



**NATIONAL DEPARTMENT OF
SOCIAL DEVELOPMENT**

MINIMUM NORMS AND STANDARDS

FOR

INPATIENT TREATMENT CENTRES

**A MANUAL DEVELOPED WITH THE SUPPORT
OF
THE UNITED NATIONS
(Office on Drugs and Crime)**

Pretoria – South Africa

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FOREWORD

The Department of Social Development is responsible for the administration of the Prevention and Treatment of Drug Dependency Act, No. 20 of 1992 (the Act). The Act provides a legal framework for the establishment, management and monitoring of inpatient treatment centres in the country. The department has now developed minimum norms and standards for these centres to standardize services, facilitate transformation and improve the quality of services.

The minimum norms and standards manual seeks to prescribe an acceptable quality of care for substance-dependent persons at these treatment centres. The manual enables an objective assessment and comparison of existing services in order to regulate and support the development and delivery of services.

South Africa is an important player globally. Today, the country is engaged in activities in the region, the African continent and the world. We are proud of the progress that has been made towards the genuine emancipation of our people. Nevertheless we are acutely aware of the fact that much still remains to be done to further reduce the crime rate, especially the significant drug abuse challenges.

These challenges, particularly as they relate to drugs, have manifested themselves in the greater participation of South Africa in the illegal regional, continental and global substance production and trading industry; in the increased availability and usage of a broader range of illicit drugs including cocaine and heroin; in the expansion of the domestic drug market, with drug prices decreasing and treatment demand for substance-related problems on the rise. Consequently, substance abuse treatment facilities have been placed under increased pressure to provide adequate and effective treatment services.

The department has adopted a multifaceted approach with other departments, relevant stakeholders and agencies to deal with the problem of substance abuse and treatment. These minimum standards are one such example of this approach. They will contribute positively towards the regulation of treatment centres as well as ensure that services rendered by these centres are sensitive to the prevailing human rights culture and are in line with the legal and constitutional framework of the country. This will help ensure that the services offered will be able to reverse in a sustainable way the harmful effects of substance abuse in the country.

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EXECUTIVE SUMMARY

Like many other countries in the world, South Africa has been experiencing unprecedented levels of substance abuse among its citizens. The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) (the Act) has provided a legal framework for the establishment, management and monitoring of inpatient treatment centres to rehabilitate the numerous victims of substance abuse in the country.

The Department of Social Development, which is responsible for administering the Act, through the support of the UN's Office on Drugs and Crime developed this manual *Minimum norms and standards for inpatient treatment centres* to assist these centres to standardize services, facilitate transformation and improve service quality.

The minimum standards will provide the policy, guidelines, minimum requirements and quality assurance for service providers to ensure that the rights of chemical dependents (and their families) are protected and that especially young people at risk (and their families) receive the best possible service.

The manual sets out the principles underlying the establishment of treatment centres (e.g. accountability, empowerment, continuum of care, restorative justice and family preservation) and also contains a useful glossary of terms and a list of the abbreviations used.

This manual is divided into eight sections: Rights and responsibilities (dealing with, for example, constitutional rights and health rights), Levels of service delivery, Prevention, Early intervention, Statutory process, Continuum of care (covering individualized treatment planning; pharmacotherapy and medical care; structured treatment programmes; release, readmission and aftercare), Treatment centre management (covering staff training and support; environment and amenities; family support and involvement; documentation, monitoring and evaluation; target groups), and Procedure for treatment centre management (covering appropriate placement, faith-based practices, visits and contact, abuse, rules, complaints and investigations, involuntary admissions, privacy and confidentiality, financial management and planning, staff complements, etc.).

For ease of reference and comparison purposes, each subsection is further subdivided into a standard statement, outcome, and practice programme and management actions.

PURPOSE OF MANUAL

To establish a set of minimum standards for the control, guidance and monitoring of inpatient treatment facilities in South Africa.

- The minimum standards will ensure that transformation is implemented in a specific, planned and effective manner.
- The minimum standards will ensure that transformation is monitored effectively and in a manner that promotes and guides change and development.
- The minimum standards will provide guidelines for the review of the funding policy and procedure related to inpatient treatment facilities.
- The minimum standards will provide the policy, guidelines, minimum requirements, and quality assurance for service providers to ensure that the rights of chemical dependents (and their families) are protected and that young people at risk (and their families) receive a quality service.

PRINCIPLES

ACCOUNTABILITY

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

EMPOWERMENT

The resourcefulness of young people 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

Young people and their families should be actively involved in all the stages of the intervention process.

FAMILY CENTRED

Support and capacity building should be provided through regular developmental assessment and programmes that strengthen the family's development over time.

CONTINUUM OF CARE

Young people at risk (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.

INTEGRATION

Services to young people (and their families) should be holistic, intersectoral and delivered by an appropriate multidisciplinary team wherever possible.

CONTINUITY OF CARE

The changing social, emotional, physical, cognitive and cultural needs of young people 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.

NORMALIZATION

Young people at risk (and their families) should be exposed to normative challenges, activities and opportunities, which promote participation and development.

EFFECTIVE AND EFFICIENT

Service provision to young people and their families should be rendered in the most effective and efficient way possible.

CHILD CENTRED

Positive developmental experiences, support and capacity building should be ensured through regular development assessment and programmes, which strengthen the young person's development over time.

RIGHTS OF YOUNG PEOPLE

The rights of young people as established in the UN Convention and the SA Constitution should be protected.

RESTORATIVE JUSTICE

The approach to young people in trouble with the law should focus on restoring societal harmony and righting wrongs rather than punishment. The young person should be held accountable for his or her actions and where possible compensate the victim.

APPROPRIATENESS

All services to young people and their families should be the most appropriate for the individual, the family and the community.

FAMILY PRESERVATION

All services should prioritise the goal to have young people remain within the family and/or community context wherever possible. When a young person is placed within the continuum of care, services should aim to retain and support communication and relationships between the young person and his/her family (unless proven not to be in the young person's best interests), and maximize the time, which the young person spends in the care of his/her family.

PERMANENCY PLANNING

Every young person within the continuum of care should be given within the shortest time possible the opportunity to build and maintain lifetime relationships within a family and/or community.

APPLICABLE LEGISLATION

- Basic Condition of Employment Act, 2002 (as amended) (Act No.10 of 2002)
- Child Care Act, 1983 (as amended) (Act No. 74 of 1983)
- Child Justice Bill 2003
- Correctional Service Amendment Act, 1992 (Act No.122 of 1992)
- Domestic Violence Act, (Act No. 116 of 1998)
- Drug Trafficking Act, 1992 (Act No.140 of 1992)
- Employment Equity Act
- Health Act, 1977 (Act No. 63 of 1977)
- Health Professional Act, 1974 (Act No. 56 of 1974)
- Labour Relations Act, 1995 (Act No.66 of 1995)
- Medicine and Related Substance Control Act, 2002 (as amended)(Act No. 59 of 2002)
- Mental Health Care Act, 2002 (Act No. 17 of 2002)
- Non-Profit Organizations Act, 1997 (Act No. 71 of 1997)
- Nursing Act, 1978 (Act No. 50 of 1978)
- Occupancy Health and Safety Act, 1993 (Act No. 85 of 1993)
- Pharmacy Act, 1974 (Act No. 53 of 1974)
- Prevention and Treatment of Drug Dependency Act, 1992 (Act No. 20 of 1992)
- Probation Services Act, 1991 (Act No. 116 of 1991)
- Promotion of Equality and Prevention of Unfair Discrimination Act, 2002 (Act No. 52 of 2002)
- Public Management Act,1999 (Act No. 1 of 1999)
- SA Constitution Act, 1996 (Act No. 108 of 1996)
- SA School Act, (Act No. 84 of 1996)
- Social Work Act, 1978 (as amended) (Act No. 110 of 1978)
- Criminal Procedure Act, 1977 (Act No. 51 of 1977, Section 296)
- Tobacco Products Control Act, 1999 (as amended) (Act No. 12 of 1999)

GLOSSARY OF TERMS

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).
Acute care:	Intensive treatment for an immediate and urgent problem.
Addiction Counsellor:	An accredited lay counsellor (i.e. a non-health or social services professional) who has demonstrated proficiency in core addiction counselling competencies and has been fully 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:	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.
Aftercare:	Follow-up care that offers ongoing support to maintain sobriety/abstinence, personal growth and assists with reintegration into the community/family.
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 tranquilizer), acts as a depressant on the central nervous system.
Benzodiazepines:	A sedative-hypnotic substance (minor tranquilizers) that acts as a depressant on the central nervous system. It is significantly dependence inducing (e.g. Valium, Rohypnol).
Centre:	Substance dependency treatment centre
Child:	Any person under the age of 18 years.
Clinical record:	An individual, permanent medico-legal document of the patient's history, assessment and treatment progress.
Co-morbid condition:	A concurrent mental health condition that exists alongside substance-related disorders. The term "dual diagnosis" often applies here.
Counselling:	A therapeutic intervention that offers support and guidance and is undertaken by a relevantly trained accredited and professional staff member.

- Critical incidents:** Any abnormal or unusual occurrence that threatens the safety or well being of patients/clients and staff.
- Detoxification:** The medical management of physical withdrawal from a substance of dependence so that the associated risks are minimized.
- Medicated detoxification is the medically supervised process by which physical withdrawal from a substance is managed through the administration of individually prescribed medicines by a medical doctor or psychiatrist. These medicines (of a similar substance class to that used by the addict/alcoholic), are prescribed in doses that taper to zero (i.e. a safe substance weaning process). Frequent skilled 24-hour observations of the patient/clients, is the key aspect of treatment, as are emergency resuscitation equipment, necessary infrastructure and competent professional nursing staff.
- Voluntary withdrawal is a form of detoxification when a patient/client chooses to stop all mood-altering substances on admission to the treatment centre without the aid of prescribed medication. This should occur on a case-by-case basis with adequate available emergency resuscitation equipment and resources at the discretion of the supervising medical doctor.
- Release criteria:** Criteria that define a patient's/client's suitability for release from the treatment centre.
- Drug:** A substance that produces a psychoactive effect. This refers here to illicit/illegal drugs, including any psychoactive drug that is being misused or abused (e.g. prescribed medication).
- Release planning:** A structured therapeutic intervention that assists patients/clients and their families/caregivers in preparing for patients'/clients' release from the centre and subsequent integration into family life and other social networks (e.g. community and work).
- Families and Caregivers:** Patients'/Clients' families (including spouses, partners and dependents) and other significant non-family members who make up the support system (e.g. guardians, employees, friends).
- 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.
- Individual counsellor:** An individual professional or accredited staff member especially assigned to patients/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.

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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.
Interdisciplinary team:	A therapeutic or multidisciplinary 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 2.17 for the minimum staff components of this team for type A and B facilities.
Mental health nurse:	A registered professional nurse (i.e. nursing sister) who has specialist mental health training accredited by the SA Nursing Council.
Mental health practitioner:	Professional staff member such as a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services
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. Wellconal, heroin, Methadone, Pethidine, Morphine and Codeine).
Parents:	A person's biological or adoptive parents, as well as legal guardians.
Patients/Clients:	People dependent on or addicted to a substance, who have been admitted to the centre.
Pharmacotherapy:	Individualized treatment and therapy using prescribed medicines.
Residential inpatient treatment:	Substance dependency/addiction treatment provided in a residential setting, i.e. patients/clients reside at the centre to obtain treatment.
Schedule drugs:	Medicines scheduled under the Pharmacy Act, No. 53 of 1974. These drugs require medical and pharmacy personnel and infrastructure for prescription, dispensing, monitoring, recording and storage (e.g. doctor, pharmacist, nurse and refrigeration).
Screening:	A brief assessment of the applicant's suitability for admission to the centre based on the centre's admission criteria and client need.
Social worker:	A person registered as such in terms of the Social Services Professions Act, 1978 (Act No. 110 of 1978)
Staff:	People employed by or contracted to the centre. This does not refer to volunteers.

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Standards:	Qualitative statements that describe what constitutes acceptable or adequate performance or resources.
Structured daily Programme:	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 dependency/addiction	A health condition that involves physical and/or psychological addiction to a psychoactive substance. The result of which is (1) a major disruption and distress in the person’s life (and usually that of his/her family/caregiver) and functioning; (2) a persistent desire or craving to take a substance (usually with unsuccessful efforts to reduce or stop); (3) a great deal of time spent in trying to acquire the substance (including often high-risk and illegal activities); (4) the continuation of the substance usage despite an awareness of the destruction and damages caused; (5) 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) (6); the presence of withdrawal symptoms if the substance is reduced or withdrawn. Substance dependency therefore affects a person’s emotional, psychological, physical, interpersonal and spiritual life and lifestyle.
Therapy:	Treatment provided by professional staff.
Treatment:	The clinical process by which the patients/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 patients’/clients’ (and their families’ and caregivers’) needs, i.e. physical, psychological, social, vocational, spiritual, interpersonal and lifestyle needs.
Treatment centre:	A public or private inpatient/residential facility that offers intensive treatment and rehabilitation for people with substance dependence (who meet the centre’s admission criteria).
Volunteer:	An individual offering services at the centre without formal employment or remuneration.
Withdrawal syndrome:	Symptoms with variable severity that occur on cessation or reduction of drug use after prolonged period of use and/or high doses. The syndrome may be accompanied by signs of both psychological and physiological disturbance (WHO, 1994).
Young people:	Children and young people under the age of 18 years, and young people who are in the Child and Youth Care System (CYC) when they turn 18 years old and who remain until 21 years.

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At risk: Young people who have their normal, healthy development placed at risk because their circumstances and/or behaviour make them susceptible to having to live away from their communities and/or families on the streets or under statutory care. OR they may be living under statutory care.

Service providers: Personnel who interface directly with young people at risk within the child and youth care system as it pertains to welfare, justice, education, health, correctional services and the SAPS. Such service providers include teachers, social workers, child and youth care workers, probation officers, prosecutors, magistrates, police officers, youth workers and nurses.

Transitional care: Residential or foster care for young people who are in need of care and protection and/or are in trouble with the law and are waiting for the finalization of the statutory process. This includes young people:

- awaiting trial
- awaiting sentences
- awaiting transfer
- awaiting designation
- awaiting placement on the continuum of care
- awaiting placement with family or friends

Transitional care may take place within a secure care facility, a place of safety, a correctional service facility, a school of industry or reform school, foster care, a shelter or a children's home.

LIST OF ABBREVIATIONS

AA	Alcoholic Anonymous
ASAM	American Society of Addiction Medicine
CDA	Central Drug Authority
DSMIV	<i>Diagnostic and Statistical Manual of Mental Disorders</i> , Volume IV. This is an internationally used standard diagnostic classification system produced by the American Psychiatric Association (1994).
HPCSA	Health Professions Council of South Africa
ICD10	<i>International Classification of Diseases</i> , Volume 10. An international disease classification system that includes physical and mental health conditions.
N & S	Norms and standards
NA	Narcotics Anonymous
NADAC	National Association of Alcohol and Drug Addiction Counsellors (UK)
NDMP	The National Drug Master Plan
NGO	Non-governmental organization
NIDA	National Institute of Drug Abuse (USA)
NPO	Non-profit organization
OT	Occupational therapist
S & C	Standards and criteria
SACSSP	South African Council of Social Services Professionals
SACENDU	South African Community Epidemiology Network on Drug Use
TB	Tuberculosis
TC	Therapeutic community
USDHSS	United States Department of Health and Social Services
UNODP	United Nations Office for Drug and Crime
VCT	Voluntary counselling and testing for HIV/AIDS
WHO	World Health Organization

1. RIGHTS AND RESPONSIBILITIES

1.1 Standard statement

The rights and legal status of the patients/clients are upheld by the treatment Centre within an ethos of patient/client dignity, appropriate treatment provision and respect for human rights.

1.2 Constitutional rights: The constitutional rights of the patients/clients are upheld and supported by the Centre.

The human rights of people affected by substance use are guaranteed by the Constitution of South Africa in the Bill of Rights and Health Rights Charter. Patients/Clients and their families and caregivers are guaranteed equal rights as specified in the Bill of Rights of the Constitution of the Republic of South Africa. These rights include the right to the following:

- a) Health care services, including reproductive health. Clause 27(1).
- b) Sufficient food and water. Clause 27 (1).
- c) Social security, including appropriate social assistance if unable to support themselves or their families. Clause 27(l).
- d) Emergency treatment. Clause 27(3).

Specific care is taken to ensure that patients/clients are not deprived of their basic constitutional rights. This includes the following rights.

- a) The right not to be deprived of freedom arbitrarily or without just cause. Clause 12(1).
- b) The right not to be treated or punished in a cruel, inhumane or degrading way. Clause 12(1).
- c) The right not to be subjected to forced labour (Clause 13) and to unfair labour practices. Clause 23.
- d) The right to bodily and psychological integrity. Clause 12(2).
- e) The right to freedom of religion, belief and opinion. Clause 15.
- f) The right to freedom of expression. Clause 16.
- g) The right to basic education. Clause 29.
- h) The right to equality, and equal protection and benefit before the law. Clause 9 (l).

1.3 Health rights: The fundamental rights of people who use substances are identical to those of other citizens. These rights include the following rights.:

- a) The right to dignified and humane treatment and care.
- b) The right to have access to treatment services, irrespective of the patients'/clients' ability to pay.
- c) The right to effective communication in a language and manner that patients/clients understand.
- d) The right to reasonable expectations in terms of the range of services offered and the quality of care provided.

- e) The right to locally available services.
- f) The right to exercise choice and guide treatment through informed consent.
- g) Freedom from discrimination in terms of inequitable access to treatment.
- h) The right to privacy and confidentiality.
- i) The right to appropriate treatment and medication.
- j) The right to protection from psychological, physical and verbal abuse.
- k) The right to adequate information about patients'/clients' clinical and treatment status and the range and options of treatments available.
- l) The right to prompt assistance, especially in emergency situations.
- m) The right to safe treatment environments and adequate water, sanitation and waste disposal.
- n) The rights to protection from life-threatening diseases.
- o) The right to express opinions and make complaints that will be investigated.

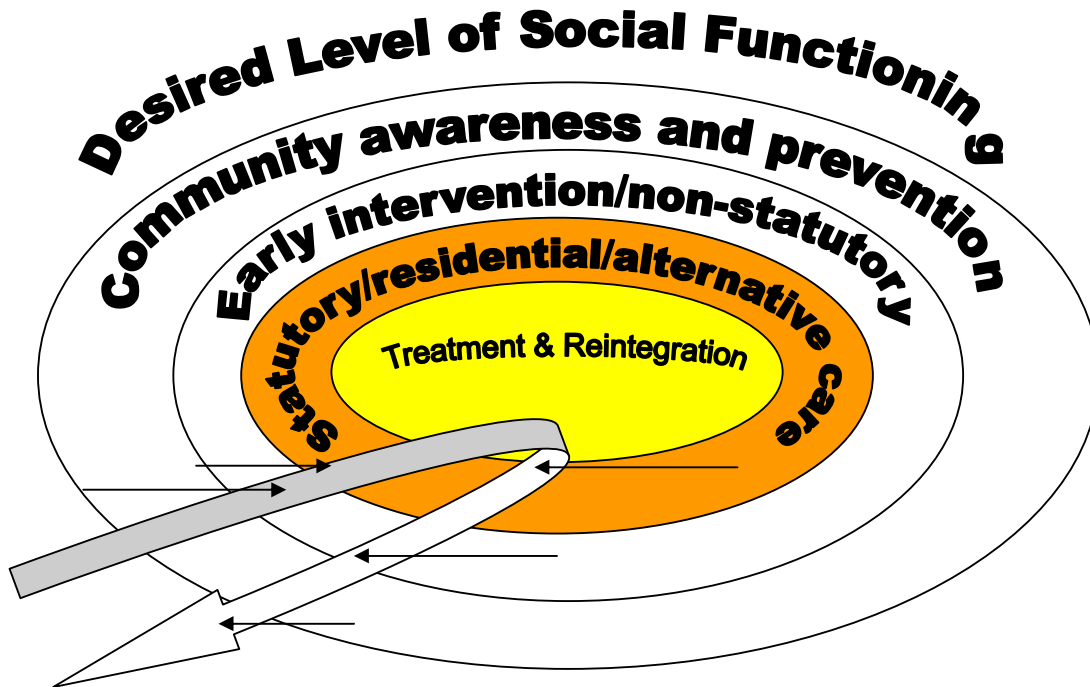
- 1.4 Rights documents:** Patients'/Clients' rights and responsibilities are clearly communicated to all patients/clients and their families and caregivers and Centre staff from the onset of the patients'/clients' entry into the Centre.

Notes and examples: Staff and patients'/clients' rights and responsibilities should be documented and displayed. These should form part of the patients'/clients' admission and orientation. Care should be taken to ensure that the rights and responsibilities are communicated in a manner appropriate to the patients'/clients' (and their families' and caregivers') age, language and competencies. Patients/Clients should sign a waiver or 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 diagram shows the levels of service delivery that include prevention, early intervention and statutory treatment and reintegration



3. MINIMUM STANDARD LEVEL 1: PREVENTION

3.1 Standard: Prevention (outreach, awareness programmes)

3.1.1 Standard statement

Patients/Clients and their families receive services and/or have access to resources that maximize existing strengths and develop new capacities that will promote resilience and increase their ability to benefit from developmental opportunities.

3.1.2 Outcome

Target groups are prevented from becoming chemically dependent.

3.1.3 Programme practice

As a first priority, service providers demonstrate that measures are taken within communities and families that

- strengthen vulnerable families and young people and develop resilience;
- are early warning mechanisms and processes for young people and families at risk, and which can immediately link them to resources;
- promote prevention programmes aimed at reducing and preventing the harmful effects of the use of alcohol and other drugs.

3.1.4 Management actions

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

4. LEVEL 2: EARLY INTERVENTION

4.1 Standard: Harm reduction

4.1.1 Standard statement

As a first priority, those at risk of using substances are assisted to remain within the family and/or community context.

4.1.2 Outcome

- **Rights and legislation:** The admission process is in line with current legislation and the patients'/clients' rights.
Notes and examples: Copies of legislation should be available and staff should be informed and educated on the contents.
- **Non-discrimination:** Admission is available to all suitable patients/clients irrespective of their race, ethnicity, gender, culture, ideology, political or religious beliefs, sexual orientation, language and HIV status (see section 1.4). This is reflected in the centre's admission criteria.
- **Accessibility:** The centre is accessible and available in terms of entry dates and times and prioritizes admissions according to clinical indicators for treatment such as the risk urgency and stress to the patients/clients, their families and their communities.

4.1.3 Programme practice

- **Excluded applicants:** The centre advises applicants excluded on the basis of the centre's admission criteria of other available and appropriate services. The centre has a referral list with names of other resources and services and contact details.
- **Orientation documentation:** Patients/Clients and their families and caregivers receive up-to-date, clear, documented orientation information on the centre.

Notes and examples: Information should include general nature and goals of treatment, rules governing patients'/clients' conduct and infractions that can lead to disciplinary action or release from the centre; patients'/clients' rights and responsibilities (e.g. access to family and telephone calls); confidentiality rules and regulations; safety and emergency procedures.

4.1.4 Management actions

- **Policy and procedures:** The centre has documented, up-to-date policies and procedures to guide and regulate the admission process. This includes the type of information that needs to be gathered and offered at admission, and procedures regarding patients'/clients' possessions and valuables.
- **Admission criteria:** The centre has documented and clear inclusion and exclusion criteria (admission criteria) determined by the centre's Definition and Scope of Practice. These admission criteria are shared with the relevant referral agents and the public.
- **Pre-admission screening:** The centre admits and accepts only applicants who meet the admission criteria as determined by a pre-admission screening process by either an appropriate referral agent or the centre.

The screening involves the following:

- a) Identification of the type(s) of substances used and length of use.
 - b) A provisional psychiatric diagnosis, according to the DSM-IV or CD 10, that determines if the applicant has a substance dependency and the likelihood of other co-morbid conditions.
 - c) Identification of the current intoxication status and need for detoxification.
 - d) Brief social history and needs assessment.
- **Admission support and welcome:** Staff (professional or accredited) are available to support and assist the patients/clients and their families and caregivers and to make them feel welcome in the centre.
 - **Admission competencies:** The centre ensures that there are adequately skilled professionals, or accredited staff, to undertake the admission process, including a pre-admission screening if appropriate.
 - **Admission communication:** The centre has documented communications to appropriate referral sources to describe its admission criteria and policy and to publicize available admission times.

5. LEVEL 3: STATUTORY PROCESS

5.1 Standard: Statutory

5.1.1 Standard statement

Statutory interventions are provided for substance-dependent persons.

5.1.2 Outcome

Substance-dependent persons are admitted to inpatient treatment centres according to statutory provisions.

5.1.3 Programme practice

The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) makes provision for referrals, admission, treatment and release of patients/clients.

- Substance-dependent persons committed to inpatient treatment centres in terms of section 22 of the Act are accompanied by a court order.
- The transfer of substance-dependent children from institutions in terms of section 30 of the Act should be accompanied by a designation from the Minister of his/her delegate.
- Voluntary patients/clients admitted in terms of section 40 of the Act should be accompanied by a voluntary admissions form.
- All admissions of substance-dependent persons to inpatient treatment centres should be accompanied by a comprehensive psychosocial report and medical certificate.
- The Criminal Procedure Act (No. 51 of 1977) makes provision for the admission of patients/clients who may have committed substance abuse-related crimes, e.g. drinking and driving.

5.1.4 Management actions

- Copies of relevant legislation are provided to all service providers.
- 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 abovementioned persons.

6. LEVEL 4: CONTINUUM OF CARE (TREATMENT)

6.1 Standard: Patient/Client assessment/treatment

6.1.1 Standards statement

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

6.1.2 Outcome

The subjection of all patients/clients to holistic assessment processes.

6.1.3 Programme practice

- **Assessment of competencies:** Assessments are undertaken by professional staff with the adequate mental health and social work skills and experience to undertake the prescribed components of the assessments.

Notes and examples: A medical or psychiatric diagnosis should not be made by an accredited addiction counselor.

- **Intake assessment:** Intake assessment/screening is undertaken by a medical practitioner within 24 hours, or, in the case of patients/clients admitted with alcohol, benzodiazepine or opiate dependency, within 8 hours of admission. The assessment includes:
 - a) Personal details and brief personal history.
 - b) Mental state examination, including intoxication status and needs.
 - c) Physical examination and history of medical conditions, including tests to facilitate evaluation.
 - d) Brief history of substance abuse (and other mental health problems).
 - e) Provisional psychiatric history and diagnosis.
 - f) Assessment of risk potential (i.e. for suicide and other forms of self-harm) and specifications for detoxification (if offered).
- **Comprehensive assessment:** A comprehensive assessment is undertaken in a timely manner by qualified and experienced professionals. The assessment includes:
 - Psychiatric and physical assessment and diagnosis, with special reference to any co-morbid conditions.
 - Comprehensive psychosocial, developmental and functional assessment including an evaluation of the patient's/client's social situation (e.g. family, employment, housing and legal situation) and vocational and developmental needs (especially in the case of adolescents/children and the elderly).
 - Referral for a more in-depth psychological, social work, psychometric or physical evaluation, as appropriate.
 - Provisional treatment goals and prognosis.
- **Psychiatric diagnosis:** Identified patients/clients receive as part of the comprehensive assessment a psychiatric diagnosis, according to DSM-IV 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 patient's comprehensive assessment are reviewed by a case manager and the centre's multidisciplinary team.

- **Documentation:** The assessments are recorded in the patients'/clients' case records in a timely and accurate manner.
- **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.
- **Patient/Client feedback:** Patients/Clients receive feedback during the assessment process on the results of the process.
- **On review of progress:** A formal review of the patients'/clients' treatment progress (including psychiatric status) is done weekly by the multidisciplinary team Multidisciplinary team. The review is made available weekly by the case manager and monthly by the Multidisciplinary team.

6.1.4 Management actions

Policy and procedures: Documented, up-to-date policies and procedures support, monitor and regulate the assessment and review process.

Patients/Clients may submit reasons to the multidisciplinary team for a change in case manager should they be dissatisfied with therapeutic relationship or the counselling provided. (Management ensures that patient are given this option.) Management attends to letters written by patients/clients in this regard.

6.2 Individualized treatment planning (IDP)

6.2.1 Standards statement

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

6.2.2 Outcome

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

6.2.3 Programme practice

- **Informed consent and information:** Informed consent is sought from all patients/clients prior to the onset of any treatment. Patients/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.

Notes and examples. See relevant legislation for the rights of children under 18 years to provide Informed consent

- **Health promotion/prevention:** The centre seeks to promote optimal patient/client health and well-being and to prevent the onset and negative impact of health and mental health/substance-related problems among patients/clients (and their families and caregivers). 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 testing, counselling and education regarding needle use and exchange).
 - c) Access to reproductive health care and support of pregnant patients/clients.
 - d) Access to nutritional support and supplements for chronic alcohol-dependent patients/clients.
- **Individual treatment selection:** Treatment is selected for all patients/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 patients/clients and recorded. The plan contains the following:

- a) Clear and concise statement of the patients'/clients' current strengths and needs.
 - b) Clear and concise statements of the short- and long-term goals the patients/clients are attempting to achieve.
 - c) Type and frequency of therapeutic activities and treatment programme in which the patients/clients will be participating.
 - d) Staff responsible for the patients'/clients' treatment and their individual counsellor.
 - e) The patients'/clients' responsibilities and commitment to the rehabilitation process.
 - f) The plan is dated and signed by the individual counsellor and the patient; a copy of the plan is given to the patient/client.
- **Participation:** As far as possible, patients/clients (and their families and caregivers, as appropriate) participate in the development and regular review of the treatment plan and referring agencies to ensure that family reconstruction services are rendered while the patients/clients are still in the treatment programme.

6.2.4 Management actions

- **Treatment standards:** All treatment offered is safe and evidence based and reflects internationally accepted standards.

Notes and examples. 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 the medical doctor or psychiatrist. All alternative therapy practitioners should be officially registered and recognized by the appropriate statutory body.

- **Case manager:** All patients/clients are assigned a case manager who is a professional staff member or addiction counsellor. Basic requirements here are the following:
 - a) The individual counsellor is responsible for assisting patients/clients to develop their treatment goals (and other individual treatment tasks), for providing regular documented support and motivation, and for acting as a liaison person for other families and caregivers and role players.
 - b) The individual counsellor meets weekly with the patient/client for a minimum of 30 minutes.
 - c) The individual counsellor is reasonably accessible to patients/clients for support and crisis intervention (i.e. outside of fixed counselling sessions).
 - d) The centre stipulates the optimum and maximum case load for each individual counsellor (e.g. 20 patients/clients) – the ratio is 1:15 for short-term treatment programmes and 1:20 for long-term treatment.

6.3 Standard: Pharmacotherapy and medical care

6.3.1 Standard statement

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

6.3.2 Outcome

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

6.3.3 Programme practice

- **Medical coverage:** Emergency medical and mental health care is available to patients/clients 24 hours a day, 7 days a week (e.g. through telephonic consultation with a medical doctor (e.g. a psychiatrist) and/or access to emergency services).
- **Clinical/Case record:** A medication record, with appropriate signatures, is kept in the patients'/clients' case records in accordance with statutory regulations. This includes at least the
 - 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.

Notes and examples: Refer to the Pharmacy Act (No. 53 of 1974) regarding the prescribed method of recording the use of schedule 6 and 7 drugs This includes additional requirements such as the doctor's qualifications and the written names of the drugs and written doses.

- **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-related monitoring:** Patients/Clients are carefully monitored by professional staff to prevent and/or respond promptly to adverse effects of prescribed and non-prescribed medication.

Notes and examples: Adequate review of the patients'/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 (i.e. storage of schedule 5, 6 and 7 medicines). Medicine prescribed for one patient/client may not be administered to or allowed to be in the possession of another patient/client.

Notes and examples: 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. 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 patients'/clients' case record.

- **Emergency equipment:** Emergency and first-aid equipment and medicines in good condition are available, and staff are skilled and equipped to use/administer them.
- **Medicine records:** Records for medicines are accurately maintained according to statutory requirements (e.g. requisition books, register of controlled substances and schedule 5, 6 and 7 substances).

- **Prescriptions**

All patients/clients receive an initial intake assessment (i.e. face-to-face examination) by a medical doctor or psychiatrist before any medicines are prescribed.

Notes and examples: Telephonic prescriptions.

- **Medical waste storage and disposal:** The centre stores and disposes of medical waste (e.g. syringes and unused medicines) according to current statutory requirements.

6.3.4 Management actions

- **Prescriptions:** Adequately skilled clinical staff (medical doctors or psychiatrists) are available to evaluate the need for and to prescribe medication in accordance with statutory and centre regulations and policy/procedures.

Notes and examples: Telephonic prescriptions for patients/clients prior to an examination by a doctor/psychiatrist are not acceptable practice.

- **Continuity of care:** No patients/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) Medicine prescriptions according to schedules and including the use of self-administered, over-the-counter drugs (e.g. cough syrups).
 - 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.
- **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, patient/client care and monitoring, and required equipment) (type A centres only).
 - d) Assessment and management of HIV/AIDS, tuberculosis and hepatitis.
 - e) Emergency procedures. The development of treatment protocols is the responsibility of the Department of Health and not that of the centre.

Notes and examples: It is not the treatment centre's responsibility to develop treatment protocols; rather, these protocols should be developed by national and provincial health departments (in collaboration with the Department of Social Development). Centres should approach their provincial Department of Health for relevant protocols.

- **Detoxification**

Essential components: For centres that render detoxification services, detoxification (including voluntary withdrawal) occurs according to written policies and procedures. All components of care are available from centres that render detoxification services. Detoxification takes place according to detoxification policy. Components of such policy include

- a) staff with an informed, non-punitive, non-judgmental and supportive approach to detoxification;
- b) assessment;
- c) 24-hour professional nursing and easily accessible medical backup;
- d) standardized, official, best practice detoxification protocols;
- e) patient/client information and explanation (i.e. the likely course of withdrawal, length and intensity of symptoms, support and treatment to be offered and associated risks);
- f) patient/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 patients'/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;

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- 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 caregivers, if appropriate.

6.4 Structured treatment programmes and daily activities

6.4.1 Standard statement

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

6.4.2 Outcome

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

6.4.3 Programme practice

Treatment and rehabilitation programme

- **Programme models/philosophy:** A formal treatment and rehabilitation programme is regularly reviewed and updated in accordance with internationally accepted standards.

Notes and examples: The treatment and rehabilitation programme describes structured weekly and daily activities and individual and group counselling/therapies; and in a time-limited programme (e.g. 3 weeks to 6 months) it also describes programme goals or stages.

- **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.

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

- **Programme duration:** The duration of the treatment programme offered by the centre is a minimum of 40 hours a week, which includes therapeutic/counselling sessions.

Notes and examples: This can take place as a component of the structured treatment programme (e.g. psychoeducational groups) and individual and family therapy/counselling.

6.4.4 Management actions

- **Programme communication and participation:** The treatment programme and daily activities/expectations are documented and communicated to patients/clients (and families and caregivers). Appropriate opportunities exist for patients/clients to participate in decision making on the daily activities and other issues that affect the centre and patient/client community.

Notes and examples: This can include orientation information, posters and regular staff/patient meetings.

- **Daily activities**
- **Policy and procedures:** The centre has documented policies and procedures that it implements to regulate and guide daily activities at the centre. These policies cover the following:
 - a) Patient/Client waking and sleeping times.
 - b) Telephone use for private conversations.
 - c) Visits from families and caregivers, friends, religious leaders and legal counsel.
 - d) Visits and outings beyond the centre.
- **Patients/Clients labour:** Patients/Clients may be involved in non-exploitative work/labour (including vocational skills training) activities (e.g. meal preparation, cleaning of residential facilities) for no longer than four hours a day.

Notes and examples: All work and vocational activities should support patients'/clients' rehabilitation needs and individual treatment goals.

- **Meals:** Patients/Clients are given a minimum of three nutritious meals a day. If patients/clients are allowed to participate in preparing meals, this must be according to documented patient/client labour policies, health regulations and food hygiene.
 - a) The centre should have proof of regular inspection and certification of the kitchen and food preparation area(s) from the local authority environmental health officers.
 - b) Nutritionists from the provincial health department should review menus and meal quality regularly.

6.5 Standard: Release, readmission and aftercare

6.5.1 Standard statement

Patients/Clients can be provided with appropriate programmes and support to enable their effective transition from a treatment centre to their families and their integration into their communities.

6.5.2 Outcome

Patients/Clients who are fully prepared to participate in after care programmes in their communities.

6.5.3 Programme practice

- **Discharge assessment and review:** All patients/clients are assessed and reviewed by the multi-disciplinary team at an appropriate time in their treatment to determine their potential for release and to facilitate release planning.
- **Release documentation:** Relevant referral agents are timeously supplied with a confidential signed and dated release report to facilitate continuity of care for all patients/clients leaving the centre. A copy of this report is kept in the patients'/clients' case records. The summary includes:
 - a) Patients'/Clients' personal details.
 - b) A brief summary of their personal history and family/social background.
 - c) A brief summary of the treatment plan and progress/participation at the centre.
 - d) Reason for release (e.g. completed programme or non-compliance).
 - e) An outline of their aftercare needs and preferences (release plan).
- **Aftercare:** Prior to release, the centre ensures adequate referral and linking of the patients/clients to their original referral social workers, local community services and self-help groups.

Notes and examples: Wherever possible, patients/clients are given an initial appointment date, address and contact name and number at their local community clinic or CHC and/or at an NGO or other support agency.

- **Release information:** Release information is provided for all patient/client families and caregivers, as appropriate, on release or expulsion. This includes:
 - a) Details and precautions/guidance on any prescribed medicines at release are not provided. And where inadvisable, e.g. in the case of an addicted person, alternative arrangements must be made, e.g. making a family member responsible for collection of the medication.
 - b) Names and details of aftercare referrals/sources (e.g. local AA branch).
 - c) Names and details of emergency and contact sources for crisis intervention associated with relapse prevention.
 - d) Procedure for readmission to the centre, if sought.

- **Caregiver support and information:** Families and caregivers are assisted in planning and anticipating the patients'/clients' release and return to their homes and communities from the onset of inpatient/client care. They are also informed, whenever possible, when patients/clients are to be released, expelled or if they have absconded.
- **Relapse prevention:** Prior to release, the patients/clients (and their families and caregivers, as appropriate) are provided with information, support and counselling to assist with relapse prevention.

6.5.4 Management actions

Legislation: Release, expulsion, aftercare and readmission occur in line with current relevant legislation.

Policy and procedures: Documented policies and procedures are available to guide and regulate release and readmission to the centre. These policies cover:

- a) Release 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) The release and transfer of patients deemed to be unsuitable for the centre.
 - d) The release of adolescents and children without parental consent
- **Expulsion:** The criteria and procedures for expelling patients/clients are clearly communicated to patients/clients and their families/caregivers. Patients/Clients have access to a fair investigation and hearing to determine their culpability when expelled for the violation of centre rules and regulations, where appropriate and feasible.
 - **Transfer and referral:** Defined and documented criteria and procedures exist for referring patients/clients in need of alternative services (e.g. outpatient/client treatment) and/or more contained or medically managed care should this be indicated (e.g. detoxification, adverse drug reactions, attempted suicide, emergency medical care and psychosis).

Notes and examples: Patients/Clients who have been transferred to a more contained or specialist health or mental health facility due to the severity or existence of a co-morbid condition may only be considered for readmission to the centre with the written permission (based on an assessment of their stability and the centre's resources) of a registered health or mental health worker

- **Self-release** Mechanisms exist for patients/clients to release themselves voluntarily at any stage in their treatment unless judged to be a danger to themselves or are legally committed. The centre staff should be satisfied that patients/clients are mentally fit to make such a decision and the consequences of self-release are clear.

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- **Release planning:** The release plans are developed and reviewed in collaboration with patients/clients and with the patients'/clients' informed consent and that of their families and caregivers. A copy of these plans are kept in the patients'/clients' case records.
- **Readmission:** The centre has policies and procedures to support the readmission of appropriate patients/clients. The treatment goals and programme for readmitted patients/clients is clearly stipulated in accordance with their treatment needs.

Staff records: All staff have up-to-date, confidential personal records.

7. TREATMENT CENTRE MANAGEMENT

7.1 Staff training and support

The centre has the appropriately qualified, skilled and supervised staff to deliver the best possible service in an ethical manner.

7.1.1 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.

Notes and examples: Such official bodies include the Health Professions Council of South Africa, the South African Nursing Council or the South African Council for Social Work Professionals, and addiction counsellors with the approved accreditation and registration bodies.

7.1.2 Accredited addiction counsellors:

Addiction counsellors are accredited and have specialist skills to assess, inform, motivate, counsel, educate and assist patients/clients at the centre. Addiction counsellors may work only under the supervision of professionals.

Notes and examples: Addiction counsellors should be able to demonstrate core competencies in order to be accredited and registered with a recognized training and registration body.

7.1.3 Core competencies:

All staff (professional and accredited) endeavour to have the skills and competencies to undertake the following in individual and group patient/client treatment. These competencies are the minimum requirements for professional health, social services and addiction counsellors.

- a) Screening to establish whether the patient/client is appropriate for the programme.
- b) Intake – Administrative and initial assessment procedures.
- c) Orientation of the patient/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.

Notes and examples: Accreditation for addiction counsellors should be subject to such counsellors possessing these core competencies. Accreditation-related training should equip counsellors with such competencies.

7.1.4 Substance abuse status: All staff at the centre, including addiction staff and volunteers, are 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) Addiction counsellors should have been drug free for a minimum period of three years before being employed in a treatment capacity. This includes staff members who have relapsed after a period of abstinence.
- c) No staff member receives treatment at the centre for his/her own addiction problems or relapse.
- d) No patient/client or recently released patient/client becomes involved in the counselling or treatment of other patients/clients.

Notes and examples: While it may be difficult to regulate and measure, all staff should be encouraged to demonstrate appropriate stress release, emotional maturity, healthy lifestyles (e.g. no smoking and appropriate use of alcohol) and positive interpersonal communication. Staff should be discouraged from engaging in any addictive behaviours 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.

7.1.5 Volunteers: The centre has documented policies and procedures to regulate the roles of volunteers. All volunteers are subject to the same regulations as staff regarding substance-free status and ethical conduct. This includes

- a) not undertaking any treatment activities unless they have the necessary professional or accredited qualifications and registration;
- b) signing a code of conduct and respecting confidentiality;
- c) avoiding financial exploitation and abuse or unregulated employment;
- d) meeting minimum requirements for training and supervision in accordance with the tasks undertaken and competencies needed.

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

7.1.7 Staff development policy and planning: The centre has a documented, up-to-date staff development strategy/policy and plan to train and develop staff to offer adequate treatment.

Notes and examples: Staff development activities should be planned and scheduled and should take advantage of available resources and opportunities (e.g. as available from the Health, Social Development and Labour Departments, NGOs, local services and private practitioners).

7.1.8 In-service training: The centre has a documented plan and evidence of attendance at regular staff development training on ongoing patient/client and treatment needs. This could include 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) Patient/Client confidentiality
- f) Patient/Client rights and treatment ethics.
- g) HIV/AIDS, tuberculosis and other related medical conditions (e.g. hepatitis).
- 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 patients/clients.
- k) Sensitivity towards and skills in responding to sexual abuse/incest and harassment.
- l) Cultural sensitivity and racial diversity.
- m) Gangs.

Notes and examples: Such training should ideally be offered by the centre, but provision should be made for centres that do not have the staff or skills to provide such training internally.

7.1.9 External training: The centre encourages staff to participate in ongoing external training education and professional development.

Note and examples: This includes attending workshops and conferences. Whenever possible, staff are kept informed about available courses and key developments in the service or profession. The centre supports professional staff in obtaining accredited educational updates in respect of their professional registration requirements

7.1.10 Clinical/Case supervision: All addiction and professional staff require regular, skilled clinical/case supervision provided by a more experienced or skilled professional person.

Notes and examples: All staff should have an opportunity to discuss regularly their cases with other health and social services professionals. Individual or group supervision is advised.

7.1.11 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.

Notes and examples: 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).

7.1.12 Research: The centre has clear ethical guidelines for any academic or product-orientated research undertaken at the centre. Staff are encouraged when appropriate to initiate, support and take part in relevant and ethical research.

- a) If such research involves the patient/clients, their informed consent is essential. Research is not conducted on an involuntary/uninformed basis (e.g. “drug trials”).
- b) Staff are encouraged to initiate quality, outcome-based research and studies to evaluate the acceptability and effectiveness of the treatment offered.

Notes and examples: Centre-initiated research is encouraged but cannot be a minimum criterion for most centres.

7.2 Environment and amenities

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

7.2.1 Legislation: The centre ensures that its amenities and physical environment comply with environmental health, statutory health and safety requirements as well as fire regulations

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

Notes and examples: Treatment centre buildings may not have been originally designed for this purpose, e.g. former school, hotel or residential facilities, but should be adequately redesigned for such services. A centre must have authorization from the local authority to practise as a dedicated centre in the particular site/location (i.e. zoning) and must meet environmental health and statutory safety requirements

7.2.3 Policies and procedures: Documented, up-to-date policies and procedures ensure a safe environment for all people using and accessing the facility, i.e. patients/clients, staff and the public. These procedures cover the following topics.

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

7.2.4 Emergency plans: Documented, up-to-date and regularly tested and reviewed emergency plans specify the following:

- a) Floor plan of centre.
- b) Action in event of fire, bomb threat or power failure.
- c) Evacuation procedures.
- d) Response to medical and psychiatric emergencies

7.2.5 Safety inspections: Regular, documented health and fire safety inspections are performed by the relevant authorities.

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

- a) Patient/Client rooms: The minimum floor space of any patient/client rooms is 10 m² with a minimum wall length of 2,6 m.
- b) Space between beds: A minimum of 900 mm between the sides of any adjacent patient/client beds, 1 200 mm between the foot of any bed and the opposite wall, or 1 500 mm between the foot of any bed and the opposite bed.
- c) Recreation: An indoor space of at least 20 m² is available for recreation purposes.
- d) Outdoors: Patients/Clients have access to adequate outdoor recreation space.

7.2.7 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 type A centres, a separate special care and examination room is available. The room(s) are

- a) easily accessible to medical and nursing staff for supervision and observation;
- b) equipped with functioning medical and emergency equipment, according to the centre's Scope of Practice and Provincial Department of Health requirements (see Section 11.10);
- c) safe so as to prevent self-harm or injury (e.g. medicines and equipment safely locked away);
- d) comfortable and calm so as to allow patients/clients to relax in comfort during detoxification.

7.2.8 Drug and weapon-free environment: The centre, its grounds and facilities are free of alcohol, illicit/illegal psychoactive substances and any weapons. 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/weapons;
- c) the investigation of and searching for substances/weapons;
- d) the control of legitimate medication within the centre.

7.2.9 Searching and confiscation: The centre has mechanisms and procedures to regulate and monitor any searching for weapons or substances on the premises in a rights-sensitive manner. This includes the documented and advertised right to confiscate illegal substances and weapons immediately, with or without the patients'/clients' or visitors' consent. Safeguards to protect patients'/clients' and their visitors rights cover the following:

- a) Whenever possible, all searching of patients'/clients' private belongings and parcels occurs only in the presence of the patients/clients, and only by professional or accredited staff.
- b) Patients/Clients are informed of such searching practices and consent to them as part of their orientation at the centre. Likewise, visitors are clearly warned about such practices
- c) The bodily integrity of patients/clients and their visitors is not violated by routine or unauthorized bodily searches. In extreme circumstances,

patients/clients may be physically searched only with the authorization of the interdisciplinary team and only by a staff member of their own gender.

Notes and examples: All illegal substances and illegal weapons should be immediately destroyed, or, in the case of firearms, given to the local police

7.2.10 Locked areas: Locked areas may be used in the centre only for the safe keeping of hazardous, valuable and confidential material and for the security protection of patients/clients and staff against crime and theft.

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

- a) Clean, well-ventilated, adequately heated, well-lit treatment and residential areas.
- b) Each patient/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 patients'/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 bars.
- h) Toilets and showers/baths in good repair.
- i) Sufficient bathrooms and toilet facilities: at least 1 toilet to every 8 patients/clients and 1 bath and shower to every 12 patients/clients.

7.3 Family support and involvement

The centre encourages the support and participation of the patients'/clients' families and caregivers as an essential and integral component of treatment and rehabilitation.

7.3.1 Policies and procedures: Various policies and procedures guide, regulate and encourage the involvement of patients'/clients' families and caregivers in the treatment process. These policies cover the following issues.

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

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

7.3.2 Practical support: Practical support is provided to assist families and caregivers to participate in the treatment process. This support includes follow-up telephone calls and financial support for transport to visit the centre.

Notes and examples: Centres located in isolated locations may have to make provision for visits by families and caregivers, e.g. by providing guestrooms and houses.

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

7.3.4 Caregiver assessment and support: Information is sought from and support offered to families and caregivers to address their problems and needs. The following issues are sensitively and routinely explored.

- a) Specific needs and conditions of patients'/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 patient/client recovery.
- d) Support for families and caregivers to cope with co-dependency and living with patients'/clients' substance abuse (e.g. referral to ALANON).
- e) Support groups at the centre (e.g. Saturday morning family support groups)
- f) Support for families and caregivers 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).
- h) Social welfare-related needs and support available to the family and caregivers (e.g. child support grants)

7.3.5 Family/Caregiver therapy and counselling: Whenever feasible and indicated, the centre provides family therapy/counselling to address longstanding maladaptive interactions/relations within the family as well as new issues related to the reincorporation of the patient/client into the family and community.

7.4. 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**

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

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

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

- a) Confidential case material is never available for public display.
- b) Whenever possible, permission is sought from patients/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.

Notes and examples: Staff should ensure that patients/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 interdisciplinary team case management process. Patients/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 patients'/clients' permission in medical/psychiatric emergencies and at post-release. These issues are covered in the centre's confidentiality policy and ethical code.

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

- a) Entries are signed legibly (clear name and professional designation) and dated.
- b) The diagnosis given to patients/clients is clearly indicated in the records.
- c) Details are provided of all patients'/clients' individualized (developmental)

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 release planning.

- d) Notes are taken of interdisciplinary case conferences, consultations and feedback on participation in group treatment programmes.
- e) Daily nursing care records are kept and included in the case records.

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

7.4.6 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**

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

7.4.8 Data collection and reporting: The 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 SACENDU). This data supports the monitoring and evaluation of key service and demographic indicators. The data covers the following:

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

7.5 Target groups

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

7.5.1 Staff competencies: All staff members (administrative, professional and accredited) are sensitized 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). Vulnerable target groups included here are children and adolescents, people with HIV/AIDS and women.

Notes and examples: There are many other vulnerable groups whose specific needs should be recognized. They include people from disadvantaged communities, those with co-morbid psychiatric conditions, those who are not conversant in English or Afrikaans, the chronically institutionalized, those with disabilities, the homeless (including street children) and the elderly

- **Children and adolescents**

7.5.2 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 South Africa in 1995) and the Bill of Rights of the South African Constitution. These rights are upheld in the Draft of the Minimum Standards for Child and Youth Care Systems (1997), which applies to care and treatment provided to children and adolescents, including those in registered treatment centres. 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.

Notes and examples. The term children has been used in this document to cover children under the age of 18 years. This includes adolescents and teenagers, which is the only appropriate child age group that should be treated at centres.

7.5.3 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 caregivers (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 individualized 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.

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

7.5.5 Consent to medical treatment: Appropriate consent, in accordance with current legislation and patients'/clients' right to privacy, is sought from the children and their parents for all medical procedures. It is essential that children and parents understand the risks and social implications of their choices. This includes consent for

- a) admission to the centre,
- b) HIV testing,
- c) reproductive health interventions (e.g. contraceptives and termination of pregnancy).

7.5.6 Parental involvement: The centre ensures that parents, families and caregivers 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 released from a residential facility for any reason;
- b) participation of families in the comprehensive assessment and release planning;
- c) attendance at family therapy/counselling and family support groups;

- d) provision by the centre of 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, this is referred to the relevant statutory social services for assistance and monitoring.

7.5.7 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.

Notes and examples: In the case of younger children, it may be appropriate to have completely separate services, e.g. for adolescents between 12-15/16 years. However, older children and adolescents may benefit from mixed and intergenerational age groups where they may obtain support from older patients/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.

7.5.8 Education: Adolescents 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.

Notes and examples: The educational input should be accredited with the Department of Education. Centres that admit adolescents for this length of time should liaise with the local education department and the adolescents' school teachers in accordance with the Policy Framework for the Management of Drug Abuse by Learners in Schools and in Public Further Education and Training Institutions (2000). The length of stay for children and adolescents at centres should not be artificially extended beyond what is necessary for their individual treatment needs as a result of in-house educational programmes. Release planning should include assistance with the reintegration adolescents into the school or other educational facility.

7.5.9 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 and express their emotions appropriately.

- b) The teaching of effective, positive ways to express and manage emotions and to communicate with and relate to others.
- c) Opportunities for positive interactions and relations with peers and staff.
- d) Staff demonstration of healthy and effective ways to communicate and express emotions.
- e) Encouragement and assistance to restore, maintain and enhance relations with families and caregivers.

7.5.10 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 (demonstration) of expected behaviours and attitudes in their interactions with patients/clients.
- d) Ensuring awareness of the consequences of their behaviour in the centre and in their communities/homes.
- e) Providing opportunities to demonstrate and practise positive behaviours.

- **HIV/AIDS and people living with HIV/AIDS**

7.5.11 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 patients/clients.
- c) **Safe sexual practices:** The centre has a documented and communicated policy and code of conduct on patients'/clients' sexual behaviour in the centre (e.g. between patients/clients and other patients/clients and between patients/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) **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.

Notes and examples: The universal precautions undertaken here are also effective against other prevalent infectious diseases such hepatitis B. These precautions include the use of adequate sterilization procedures, surgical gloves and a resuscitation mouthpiece.

7.5.12 Discrimination: The centre does not discriminate against any applicant or patient/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 patients'/clients' rights,

sexual preferences and emotional/physical needs.

7.5.13 Confidentiality: Patient/Client HIV status remains confidential.

7.5.14 Risk assessment. An assessment of HIV-risk behaviours is part of all patients'/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) Patients/Clients who have experienced rape or sexual abuse and may have been exposed to HIV. They include men and women, especially prison inmates

7.5.15 HIV and AIDS testing: The centre ensures that voluntary HIV/AIDS diagnostic testing and counselling is readily available to all patients/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 patients/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 patients'/clients' family members without the patients'/clients' informed consent.
- j) The centre has adequate facilities for ensuring quality control of any specimen tests (e.g. fridge for storing blood samples).

7.5.16 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 patients/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 ways of preventing 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 .

7.5.17 Provision of medical treatment: The centre refers HIV-positive patients/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 regimes with the approval of the centre's medical doctor.

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

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

- **WOMEN**

7.5.19 Principles and values: The centre seeks to 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 victimization embedded in women's experiences).
- c) Treatment addresses all aspects of a woman's life, including the practical needs of women (housing, transportation, job training and child care).

7.5.20 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 (e.g. male-only treatment programmes).
- 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 and leave provisions).

7.5.21 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) Rejection by the centre of any court-appointed applicant who has committed a crime of physical or sexual assault against women.
- b) Provision of secure and private women-only sleeping and ablution facilities.
- c) Reporting to the police of any incident of sexual abuse and removal of staff and patients/clients who are at risk of committing or have committed acts of physical or sexual violence against women.
- d) Sensitization of male and female patient/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).

7.5.22 Assessment and treatment: The 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 and sexual abuse). The centre ensures that women with such conditions/problems

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receive adequate care and referral, if required, in accordance with the centre's Scope of Practice.

- b) The needs of pregnant patients/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.

Notes and examples: 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.

8. PROCEDURE FOR TREATMENT CENTRES MANAGEMENT

- 8.1 Appropriate placement:** The centre admits and retains only patients/clients according to its current Scope of Practice and its treatment and resident capacities. Appropriate referrals are made for patients/clients considered unsuitable for treatment at the centre.

Notes and examples: Patients/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.

- 8.2 Incident reporting and monitoring:** Every suspicious death, injury and neglect of a patient/client are investigated by a suitably qualified and independent review tribunal. Incidents are accurately documented in an incident register and reported to the governing body and relevant authorities (i.e. local magistrate and police).

Notes and examples: The review body includes one or more independent members (e.g. patient/client and community representatives). It seeks to identify individual and systemic factors and, when relevant, related service problems and culpability for the role of the magistrate in accordance with the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992).

- 8.3 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.

- a) This religious orientation and associated practices (e.g. church attendance) are not imposed upon any client/patient.
- b) Patients/Clients are free to practise their own religion at the centre.
- c) Provision is made for patients/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.

Notes and examples: The spiritual emphasis in the 12 steps programmes should not be used to support involuntary religious practices. Religious instruction should not be an essential component of the treatment programme, but it could be a voluntary daily/weekly activity for interested patients/clients.

- 8.4 Visits and contact:** Patients/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). A documented, enforceable code of conduct for all visitors to the centre is clearly displayed.

Notes and examples: Visiting hours should be stipulated but planned to facilitate access. The right to contact should be balanced with the need for patient/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 patients/clients cannot be denied as a form of punishment

8.5 Abuse: Patients/Clients (and their families and caregivers) 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.

8.6 Centre rules: Patients/Clients, their families and caregivers 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 patients/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 patients'/clients' case records.
- d) Clear indications are given on admission as to the consequences of patients/clients using or possessing drugs and/or alcohol or any weapon while receiving treatment

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

8.7 Behaviour management: Patients/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) Exercise.
- g) Inappropriate or excessive work.
- h) Undue influence by staff regarding patients'/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 caregivers.
- l) Measures that discriminate on the basis of cultural, linguistic, heritage, gender, race or sexual orientation.
- m) Punishment by another patient/client or staff member.
- n) Any treatment or medical procedure.
- o) Bodily searches.

8.8 Report and monitoring: All serious behavioural problems and behavioural management interventions are reported to the local magistrate in accordance with current legislation.

- a) This legislation is supported by the centre's policies and procedures.
- b) Such problems are documented in the patients'/clients' case records and the incidence register.
- c) Supported by regular liaison and communication with the local magistrate and police.

Notes and examples: This is a requirement of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992).

8.9 Complaints and investigations: The centre ensures that clear, confidential, support mechanisms exist whereby patients/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 to all valid complaints.

Notes and examples: The complaints are regularly reviewed and monitored by management, the governing body and an external arbitrator. A national, independent body should be established to monitor and investigate such complaints.

8.10 Involuntary admissions: Only patients/clients legally committed to the centre in strict accordance with current statutory requirements and their constitutional rights can be detained at the centre against their will. Patients'/Clients' rights are violated if patients/clients are detained in the following circumstances.

- a) As part of the centre's behaviour management or modification practices.
- b) As minors in accordance with parental control and preference.
- c) In response to any undue coercion from families, centre staff and management, employers, religious leaders, law enforcement or any non-legal source

8.11 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 and social services legislation and policy. This may occur only in the following

circumstances.

- a) Patients/Clients are an immediate danger to themselves or others, e.g. in the case of acute intoxication or psychosis.
- b) Patients/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 patients/clients can be transferred to a more secure or contained health or police facility.
- f) Patients/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) Staff are competent and skilled in coping with aggressive or threatening behaviour.
- j) All cases of restraint and seclusion are reported to the local magistrate within 72 hours.

Notes and examples: 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 provincial department of health and it is the centre's responsibility to ensure that they have such protocols.

- 8.12 Informed consent:** The patients/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.

Notes and examples: The patients/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.

- 8.13 Ethics:** The centre has a documented and displayed policy of ethical behaviour to which all staff adhere 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) Staff are made aware of the consequences of the violation of 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).

Notes and examples: Ethical codes of conduct should be practised by professional and accredited staff. These codes should be in line with those developed by statutory professional associations (e.g. HPCSA or lay accrediting bodies). The codes cover issues such as alcohol and drug-free status as well as sexual, legal, financial/business and interprofessional conduct (e.g. no sexual or romantic relations between staff and patient/clients; prohibition of paying commission to referral agents or lack of transparency regarding staff members'/management's financial interest in centres).

- 8.14 Staff selection:** The centre makes every effort not to employ staff members who have been perpetrators of any sexual or child abuse or have a criminal history of repeated perpetration of physical and emotional abuse.

Notes and examples: Mechanisms may need to be developed to ensure that this process is supported by current anti-discrimination and employment legislation. At the very least, the centre should routinely require staff to check if applicants have a criminal record.

- 8.15 Staff retention and reporting:** The centre acts to remove from its service staff members who, through due process, are identified as perpetrators of human rights abuses. It reports staff guilty of physical and sexual abuse to the police and other relevant authorities.

- 8.16 Labour:** Patients/Clients are protected against labour exploitation in the centre. No labour is undertaken by patients/clients for the private or personal gain of centre staff or management or the upkeep or repair of the centre.

Notes and examples: All work programmes in facilities (centres) should be solely for the patients'/clients' benefit as part of a supervised rehabilitation programme, the individual goals of which should be stated in the individual (developmental) treatment plan. There should be no unfair discrimination in employment or work tasks.. Work-related activities should not constitute more than four hours of the daily rehabilitation programme.

- 8.17 Transparency and access:** The centre is transparent and open to community, media and public scrutiny with regard to human rights abuses, governance and standards of care.

Notes and examples: Such scrutiny should, however, be in accordance with the patients'/clients' (and their families') rights to privacy and confidentiality.

- 8.18 Privacy and confidentiality:** The patients'/clients' (and their families'/caregivers') privacy and right to confidentiality are respected and upheld by the centre. Documented policy and procedures regulate and support patient/client confidentiality and privacy. For example:

- a) Whenever possible, patients/clients give informed consent for any personal information to be communicated to others (e.g. parents/guardians and schools).
- b) Patients/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 patients'/clients' consent.
 - d) Clear ethical guidelines exist for instances where patient/client confidentiality is violated, such as threatened violence and abuse or patients'/clients' refusal to inform a regular sexual partner of their HIV/AIDS positive status.

Notes and examples: All patients/clients should also be assisted to develop guidelines and rules and to respect confidential material shared by other patients/clients in therapeutic group contexts.

8.19 Diagnostic procedures and interventions: Patients'/Clients' (or their legal guardians') informed consent is always sought for all diagnostic procedures, and patients'/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 patient/client confidentiality and the legitimate rights of others in this regard (e.g. sexual partners and parents).

8.20 Privacy: All correspondence and personal effects of persons undergoing treatment are regarded as private. Policies and procedures exist to protect patient/client privacy and the legitimate rights of others in this regard.

8.21 Law enforcement and treatment status: Patients/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). The confidentiality of patients'/clients' personal case information is upheld as specified by the relevant legislation in this regard.

8.22 Leisure and lifestyle: All patients/clients are entitled to rest and are given opportunities for appropriate physical exercise and leisure activities whilst being treated at the centre.

8.23 Data collection and performance monitoring: The centre collects quantitative and qualitative data on patient/client profiles and service rendering as required for regulatory bodies and for service improvement.

8.24 Financial management and planning

- **Budget:** The centre has an annual budget that is available for review by the governing body and other regulatory parties.
- **Financial regulations:** All financial activities at the centre are in line with current statutory financial regulations (e.g. audited annual reports on finances, assets and liabilities for tax, VAT for insurance purposes).
- **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 the governing body. These reports are also readily available to other interested parties.

8.25 Human resources management

Staffing plan: A documented staffing plan identifies the number, categories and qualifications of staff at the centre.

Staff complements: All centres employ suitable professional staff and accredited addiction counsellors (only if the use of accredited addiction counsellors is in accordance with their treatment philosophy).

- a) A medical doctor and psychiatrist are employed or are on call for 24-hour backup and consultation.
- b) The minimum interdisciplinary team consists of a professional staff member (a social worker or clinical/counselling psychologist), accredited addiction counsellors and a part-time professional nurse.
- c) Type A centres' interdisciplinary teams consist of a medical doctor, a psychiatrist (full time, part time or contracted), a social worker, a clinical/counselling psychologist, an occupational therapist (OT) (if an OT is required by the treatment programme) and accredited addiction counsellors.

Staff numbers and coverage: The centre has adequate staff to render a 24-hour specialist substance dependency service.

- a) The staffing norm is one staff member for every 20 patients/clients. A staff member here refers to professional staff and accredited addiction counsellors only.
- b) The minimum number of professional staff available during programme hours is 1,5, i.e. one full-time staff member and one-part/half-day staff member.
- c) The minimum number of professional nurses available during programme hours is 0,5, i.e. working part time/half days.
- d) Type A centres have a professional nurse on duty 24 hours a day, i.e. during daily programme times and after hours. Other categories of nurses may be employed to provide support.

8.26 Job descriptions and contract: All staff (full time and those working on a consultant basis) should have written job descriptions and signed contracts that are regularly reviewed by management. These descriptions include professional staff members' registration numbers and current registration status.

8.27 Human resources policies: Documented, up-to-date human resource policies and procedures cover the following topics.

- a) Recruitment selection and registration of staff and volunteers
- b) Staff orientation (on starting employment)
- c) Wage and salary administration
- d) Skills and qualifications
- e) Training and development

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- f) Promotions
- g) Employment benefits
- h) Pay conditions of service
- i) Line of authority
- j) Case supervision
- k) Rules, conduct and ethics
- l) Disciplinary actions and dismissal of staff
- m) Methods of handling cases of inappropriate care or conduct violation
- n) Work performance appraisal
- o) Staff accident and safety
- p) Staff grievances
- q) Staff suspected of using or abusing substances

Notes and examples: Policies on staff competencies and behaviour and on patients'/clients' safety and rights should receive priority attention.