- (e) Conduct of clients and Group norms.

- **Clients labour:** Clients may be involved in non-exploitative work/labour including vocational skills training activities (e.g., meal preparation, cleaning of residential facilities) as may be prescribed in the treatment programme. All work and vocational activities should support clients' rehabilitation needs and individual treatment goals.
- **Meals:** Clients are given a minimum of three nutritious meals a day. If clients are allowed to participate in preparing meals, this must be according to documented client labour policies, health regulations and food hygiene. The centre should have proof of regular inspection and certification of the kitchen and food preparation area(s) from the local authority or public health officer. Nutritionists from the relevant health ministry should review menus and meal quality regularly.

6.6 Standard: Discharge and Re-admission

6.6.1 Standard statement

Clients are provided with appropriate programmes and support to enable their effective transition from a treatment centre to their families and re-integration into their communities.

6.6.2 Outcome

Clients fully prepared to participate in continuing care and follow-up programmes in their communities.

6.6.3 Programme practice

- **Discharge assessment and review:** All clients are assessed and reviewed by the multi-disciplinary/trans-disciplinary team towards the end of treatment to determine their readiness for discharge and to facilitate discharge planning.
- **Discharge documentation:** Relevant referral agents are supplied with a confidential, signed and dated discharge summary on time to facilitate continuity of care for all clients leaving the centre. A copy of this report is kept in the client's case record. The summary includes:
 - (a) Clients' personal details.
 - (b) Personal history and family/social background.
 - (c) Treatment plan and progress/participation at the centre.
 - (d) Reason for discharge (e.g., completed programme or non-compliance).
 - (e) Continuing care needs and preferences (discharge plan).

- **Continuing care:** Prior to discharge, the centre links the clients to their original referral and any other community resource e.g., social workers and self-help groups.
- **Discharge information:** Discharge information is provided for all client families and significant others, as appropriate, on discharge, expulsion or leaving against staff advice. The discharge information includes:
 - (a) Details, precautions and guidance on any prescribed medicines at discharge. Where advisable for a particular client, alternative arrangements must be made for the collection of medication by a family member or a significant other.
 - (b) Names and details of Continuing care referrals/sources (e.g., AA and NA meetings).
 - (c) Names and details of emergency and contacts for crisis intervention associated with relapse prevention.
 - (d) Procedure for readmission to the centre, if sought.
- **Information for significant others:** Families and significant others are assisted in planning and anticipating the client's discharge and return to his/her home (alternative dwelling) and community from the onset of inpatient/residential care. They are also informed, whenever possible, when clients are to be discharged, suspended, expelled or if they have absconded or dropped out.
- **Client's relapse prevention and management plan:** Prior to discharge, clients, families and significant others are provided with information, life skills, support and counselling to assist with relapse prevention and management.

6.6.4 Management actions

- **Policy and procedures:** Documented policies and procedures are available to guide and regulate discharge, suspension, expulsion, Continuing care and readmission to the centre. These policies cover:
 - (a) Discharge planning, procedures and related documentation.
 - (b) Expulsion from the centre due to serious violation of rules and regulations (e.g., possession of harmful substances or weapons, sexual harassment, violence or repeated threats of violence and substance abuse).
 - (c) Discharge and transfer of clients deemed to be unsuitable for the centre.
 - (d) Discharge of children and adolescents without parental consent.

- **Suspension and expulsion:** The criteria and procedures for suspending and expelling clients are clearly communicated to them and their families. Clients have access to a fair investigation and hearing to determine their culpability when suspended or expelled for the violation of centre rules and regulations.
- **Absconding:** Record cases of absconding from the centre into the occurrence book immediately upon detection. Fill out the abscondee form that describes the client's physical features, mode of dressing, perceived mental status, date and time of absconding, staff on duty at the time and their designation. The abscondee form is taken to the nearest Police Station where the report is filed and a stamped copy is retained in the client's file. The family or significant others are also informed.
- **Transfer and referral:** Defined and documented criteria and procedures exist for referring clients in need of alternative services, for example, outpatient treatment, detoxification, adverse drug reactions, attempted suicide, emergency medical care and psychosis. Clients who have been transferred to specialised or mental healthcare facility due to the severity or existence of a co-morbid condition may only be considered for readmission to the centre with the written report of a doctor or psychiatrist.
- **Voluntary discharge:** Mechanisms exist for clients to discharge themselves voluntarily at any stage in their treatment unless judged to be a danger to themselves or are legally committed. The centre staff must be satisfied that a client is mentally fit to make such a decision and the consequences of voluntary discharge are clear.
- **Discharge planning:** The discharge plans are developed and reviewed in collaboration with clients and with the clients' informed consent. An input from the family, employers and significant others in discharge planning is sought. A copy of the discharge plan is kept in the clients' records.
- **Re-admission:** The centre has policies and procedures to support the readmission of clients. The treatment goals and programme for readmitted clients is clearly stipulated in accordance with their treatment needs.

7. LEVEL 4: CONTINUING/AFTERCARE

7.1 Standard statement

Clients placed in appropriate programmes and support structures to enable their effective transition to their families and re-integration into their communities.

7.2 Outcome

Clients participate in continuing/aftercare and follow-up programmes in their communities and are fully reintegrated.

7.3 Programme practice

- Substance-dependent persons discharged from treatment centres are appropriately placed in continuing/aftercare programmes.
- A need based continuing/aftercare plan is developed by a continuing/aftercare provider in consultation with discharging centre.
- Based on their plan, clients participate in one or more of the following continuing/aftercare services: follow up outpatient services, halfway houses, transitional houses, community/significant others support, re-integration services and self help programmes.

7.4 Management actions

- Management provide policies and procedures on a continuing/aftercare services.
- The management provides adequate and appropriate facilities as described under the section on “management of treatment centres”.
- Management ensures close supervision, monitoring and evaluation of continuing/aftercare services provided.

8. FAMILY SUPPORT AND INVOLVEMENT

The centre encourages the support and participation of the clients’ families and significant others as an essential and integral component of treatment and rehabilitation.

8.1 Policies and procedures: Various policies and procedures guide, regulate and encourage the involvement of clients’ families and significant others in the treatment process. These policies cover the following issues:

- (a) Appropriate involvement of families and significant others.
- (b) Confidentiality and disclosure.
- (c) Involvement of parents of children and adolescents.

This should include clearly stipulated instances when families and significant others should be contacted, e.g., to gather collateral information for the comprehensive assessment and admission criteria for children and adolescents.

8.2 Practical support: Practical support is provided to assist families and significant others to participate in the treatment process. This support includes follow-up telephone calls. Centres located in isolated locations may have to make provision for visits by families and significant others.

8.3 Family and significant others interview: Unless specifically contra-indicated, at least one family or significant other interview is held as part of the clients' assessment and/or treatment plans. The interview is documented in the case records.

Information is sought from and support offered to families and significant others to address their problems and needs. The following issues are sensitively and routinely explored:

- (a) Specific needs and conditions of clients' children and dependants.
- (b) Active sexual and domestic abuse within the family, especially of women, children and the elderly.
- (c) Identification of other family members abusing substances within the family and the impact of this on client recovery.
- (d) Support for families and significant others to cope with co-dependency and living with clients' substance abuse (e.g., referral to Al-Anon).
- (e) Support groups at the centre (e.g., Saturday morning family support groups).
- (f) Support for families and significant others to address other mental health and developmental problems within the family (e.g. depression and scholastic difficulties).
- (g) Support and referrals for legal advice or counsel (e.g., Legal Aid).

8.4 Family therapy and counselling: Whenever feasible and indicated, the centre provides family therapy to address longstanding maladaptive interactions within the family as well as new issues related to the reintegration of the client into the family and community.

Family therapy will only be conducted by a trained family therapist or a psychologist with family therapy training.

8.5 DOCUMENTATION, MONITORING AND EVALUATION

Treatment and other service delivery activities are recorded and documented to ensure regular monitoring, evaluation and quality of care.

- Individual case records.

8.5.1 Individual files/folders: All clients have their own permanent, separate client files/folders for their case records.

8.5.2 Confidentiality: The centre has policies and procedures to ensure that confidentiality is protected in all documentation processes in accordance with relevant legislation and regulations.

8.5.3 Document safety and privacy: Case records and other client information are securely stored and transported, and only authorized persons have access to information about clients.

- (a) Confidential case material is never available for public display.
- (b) Whenever possible, permission is sought from clients when confidential information and material is shared with *bona fide* health/social services professionals operating outside the centre (e.g., referral agents) or parents/guardians or school/educational authorities in the case of children and adolescents.
- (c) Case records or reports are stored in secure cupboards and transported in sealed envelopes.
- (d) Attendance registers are treated with the same degree of confidentiality.
- (e) Case records or information managed through computer information systems are secure and confidential.
- (f) All case documentation must be based on the nationally accepted formats. *Staff should ensure that clients are aware, from admission, that all evaluations and therapy/counselling contents and documentation are handled in a respectful and confidential manner and that such material is shared with the centre's multidisciplinary team case management process. Clients may sign a waiver on admission to permit the sharing of confidential material. Confidential case material may have to be shared with external agents without the clients' permission in medical/psychiatric emergencies and at post-discharge. These issues are covered in the centre's confidentiality policy and ethical code.*

8.5.4 Comprehensive records: Case records are a comprehensive factual and sequential record of clients' condition and the treatment and support offered.

- (a) Entries are signed legibly (clear name, signature and professional designation) and dated.
- (b) The diagnosis or clinical impression given to clients is clearly indicated in the records.
- (c) Details are provided of all clients' individualized (sequential) treatment plans including assessment, results of other tests or procedures, and range of treatments and interventions undertaken, other agencies or organizations involved, relevant correspondence (including relevant telephone calls), ongoing progress and discharge planning.
- (d) Notes are taken of multidisciplinary case conferences, consultations and feedback on participation in group treatment programmes.

(e) Daily nursing care records are kept and included in the case records.

8.5.5 Continuity of care: Case records and information are available to facilitate continuity of care. Adequate referral letters and discharge reports are produced in an accurate and timely manner.

8.5.6 Documentation procedures and protocols: The centre has documented protocols and procedures to guide staff in the collection and recording of case records.

- Service improvement and monitoring.

8.5.7 Record quality: The treatment centre monitors its performance through a regular internal audit (at least annually) of its case records in order to improve performance.

8.5.8 Data collection and reporting: The treatment centre collects accurate qualitative and quantitative data that is openly reported and communicated to the governing body, referral sources and relevant role players (such as NACADA Authority). This data supports the supervision, monitoring and evaluation of key service and demographic indicators. The data covers the following:

- (a) Demographic and patient profiles.
- (b) Number of clients to determine patient/staff ratios and occupancy rates.
- (c) Critical incidents (e.g., abscondment, physical violence and sexual acting out).
- (d) Number of detoxifications.
- (e) Length of stay.
- (f) Number of therapeutic/counselling encounters (to estimate level of participation of client).
- (g) Length of time spent on waiting list.
- (h) Client treatment evaluations.

8.6 Special Populations

The centre seeks to ensure that the special needs and rights of special populations, i.e. vulnerable clients, are addressed in its services.

Vulnerable target groups included here are children, adolescents, and people with HIV/AIDS, women, lesbians, gays, bisexual and transgender (LGBT).

There are other vulnerable groups whose specific needs should be recognized. They include people from disadvantaged communities, those with co-morbid psychiatric conditions, prisoners, those with disabilities, the homeless (including street children) and the elderly.

8.6.1 Staff competencies: All staff members (administrative, professional and

accredited) are sensitised to and receive basic education on the specific needs and rights of vulnerable target groups. Professional and accredited staff should be competent to provide specific assessment and counselling for vulnerable groups (e.g. HIV/AIDS counselling).

- Children and adolescents

8.6.2 Rights and principles: The rights and special protection of children are defined by the United Nations Convention on the Rights of the Child (ratified by Kenya through the Children's Act). Key principles here are:

- (a) The best interests of children.
- (b) The survival and optimal development of children.
- (c) The fair and equitable treatment of children.
- (d) Protection of children from unfair discrimination.
- (e) Participation of children in meaningful decision making in all matters that concern them.
- (f) Protection from child labour, physical and sexual abuse

The term children have been used in this document to cover children under the age of 18 years.

8.6.3 Rights in residential care: These rights state that children and adolescents, including those within care, should:

- (a) be protected from maltreatment, neglect, exploitation, abuse and exposure to violence or any other harmful behaviour;
- (b) be protected from economic exploitation, illegal labour or any work that places them at risk;
- (c) not be detained except as a last resort (and according to the provisions made in legislation) and should be kept separately from adults over the age of 18 years, treated in a manner that takes account of their age and developmental needs, have access to legal counsel;
- (d) have regular access and contact with their families and significant others (unless a legal order indicates otherwise, or it is not in their best interest or they choose otherwise);
- (e) receive an assessment of their developmental needs, which are addressed in individualised care;
- (f) receive family-centred interventions that seek to strengthen family development;
- (g) respect the rights of parents to be informed about any action or decision taken in a matter concerning the child, which significantly affects the child;

- (h) have access to education and vocational information and guidance, appropriate to their age, aptitude and ability;
- (i) have access to basic health care, including confidential access to health promotion and prevention (e.g. HIV/AIDS, sexuality and reproduction);
- (j) have access to rest and leisure and engage in play and recreational activities appropriate to their age.

8.6.4 Appropriate care: The treatment centre ensures that all children and adolescents admitted to the centre are correctly placed in terms of the centre's admission criteria.

8.6.5 Consent to medical treatment: Appropriate consent, in accordance with current legislation and clients' right to privacy, is sought from their parents/guardians for all medical procedures. If the parents and guardians cannot be reached in good time medical aid will be provided in cases of emergencies. It is essential that children and parents understand the risks and social implications of their choices. This includes consent for admission to the centre, HIV testing, and reproductive health interventions e.g. education.

8.6.6 Parental involvement: The centre ensures that parents, families and significant others are encouraged and assisted to participate in their children's treatment process. This includes:

- (a) immediately informing them if children fall ill, are injured or are moved or discharged from a residential facility for any reason;
- (b) participation of families in the comprehensive assessment and discharge planning;
- (c) attendance at family therapy/counselling and family support groups;
- (d) provision by the centre the ethical guidelines on the types of confidential information and circumstances for the sharing of such information with parents or other authorities (e.g. educational and legal).

The need for parental involvement is noted as part of the admission criteria. When parents are unable to support their children in this manner, either through parental incapacity or neglect, and this is referred to the relevant statutory social services for assistance and monitoring.

8.6.7 Developmentally appropriate care: The centre provides children and adolescents with developmentally appropriate care. This may include:

- (a) appropriate length-of-stay treatment that does not remove children for longer periods than necessary from their families and school-based education;
- (b) developmental assessment as part of their comprehensive assessment to identify age-appropriate developmental needs;

- (c) separate therapy groups, individual sessions and activities that address age-appropriate developmental needs (e.g. education, vocational guidance, peer relations and sexuality);
- (d) separate sleeping facilities for all children under 12 years of age.

In the case of younger children, it may be appropriate to have completely separate services, e.g. for adolescents between 12-16 years. However, older children and adolescents may benefit from mixed and intergenerational age groups where they may obtain support from older clients and address parent-related issues. Length of stays for children and adolescents should balance rehabilitation needs with the imperative to remove them from their homes, families and schools for the minimum period necessary.

8.6.8 Education: Children continue to receive educational inputs if they are in a residential facility for more than one month. Educational activities do not interfere, however, with prescribed treatment programme activities.

Centres that admit adolescents for this length of time should liaise with the local education department and the adolescents' school teachers. The length of stay for children and at centres should not be artificially extended beyond what is necessary for their individual treatment needs as a result of in-house educational programmes. Discharge planning should include assistance with the reintegration adolescents into the school or other educational facility.

8.6.9 Relationships and communication: Children and adolescents receive appropriate care and treatment that enables them to develop positive relationships and give effective expression to their emotions. This includes:

- (a) encouragement to identify, express and manage their emotions appropriately.
- (b) opportunities for positive interactions and relations with peers and staff.
- (c) staff demonstration of healthy and effective ways to communicate and express emotions.
- (d) encouragement and assistance to restore, maintain and enhance relations with families and significant others.

8.6.10 Behavioural management: Children and adolescents are assisted to behave in a constructive and socially acceptable manner. They are not subjected to punitive "discipline". Positive support includes:

- (a) ensuring that there is adequate information and communication on centre routines (e.g. meal times, wake-up times and bed time), rules, expectations and responsibilities, which facilitates understanding and cooperation.

- (b) providing assistance to meet behavioural expectations through skill development and therapeutic support.
- (c) staff modelling of expected behaviours and attitudes in their interactions with clients.
- (d) ensuring awareness of the consequences of their behaviour in the centre and in their homes and communities.
- (e) providing opportunities to demonstrate and practise positive behaviours.

- **HIV/AIDS and People living with HIV/AIDS (PLWHA)**

8.6.11 HIV transmission: The centre follows guidelines and practices for the prevention of HIV transmission. These guidelines include:

- (a) **HIV/AIDS education** as an integral part of the treatment programme.
- (b) **Accidental transmission:** Universal precautions are taken to prevent HIV transmission. Policies and procedures are in place to treat staff or clients.
- (c) **Safe sexual practices:** The centre has a documented and communicated policy and code of conduct on clients' sexual behaviour in the centre (e.g. between clients and other clients and between clients and staff members). Prevention of HIV through safe sex and/or sexual abstinence is facilitated by health promotion activities, access to condoms and education on the effect of substances on safe sex decision making.
- (d) **Education of ART and substance use:** Health education about the dangers of concurrent alcohol/substance use and ART (e.g. toxicity, compounded immune suppression, non compliance) and the risk of unprotected sex in the transmission of the HIV and development of ARV drug resistance.
- (e) **Safe injection practices:** Regardless of HIV status, injection drug users are informed about harm reduction techniques and safe injecting practices to reduce the risk of contracting or transmitting the virus.

The universal precautions undertaken here are also effective against other prevalent infectious diseases such as Hepatitis B. These precautions include the use of adequate sterilisation procedures, surgical gloves and those governing a resuscitation mouthpiece.

8.6.12 Discrimination: The treatment centre does not discriminate against any applicant or client who is known or suspected to be HIV positive. All

assessments of and treatment/counselling for HIV/AIDS is undertaken in a sensitive, non-judgmental and supportive manner that respects the clients' rights, sexual preferences and emotional/physical needs.

8.6.13 Confidentiality: Client HIV status remains confidential.

8.6.14 Risk assessment: An assessment of HIV-risk behaviours is part of all clients' intake and comprehensive assessment. Based on the findings of this assessment, recommendations are made for further voluntary counselling and testing (VCT). This assessment is undertaken in a sensitive and non-judgmental manner and includes questions on the following:

- (a) Recent sexual history.
- (b) Multiple sexual partners and the use of condoms with these partners.
- (c) Male-to-male sexual partners and the use of condoms with these partners.
- (d) Recent sexually transmitted infections (STIs).
- (e) Commercial sexual activities (including the exchange of sex for money) and the use of condoms with these partners.
- (f) Intravenous drug use, including the sharing of needles, syringes, injection equipment (works), and drug paraphernalia.
- (g) Clients who have experienced rape or sexual abuse and may have been exposed to HIV. They include men and women, especially prison inmates.

8.6.15 HIV and AIDS testing: The centre ensures that voluntary HIV/AIDS diagnostic testing and counselling is readily available to all clients either at the centre itself or through access to support services. Voluntary counselling and testing (VCT) services meet the following criteria:

- (a) All HIV and AIDS diagnostic testing occurs in a voluntary manner without coercion.
- (b) VCT occurs in a private room.
- (c) VCT is conducted only by trained, qualified staff.
- (d) Testing and counselling is voluntary and free of coercion.
- (e) The HIV test and testing procedure is explained to the clients.
- (f) Informed consent is given before HIV testing takes place.
- (g) Refusal of VCT services does not prejudice further access to health, social, or substance abuse treatment services.
- (h) VCT documentation remains strictly private and confidential (e.g. laboratory test results sheets).
- (i) VCT results are confidential and as such cannot be disclosed to the rest of the staff, other clients, or the clients' family members without the clients' informed consent.

- (j) The centre has adequate facilities for ensuring quality control of any specimen tests (e.g. fridge for storing blood samples).

8.6.16 HIV/AIDS post-test counselling: Post-test counselling, irrespective of the results, addresses ways of reducing HIV risk and transmission of the virus. If people test positive for HIV, counselling:

- (a) Supports clients during the personal and emotional impact of the news of their HIV status;
- (b) Provides linkages and appropriate referrals to other support services (e.g. support groups, further counselling, medical treatment);
- (c) Deals with partner notification;
- (d) Deals with ways of remaining healthy;
- (e) Deals with prevention MTC transmission (e.g. use of anti-retroviral drugs and formula feeding) in the case of pregnant women who are HIV positive;
- (f) Deals with safe injection practices.

8.6.17 Provision of medical treatment: The centre refers HIV-positive clients to quality, evidence-based care. This care includes:

- (a) Provision of anti-retroviral medication where possible.
- (b) Delivery of high quality HIV/AIDS information and services.
- (c) Referral to agencies that can provide pregnant women with anti-retroviral medication to prevent MTC transmission.
- (d) Appropriate diagnosis and treatment of sexually transmitted infections (STIs) or referral of people with STIs to STI clinics.
- (e) Treatment of opportunistic infections associated with HIV or referrals to other treatment services.
- (f) Health promotion information and assistance, e.g. regarding nutrition and stress management.
- (g) Continuation of all appropriate prescribed medicines or medical regimen with the approval of the centre's medical doctor.

8.6.18 Ongoing support and counselling: Clients' HIV-positive status is incorporated as an integral and integrated part of their treatment planning and support.

Individual counsellors should seek to provide ongoing support and assistance to address holistically all aspects of clients' HIV/AIDS and substance-related recovery needs (e.g. personal and family and significant others support, spiritual and physical needs). The impact of clients' HIV/AIDS status and their substance-related recovery should be sensitively understood and explored. Counsellors must therefore be skilled and equipped to deal with HIV/AIDS related issues as part of their treatment interventions.

8.6.19 Women's Treatment: Principles and values: Treatment centre must ensure that it offers gender-sensitive treatment for women. This covers the following:

- (a) The social, gender and economic barriers to treatment for women are recognized (e.g. stigma facing women who abuse substances and the lack of an independent income to pay for treatment).
- (b) Treatment supports the empowerment of women and does not reinforce gender stereotypes. It also encourages a woman-centred approach (e.g. awareness of women's social conditions, experience of inequality and the victimisation embedded in women's experiences).
- (c) Treatment addresses all aspects of a woman's life, including the practical needs of women (housing and sanitation, transportation, job training and child care).

8.6.20 Access: The centre strives to make its services more accessible to women who abuse substances. For example:

- (a) The centre does not discriminate against female substance abusers.
- (b) The centre establishes linkages with other organizations serving women (such as Rape Crisis and Domestic violence organizations).
- (c) The centre recognizes the needs of mothers with dependent children and provides support where possible (e.g. more flexible visiting provisions).

8.6.21 Safety and abuse: The centre offers women a safe environment free from sexual or emotional abuse and negative gender stereotypes. It has policies and procedures to prevent and deal promptly with all incidents of abuse in a sensitive, non-victimizing manner. For example:

- (a) Provision of secure and private women-only sleeping and ablution facilities.
- (b) Reporting to the police of any incident of sexual abuse.
- (c) Removal of staff and clients who are at risk of committing or have committed acts of physical or sexual violence against women.
- (d) Sensitisation of male and female clients to sexual violence and abuse issues and gender-related rights (e.g. a woman's right to refuse sexual advances and the impact of substance abuse upon impulse control) as part of the treatment programme (e.g. psycho educational and self-help groups).

8.6.22 Assessment and treatment: The treatment centre conducts screening and post-admission evaluations to ensure that the specific needs/problems of women are addressed. For example:

- (a) The co-morbid mental health and social conditions/problems commonly experienced by women are assessed (e.g. clinical depression, Post Traumatic Stress Disorder (PTSD) and sexual abuse). The centre ensures

that women with such conditions/problems receive adequate care and referral, if required, in accordance with the centre's Scope of Practice.

- (b) The needs of pregnant clients/women are assessed and addressed.
- (c) Treatment is woman focused and addresses the unique issues and needs of female substance abusers (e.g. history of domestic violence and/or physical and sexual abuse).
- (d) Access is granted to necessary health care, including reproductive health care.
- (e) The specific needs of women and girls regarding HIV/AIDS transmission (e.g. power in relationships) are addressed.

The statistically high incidence of co-morbid mental health conditions among women should alert centre staff and referral agents to assess adequately for these conditions.

9. TREATMENT CENTRE MANAGEMENT

9.1 Registration

Each treatment facility must be legally registered in accordance with the requirements of the Laws of Kenya and accredited by relevant government agencies.

9.2 Management structure and composition

Treatment facilities shall have a Board of Directors/Trustees, a director/manager in charge of facility administration, and another director/manager in charge of the treatment and care programme. Where responsibility is shared or overlaps, this should be clearly identified and explained. Board members shall not be abusers of alcohol, tobacco and other drugs.

The members of the management shall have a minimum of a diploma or its equivalent and two years of experience in their areas of specialisation.

The facility, whether independent or part of a multi-faceted organization, must have a written description of itself and of its services, which details ownership and the structure of its administration. Lines and boundaries of authority and accountability (organogram) should be clearly defined, and be referred to in job descriptions.

9.3 Conflict of interest

A Conflict-of-Interest Policy must be developed and strictly applied. This will apply in the event of a business relationship, direct or indirect, between any person on the managing body and the programme itself.

9.4 Quality Assurance Programme

To ensure that treatment is of the highest quality, there must be a Quality Assurance Policy. This will enable the facility and its programmes to be monitored and evaluated for performance and outcome.

The quality and effectiveness of the service provided by the treatment programme will be monitored and evaluated in accordance with the standards laid down by the relevant government authority. These standards are provided specifically to ensure that each client receives accurate assessment, effective treatment and continuing care.

Performance against standards will be regularly evaluated. The evaluation process must provide evidence that the quality assurance programme has influenced organization and programme planning, and explain any failure to meet goals and objectives.

Facilities must prepare written description of services offered so that the

functions of the organization can be set out along with goals and objectives which relate to the needs of both the organization and the clients served. This document will also be used for evaluating the programme and its progress in attaining program goals and objectives.

As a general rule, the written description of services should incorporate:

- A vision, mission statement, treatment philosophy and core values
- Services provided (residential, outpatient, medical care, day care, family, continuing care).
- Evidence based approaches to SUD treatment.
- Clientele served.

It should also contain a description of the programmes, detailing:

- Intake/admission process.
- Assessment, placement and orientation.
- Treatment plan and process.
- Relapse prevention and discharge planning.
- Discharge.
- Continuing Care and self help.

When facilities are organized by departments, services or programmes such a description should show how services relate to each other and to the facility's overall goals. Methods of evaluation, follow-up and outcome should be included in this document.

This description of service is a tool to help the facility ensure that it has sufficient and appropriate professional, administrative and support staff to assess and address the identified clinical needs. The document should describe the organizational lines and boundaries, the role of staff and supervisory arrangements, setting out the procedure for supervision of all clinical activities by qualified experienced personnel.

Management conducts an annual quality assurance review of the facility's services and programs and presents the review report to the Board for its review, recommendations and decision making. The recommendations and decisions are presented to staff for implementation.

9.4.1 Qualifications of staff

The minimum qualification for the clinical team is a Diploma in their areas of specialisation or otherwise specified by the certification boards.

9.4.2 Administrative and clinical supervision

Treatment centers should ensure regular administrative and clinical supervision by accredited supervisors for professional competence and development, institutional integrity, evidence based practices and positive outcomes.

Administrative supervision should be held quarterly while clinical individual and group supervision should be held at least once a month.

Formative and summative evaluations should be carried out and incorporated in practice.

9.4.3 Role of professional bodies

All professional staff must be registered with relevant professional bodies.

9.4.4 Treatment outcome indicators

The management of the treatment facility will ensure that treatment programs meet defined minimum treatment outcome indicators set by the Quality Assurance Board.

9.4.5 Financial management and planning

- **Budget:** The centre has an annual budget that is available for review by the board of directors and other regulatory bodies.
- **Financial regulations:** All financial activities at the centre are in line with current statutory financial regulations (e.g. annual statement of accounts, audited annual reports on finances, assets and liabilities for tax).
- **Planning:** The centre has a strategic and annual business plan that encompasses key aspects of the service and performance indicators of the centre.
- **Annual reports:** The centre submits annual reports to its board. These reports are also readily available to other interested parties.
- **Financial and administration Policy:** The centre develops a financial and administration policy

9.4.6 Meetings

The management bodies must meet at least quarterly or more often if specified by the rules laid down in their constitutional articles. Where these do not exist, rules must be written that ensure regular meetings of any such body. The responsibilities of such bodies and the purposes of any meeting should be clearly defined.

9.4.7 Physical Services

Facilities will have a Health and Safety Policy and Programme in line with the

guidelines and regulations of the existing statutes as provided by the Building Code and other relevant statutory regulations. This policy and its supporting programme should come under the direction of the staff management.

A facility's Health and Safety programme should specify and detail policies and procedures in connection with:

- (a) Fire safety and equipment (including arrangements for the fire drills and notices).
- (b) Emergencies.
- (c) In-house infections.
- (d) Risk management/Liabilities.
- (e) Hazardous wastes.
- (f) On the job injuries.

The safety of the facility will be monitored by means of written staff reports. In this way, policies and procedures can be developed and reviewed bi-annually, with a record kept of policy changes and incidences. It is important that all employees receive the necessary training to ensure that they are able to do their job safely.

9.4.8 Nutrition

All residential facilities must serve at least three nutritious meals per day. In particular, organizations providing 24 hour care that have therapeutic goals relating to nutritional needs and who have services for individuals who require special nutrition considerations should develop written policies and procedures to address all aspects of nutrition and food services. Such policies should include the responsibilities and authority for nutrition and food services of staff at the facility.

9.4.9 Food operations

All nutrition and food services on site are expected to observe applicable statutory regulations concerning hygiene and sanitation. In addition, facilities are required to have a written statement of policy for their food services if they maintain a kitchen. There should be clear guidance with regard to:

- (a) Food purchasing, storage and handling.
- (b) Adequate space, equipment and supplies.
- (c) Maintenance of food services in a hygienic and sanitary manner, particularly as it applies to the preparation and serving of food, the care and cleaning of equipment and work areas and the washing of dishes.

In the event that the policy of the entire facility is to assign individual clients to work in food service for therapeutic or vocational purposes, the method of their assignment will be fully outlined in written policies and procedures. Facilities will produce a special handbook on food operations, which will be reviewed annually as necessary. Nutritional staff must have basic training and understanding in the behavioural and therapeutic needs of the clients. They should encourage the clients to participate in menu planning.

9.4.10 Laboratory services

Facilities must have access to laboratory services necessary for drugs screening, HIV/AIDS and other medical examinations.

9.4.11 Spiritual services

Facilities will provide the opportunity for spiritual services in accordance with the needs of the clients. Arrangements can either be made directly by the facility through a working relationship with local spiritual leaders or through clients establishing such a relationship themselves. There will be written policies and procedures governing such internal and external contact within the facility. Participation in spiritual exercises is strictly voluntary unless the model used is faith-based and clearly stated at the time of admission.

9.5 Human resources management; Staff, training & support

9.5.1 Staffing plan: Treatment facilities will have a staffing plan to identify the number, categories and qualifications of staff.

9.5.2 Staff qualifications and registration: Facilities employ only professional, accredited and administrative staff with the appropriate accredited and recognized professional qualifications. All professional staff are appropriately registered with an official professional or accrediting body. The minimum qualification for the clinical team is a Diploma in their areas of specialisation

9.5.3 Staff composition: Treatment facilities will have the following composition of staff:

- (a) A medical doctor/ psychiatrist and a nurse are employed or are on call for 24-hour backup and consultation.
- (b) The minimum multidisciplinary team consists of a social worker, clinical/ counselling psychologist, accredited addiction counsellor and access to a trained nurse.
- (c) Where detoxification is carried out, a multidisciplinary team will consist of a medical doctor, a psychiatrist and a trained nurse.

9.5.4 Staff numbers and coverage: The treatment centre must have adequate staff to render 24-hour substance dependency services. The staffing norm is as stipulated under “Individualised Treatment Planning (ITP)” section. The minimum number of professional staff available during programme hours is 3 persons i.e. a counsellor, a nurse and access to a social worker.

9.5.5 Job descriptions and contracts: Staff must have written job descriptions and signed contracts that are regularly reviewed by management.

9.5.6 Human resources policies: Treatment centres must have documented up-to-date human resource policies and procedures in line with employment/labour laws that cover the following:

- (a) Recruitment, selection and registration of staff and volunteers.
- (b) Staff orientation.
- (c) Wage and salary administration.
- (d) Skills and qualifications.
- (e) Training and development.
- (f) HIV/AIDS and alcohol and drug policies.
- (g) Promotions.
- (h) Employment benefits.
- (i) Pay conditions of service.
- (j) Lines of authority.
- (k) Case supervision.
- (l) Rules, conduct and ethics.
- (i) Disciplinary actions and dismissal of staff.
- (j) Methods of handling cases of inappropriate care or conduct violation.
- (k) Work performance appraisal.
- (l) Staff accident and safety.
- (m) Staff grievances.
- (n) Staff suspected of using or abusing substances.

9.5.7 Substance abuse status: Staff at the centre, including addiction staff and volunteers, is subject to clear policy and procedures and ethical guidelines regarding their use of substances and subsequent employment at the centre. For example:

- (a) No staff member should be actively abusing substances.
- (b) Recovering addiction counsellors should have been alcohol and drug free for a minimum period of two years before being employed in a treatment capacity. Staff members who have relapsed must have two years of

abstinence and recovery before counselling clients.

- (c) No staff member should receive treatment at the centre for his/her own addiction problems or relapse.

While it may be difficult to regulate and measure, all staff should be encouraged to demonstrate appropriate stress management, emotional maturity, healthy lifestyles (e.g. no smoking and use of alcohol) and positive interpersonal communication. Staff should be discouraged from engaging in any addictive behaviour such as smoking and pathological gambling – this may be included in the centre's code of ethics. Medical staff, with a history of substance dependency and access to medicines and other psychoactive substances, may need additional recovery time before they are able to resume unsupervised medical duties.

9.5.8 Induction, orientation and in-service training: Every treatment centre will have an on-going orientation and in-service training programme for all administrative, therapeutic and support staff. The centre has a documented plan and evidence of attendance at regular staff development training on on-going client and treatment needs. This should include but not limited to training in the following areas:

- (a) General substance dependency, treatment and rehabilitation issues, including new and up-to-date evidence-based interventions.
- (b) First aid and medical emergencies.
- (c) Crisis intervention, including rape and other traumas.
- (d) Counselling skills development.
- (e) Client confidentiality.
- (f) Client rights and treatment ethics.
- (g) HIV/AIDS, tuberculosis, hepatitis B and C and other related medical conditions.
- (h) Common mental health problems (e.g. depression, suicide, psychoses, eating disorders).
- (i) Care of children and adolescents.
- (j) Crisis management, including managing aggression and disturbed, intoxicated clients.
- (k) Sensitivity towards and skills in responding to sexual abuse, incest and harassment.
- (l) Cultural sensitivity and racial diversity.
- (m) Militia/organised gangs/vigilante.
- (n) Sexual orientation and counselling.

- (o) Basic family therapy.
- (p) Vocational training and life skills.

The centre has a documented, up-to-date staff development policy and strategy to train and develop staff to offer adequate treatment. Staff development activities should be planned, scheduled and takes advantage of available resources and opportunities as available internally and externally. On appointment and annually thereafter, staff must be inducted on the Codes of Ethics, Confidentiality, Equal Opportunities, Policies and Procedures.

9.5.9 Staff conduct: All staff adheres to an up-to-date, documented code of ethical conduct that identifies professional boundaries, responsibilities and the consequences of their violation.

9.5.10 Employment assistance: The emotional, mental health and crisis-related needs of staff are recognized. A minimum requirement here is a regular staff support group to discuss problems and issues related to staff members' work and associated interpersonal and personal issues. This includes access to and/or the provision of counsellors and support groups to assist staff to cope with "burnout", work-related stress, their own substance abuse-related issues and critical incidents (e.g. physical assault, sexual harassment).

9.5.11 Research: The centre has clear ethical guidelines for any academic or product-oriented research undertaken at the centre. Staff are encouraged when appropriate to initiate, support and take part in relevant and ethical research. If such research involves the clients, their informed consent is essential. Research is not conducted on an involuntary/uninformed basis (e.g. "drug trials"). Staff are encouraged to initiate quality, outcome-based research and studies to evaluate the acceptability and effectiveness of the treatment offered.

9.5.12 Volunteer services: In cases where volunteer services are used, the objectives and scope of the volunteer service shall be clearly stated in writing. All volunteers who are recovering from alcohol/drug and other dependencies are recommended to have a minimum of two years recovery period, if to be selected to work with clients. Referees, experience and/or training in the alcohol and drug discipline are essential prior to recruitment.

9.5.13 Ethics: The centre has a documented and displayed policy of ethical behaviour to which all staff adheres and are bound.

- (a) Mechanisms exist to ensure that such ethical standards are practised at the centre – this can include staff education, behaviour monitoring and sanction.
- (b) Staffs are made aware of the consequences of violating such ethical

behaviour (e.g. being reported to their professional accrediting board or dismissal from the centre).

- (c) Criminal violations are reported to the police (e.g. theft, fraud and sexual harassment and abuse).

9.6 Therapeutic Environment

The environment and physical structures of the centre are safe and they are alcohol and drug free, and they support adequate residential care and treatment.

9.6.1 Legislation: The treatment centre will ensure that its amenities and physical environment comply with public and environmental health, statutory health and safety requirements as well as fire regulations.

9.6.2 Designation: The building/location used by the treatment centre is dedicated solely to treatment services, and has been designated and authorised for this sole function by the licensing authority.

9.6.3 Policies and procedures: Treatment centres must have documented up-to-date policies and procedures that ensure a safe environment for all people using and accessing the facility, i.e. clients, staff and the public. These policies and procedures cover the following:

- (a) Alcohol and drug-free environment.
- (b) Smoke-free environment.
- (c) Fire safety, including fire drills and functional fire extinguishers.
- (d) Storage of hazardous waste.
- (e) Weapon control and removal.
- (f) Managing aggressive/disturbed behaviour.
- (g) Hazardous areas such as swimming pools/open water, roofs and cliffs.
- (h) Hygiene and pest control.
- (i) Prevention of violence and sexual abuse.
- (j) Access for the physically disabled.
- (k) Security.

9.6.4 Emergency plans: The treatment centre must have documented, up-to-date and regularly tested and reviewed emergency plans specifying the following:

- (a) Floor plan and layout of the centre.
- (b) Instructions in the event of fire, bomb threat or power failure.
- (c) Evacuation procedures.
- (d) Response to medical and psychiatric emergencies.
- (e) Abscondment.
- (f) Emergency contacts.

9.6.5 Safety inspections: The treatment centre must ensure that regular, documented health and fire safety inspections are performed by the relevant authorities.

9.6.6 Space: The treatment centre must provide adequate and appropriate spaces in the centre and its grounds for treatment activities, relaxation, solitude, recreation and exercise.

9.6.7 Provision of recreational services

Every treatment facility shall provide a planned, diversified program of recreational activities that allows clients to participate on an individual or group basis in physical, social, intellectual, religious and cultural activities both indoor and outdoor.

The centre's administrator or designee shall provide for the direction, provision and quality of the recreation service and in so doing shall be responsible for at least the following:

1. Development and implementation of written objectives, policies and procedures, an organisational plan, and a quality assurance program for the recreation service.
2. Ensuring that recreational services are provided for each client as specified in the client's treatment plan and coordinated with other client. Care services to provide a continuum of the care of the client, with documentation of services provided in the client's treatment record.
3. Assisting in the development of written job descriptions for recreational service personnel.
4. Posting a current weekly recreational activities schedule where it can be read by both clients and staff.
5. In centres serving women and children, the provision of age-appropriate recreational activities for the children while the mothers are participating in treatment services as well as the provision of recreational activities for mothers and their children.

9.6.8 Special care and examination facilities: Private rooms or wards are provided as special care and examination rooms for medical procedures/examinations, emergencies and detoxification. In a detoxification centre, a separate special care and examination room is available. The rooms are:

- (a) Easily accessible to medical and nursing staff for supervision and observation;

- (b) Equipped with functioning medical and emergency equipment, according to health ministry specifications;
- (c) Safe so as to prevent self-harm or injury or harm to others (e.g. medicines and equipment safely locked away);
- (d) Comfortable and calm so as to allow clients to relax in comfort during detoxification.
- (e) Provision of a hospital bed in detoxification facilities.

9.6.9 Drug and weapon-free environment: The centre, its grounds and facilities are free of alcohol, tobacco, illicit/illegal psychoactive substances and any weapons. All objects that could be used as weapons shall be kept in custody or if they are for use in the centre they must be accounted for.

This is supported and regulated by appropriate rights-based policy and procedures. Mechanisms exist to monitor and regulate:

- (a) Centre access, including admission procedures;
- (b) The distribution and potential concealment of substances and weapons;
- (c) The investigation of and searching for substances and weapons;
- (d) The control of legitimate medication within the centre.

9.6.10 Searching and confiscation: The centre has mechanisms and procedures to regulate and monitor any one searching for weapons or substances on the premises in a rights-sensitive manner. This includes the documented and advertised right to confiscate any psychoactive substances and weapons immediately, with or without the client's or visitor's consent.

Safeguards to protect clients' and their visitors' rights cover the following:

- (a) Whenever possible, all searching of clients' private belongings and parcels occurs only in the presence of the clients, and only by professional or accredited staff.
- (b) Clients and visitors are informed through instructions displayed prominently at the point of entry of such searching practices, and consent to them as part of their orientation at the centre.
- (c) The bodily integrity of clients and their visitors is not violated by routine or unauthorised bodily searches. In extreme circumstances, clients may be physically searched only with the authorisation of the multidisciplinary team and only by a staff member of their own gender.

All psychoactive substances will be immediately destroyed. In the case of weapons they will be destroyed immediately, handed over to family or kept in custody and returned upon discharge. In the event of firearms they will be handed over to the local police

9.6.11 Locked areas: Locked areas may be used in the centre only for the safe keeping of hazardous, valuable and confidential material belonging to clients and staff against crime and theft.

9.6.12 Residential and therapeutic amenities: The centre provides an acceptable residential environment that enhances the positive self-image of clients and preserves their human dignity. This covers the following:

- (a) Clean, well-ventilated, well-lit treatment and residential areas.
- (b) Each client has his/her own sturdily constructed bed with adequate bedding.
- (c) Windows that can open, with curtains and/or blinds.
- (d) Optimum number of clients' beds per room to avoid overcrowding.
- (e) Access to clean linen, towels and toilet paper.
- (f) Permission to display appropriate personal belongings, decorations that support a substance-free culture.
- (g) Adequate security against theft and crime, such as perimeter fencing and burglar proof bars.
- (h) Toilets and showers/baths in good repair.
- (i) Sufficient bathrooms and toilet facilities: at least one toilet to every 15 male clients and one bath and shower for every 12 female clients. All female toilets must have a sanitary bin.

10. PROCEDURE FOR TREATMENT CENTRES MANAGEMENT

10.1 Appropriate placement: The treatment centre admits and retains only clients according to its current Scope of Practice and its treatment and resident capacities. The capacities should always be defined as part of the centres' operational policy/guidelines. Appropriate referrals are made for clients considered unsuitable for treatment at the centre.

Clients may not be admitted or retained at a centre that does not have the adequate staff, resources and expertise to manage their specific treatment needs. This includes detoxification (including voluntary withdrawal) and co-morbid mental health conditions. Centres should not be overcrowded and admit beyond their occupancy capacity.

10.2 Incident reporting and monitoring: Every incidence of death and grievous injury are accurately documented in an incident register and reported to the relevant authorities.

10.3 Faith-based practices: If the centre has a religious orientation, a written description is provided of particular religious practices that are observed and any religious restrictions. It must clearly inform the prospective clients about the requirement of religious participation as part of their therapeutic approach.

Provision is made for clients to observe religious dietary requirements and access religious leaders and services within the framework of the centre's visiting and leave-of-absence policies.

10.4 Visits and contact: Clients have the right to maintain contact with and receive visits from their families, friends and other persons (e.g. teachers, employers, legal counsel and religious leaders) as may be stipulated in the centres' policies. A documented, enforceable code of conduct for all visitors to the centre is clearly displayed.

Visiting hours must be stipulated but planned to facilitate access. The right to contact should be balanced with the need for client safety and recovery and the need to maintain a drug-free environment. Reasonable steps may be taken, however, to ensure that visitors are not carriers of psychoactive substances into the centre (e.g. by searching parcels and gifts) and do not violate the documented behavioural rules and expectations of the centre (e.g. high noise levels or abusive behaviour). The centre reserves the right to ask such visitors to leave the centre or, if they are involved in illegal or dangerous activity, to report this and seek assistance from the local police. Contact and visits to clients cannot be denied as a form of punishment.

10.5 Abuse: Clients, their families and significant others should not be subject to any activity or procedure that is negligent, demeaning, exploitative or abusive and/or threatens their physical, sexual, and emotional safety or their recovery process.

10.6 Centre rules: Clients, their families and significant others are supported in complying with the behavioural expectations of the centre.

For example:

- (a) They are clearly informed on admission of their behavioural responsibilities in accordance with the rules and regulations of the centre and the consequences of violating these rules.
- (b) Documented rules, expectations and related information are included as part of the admission process and explained to the clients in their own language or at their functional level.
- (c) A signed commitment or contract to abide by such regulations while receiving treatment at the centre is kept in the clients' case records.
- (d) Clear indications are given on admission as to the consequences of clients using or possessing drugs and/or alcohol or any weapon while receiving treatment

These behavioural expectations should be documented in referral and admission information, and should be developed and reviewed by the governing body and the client community with a view to developing further criteria on this issue.

10.7 Behaviour management: Clients do not undergo any “disciplinary” or “initiation” procedure that involves any form of the following:

- (a) Physical abuse. This includes any form of corporal punishment, i.e. any punishment applied to the body such as beating and “caning”.
- (b) Sexual abuse.
- (c) Verbal and emotional abuse, including humiliation and ridicule.
- (d) Incarceration and inappropriate isolation.
- (e) Withholding of any form of medical care, including medicines to ease and facilitate detoxification.
- (f) Punitive exercise.
- (g) Inappropriate or excessive work.
- (h) Undue influence by staff regarding clients' religious or personal beliefs (including sexual orientation).
- (i) Group punishment for individual misbehaviour.
- (j) Withholding of basic necessities such as food, shelter, bedding, sleep and clothing.

- (k) Deprivation of access to and contact visits with family and significant others.
- (l) Measures that discriminate on the basis of cultural, linguistic, heritage, gender, race or sexual orientation.
- (m) Punishment by another client or staff member.
- (n) Any treatment or medical procedure.
- (o) Unwarranted bodily searches.

10.8 Complaints and investigations: The centre ensures that clear, confidential, support mechanisms exist whereby clients can make formal complaints and request investigations into the centre's disciplinary decisions or seek redress for rights abuses.

- (a) An accessible, monitored Complaints Register is kept with data on the investigations conducted and the results as well as the actions taken. The complainant signs the register.
- (b) The centre acts appropriately on all valid complaints within two weeks.

The complaints are regularly reviewed and monitored by management and the governing body. A national, independent body should monitor and investigate such complaints.

10.9 Restraint and seclusion: The centre has clear policy and procedures for temporary seclusion and physical restraint in a safe and non-threatening environment in strict accordance with current Mental Health Act. This may occur only in the following circumstances:

- (a) Clients are an immediate danger to themselves or others, e.g. in case of acute intoxication or psychosis.
- (b) Clients must be assessed as soon as possible by a medical doctor/psychiatrist on call.
- (c) The directive for any restraint or seclusion is confirmed in writing by the centre's medical doctor and is monitored according to accepted protocols.
- (d) The local police are informed of any such action and their assistance is immediately requested.
- (e) Such clients can be transferred to a more secure or contained health or police facility.
- (f) Clients are not secluded for longer than two hours.
- (g) No mechanical restraint is ever used (e.g. ropes or chains).
- (h) Restraint and seclusion is never used as a behavioural management or modification procedure.
- (i) Staffs are competent and skilled in coping with aggressive or threatening behaviour.

The United Nations “Principles on The Protection of persons with Mental illness” state that restraint or seclusion must not be employed except in accordance with the officially approved procedure of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to users or others (Resolution 46/119 principle 11.11). Restraint and seclusion protocols should be developed by the Health Ministry and it is the centre’s responsibility to ensure that they have such protocols.

10.10 Informed consent: The clients (or their legal guardians) /are supported in their right to exercise choice and guide all treatment and participation in any research through informed consent.

The clients should be fully informed as to the nature and content of treatment, confidentiality issues, as well as the expected risks and benefits. This includes participation in any medicine-related “drug trials” undertaken by staff.

10.11 Transparency and access: The centre is transparent and open to scrutiny with regard to human rights abuses, governance and standards of care.

Such scrutiny should, however, be in accordance with the clients’ (and their families’) rights to privacy and confidentiality.

10.12 Privacy and confidentiality: The clients’ (and their families’/significant others’) privacy and right to confidentiality are respected and upheld by the centre. Documented policy and procedures regulate and support client confidentiality and privacy. For example:

- (a) Whenever possible, clients give informed consent for any personal information to be communicated to others (e.g. parents/guardians and schools).
- (b) Clients are not coerced to reveal confidential information to a third party (e.g. family member, employment or therapeutic group).
- (c) No audiotapes, photographs, videotape/films are recorded/taken without the clients’ consent.
- (d) Clear ethical guidelines exist, for instances, where client confidentiality is violated, such as threatened violence and abuse or clients’ refusal to inform a regular sexual partner of their HIV/AIDS positive status.
- (e) All correspondence and personal effects of persons undergoing treatment are regarded as private.
- (f) All clients should also be assisted to develop norms and to respect confidential material shared by other clients in therapeutic group contexts.

- 10.13 Diagnostic procedures and interventions:** Clients' (or their legal guardians') informed consent is always sought for all diagnostic procedures, and clients' right to request voluntary and timely access to such testing is supported.
- (a) This includes diagnostic tests for tuberculosis and sexually transmitted infections (including HIV/AIDS).
 - (b) Policies and procedures exist to access such tests and protect client confidentiality and the legitimate rights of others in this regard (e.g. sexual partners and parents).
- 10.14 Law enforcement and treatment status:** Clients are not asked or coerced to provide general drug-related information to assist the police or other law enforcement agencies (e.g. information on drug sources such as local drug dealers). Unless in circumstances where the client was admitted as a referral from the police department or social services department. The confidentiality of clients' personal case information is upheld as specified by the relevant legislation in this regard.
- 10.15 Leisure and lifestyle:** All clients are entitled to rest and are given opportunities for appropriate physical exercise and leisure activities whilst being treated at the centre.
- 10.16 Data collection and performance monitoring:** The centre collects quantitative and qualitative data on client profiles and service rendering as required for regulatory bodies and for service improvement.

International Precedent Standards

1. National Department of Social Development (South Africa)
 - Minimum Norms and Standards for Inpatient Treatment Centres.
 - Minimum Norms and Standards for Out-patient Treatment Centres.
 - Model for the Treatment of Substance Dependent Youth in Residential Facilities.
2. European Association for Treatment of Addiction (UK) - Standards for the treatment and care of those suffering from Alcoholism and other dependencies.
3. Commission for Accreditation for Rehabilitation Facilities (CARF International)
4. Code of Maryland Regulations(COMAR)
5. State of Rhode Island Rules & Regulations for the Certification Of Substance Abuse Prevention Organizations.
6. Delaware Department of Health & Social Services, Division of Substance Abuse & Mental Health, Substance Abuse facility Licensing Standards.
7. Michigan Department of Community Health Office of drug Control Policy Credentialing Standards for Substance Use Disorders Services.
8. Boston Substance Abuse Standards of Care.
9. Substance Abuse Program Administrator's Certification Commission (www.sapacc.org).
10. Strategies for Developing Treatment Programmes for People with Co-occurring Substance Abuse & Mental Disorders.
11. National Strategy for the Prevention, control and mitigation of drug and substance abuse, 2007

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