



**NATIONAL DEPARTMENT OF  
SOCIAL DEVELOPMENT**

**MINIMUM NORMS AND STANDARDS**

**FOR**

**OUT-PATIENT 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 treatment centres in the country. The department is currently undertaking a process of reviewing the Act, which will outline how the out patient services should be rendered.

The main objective of this document is to describe what is an acceptable and adequate quality of services that should be provided to people with substance abuse condition, as well as their significant others, at out-patient treatment centres.

This document suggests basic acceptable parameters, which must be adhered to in order for out-patient treatment centres to function adequately. Due to the diversity of out-patient service available, two categories of facilities are provided for, namely: Therapeutic intervention with medical services and Therapeutic intervention without medical services.

In view of the threat that substance abuse holds for South Africa it is imperative that a continuum of specialized treatment is available to address chemical dependency. Realistically outpatient treatment programmes /facilities are a modality which promotes community based interventions that are effective, affordable and accessible. There are a broad of acceptance models for out-patient treatment programme, there is however, a need to ensure that certain minimum norms and standards are established and adhered to protect the communities served. Minimum norms and standard will also promote maximum efficiency of the treatment interventions in the context of limited financial and human resource in South Africa

Minimum norms and standards will ensure that a credible service will be available at all out patient treatment centres throughout South Africa. These standards will also contribute positively towards improving quality control and facilitate transformation of 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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## PURPOSE OF MANUAL

To establish a set of minimum standards for the control, guidance and monitoring of out-patient treatment centres in South Africa.

- 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 out-patient 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**

Out-patient treatment centres should be such that communities are willing to utilise the facilities and services in the knowledge that the quality of services is at an acceptable level based on prescribed minimum norms and standards and that mechanism are in place to ensure accountability.

### **EMPOWERMENT**

The resourcefulness of service users 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**

Service users 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**

Service users 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 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 service users 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**

Service users and their families should be exposed to normative challenges, activities and opportunities, which promote participation and development.

### **EFFECTIVE AND EFFICIENT**

Service provision to service users 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 service users in trouble with the law should focus on restoring societal harmony and righting wrongs rather than punishment. The service user should be held accountable for his or her actions and where possible compensate the victim.

**APPROPRIATENESS**

All services to service users 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 service users remain within the family or community context wherever possible

**PERMANENCY PLANNING**

Service users within the continuum of care should be given within the shortest time possible the opportunity to build and maintain lifetime relationships within a family 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
- Criminal Procedure Act, 1977(Act No.51 of 1977,section 296)
- 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, 1998 (Act No 55 of 1998)
- 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)
- 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:	A staff member who provides support services to the multi-disciplinary team.
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.
Evaluation	The systematic identification of a service users'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).
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.

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- 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 service users'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 service users and their families/caregivers in preparing for service users release from the centre and subsequent integration into family life and other social networks (e.g. community and work).
- Families and Caregivers:** Service user's families (including spouses, partners and dependents) and other significant 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.
- 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

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state; intellectual, linguistic or educational abilities; freedom from coercion or age-related maturity and current relevant legislation.

Multidisciplinary team:	A therapeutic or multidisciplinary team of health and social development professionals and support staff.
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).
Out-Patient Facility:	An out-patient substance abuse treatment centre is a community based facility where service users are required to attend on a sessional basis for a specified time, however they are not required to reside there. The centre must offer a specialist rehabilitation programme, offered by professional staff, to address substance abuse problems.
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.
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.
Standards:	Qualitative statements that describe what constitutes acceptable or adequate performance or resources.
Structured daily	An organized programme of activities and treatment offered by the

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Programme:	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.
Support staff:	The support staff referees to the following categories of workers: Accredited addiction counsellors, Social Auxiliary workers and Child and Youth care workers employed by a treatment centre.
Therapy:	Treatment provided by professional staff.
Treatment:	The clinical process by which the service users 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 out-patient centre 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 Symptoms:	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).

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- Young people: Children and service users under the age of 18 years, and service users who are in the Child and Youth Care System (CYC) when they turn 18 years old and who remain until 21 years.
- At risk: Service users who have their normal, healthy development placed at risk because of their circumstances and behaviour
- Service providers: Organisations rendering social and medical services to service users

**LIST OF ABBREVIATIONS**

<b>AA</b>	Alcoholic Anonymous
<b>CDA</b>	Central Drug Authority
<b>CYC</b>	Child and Youth Care
<b>DSMIV</b>	<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).
<b>HPCSA</b>	Health Professions Council of South Africa
<b>ICD10</b>	<i>International Classification of Diseases</i> , Volume 10. An international disease classification system that includes physical and mental health conditions.
<b>MTC</b>	Mother to child transmission
<b>N &amp; S</b>	Norms and standards
<b>NA</b>	Narcotics Anonymous
<b>NDMP</b>	The National Drug Master Plan
<b>NGO</b>	Non-governmental organization
<b>OT</b>	Occupational therapist
<b>S &amp; C</b>	Standards and criteria
<b>SACSSP</b>	South African Council of Social Services Professionals
<b>SACENDU</b>	South African Community Epidemiology Network on Drug Use
<b>STI</b>	Sexually Transmitted Disease
<b>TB</b>	Tuberculosis
<b>UNODP</b>	United Nations Office for Drug and Crime
<b>VCT</b>	Voluntary counselling and testing for HIV/AIDS
<b>WHO</b>	World Health Organization

## 1. RIGHTS AND RESPONSIBILITIES

### 1.1 Standard statement

The rights and legal status of the service users are upheld by the treatment Centre within an ethos of service users dignity, appropriate treatment provision and respect for human rights.

### 1.2 Constitutional rights: The constitutional rights of the service users 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. Service users 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 service users 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 service users' ability to pay.
- c) The right to effective communication in a language and manner that service users 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 service users 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.

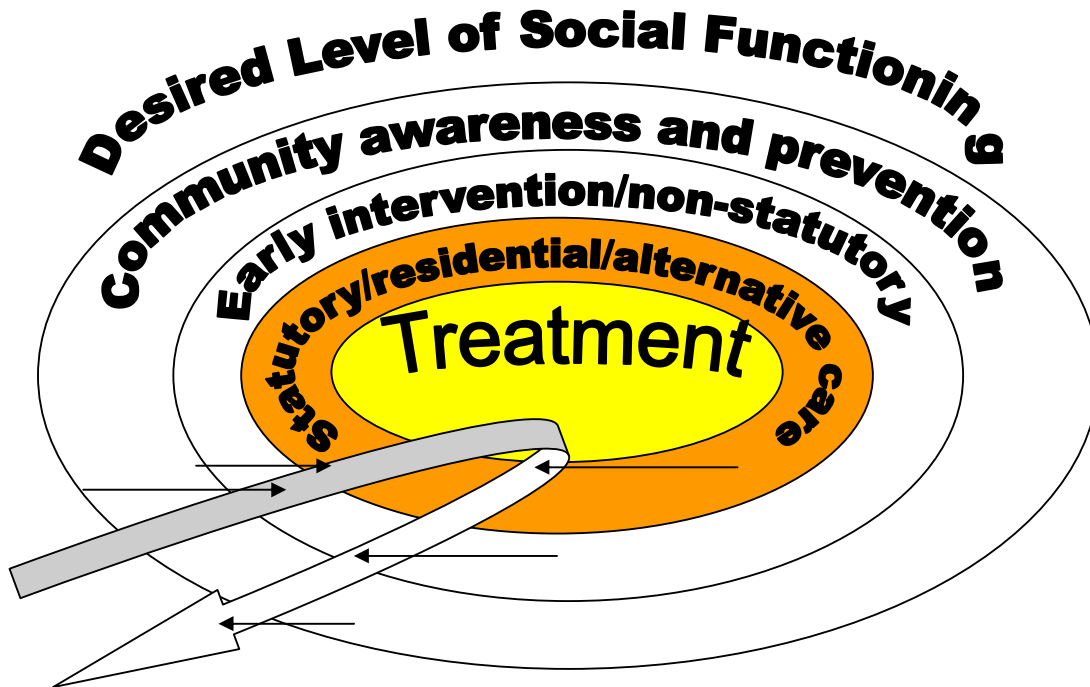
**1.4 Rights documents:** Service users' rights and responsibilities are clearly communicated to all service users, their families, caregivers and Centre staff from the onset of the service users' entry into the Centre.

*Notes and examples: Staff and service user's rights and responsibilities should be documented and displayed. These should form part of the service users' admission and orientation. Care should be taken to ensure that the rights and responsibilities are communicated in a manner appropriate to the service users' age, language and competencies. Service users 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

Service users 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.

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- Promote information and awareness programme for general population.
- Culturally appropriate and sensitive approach to prevention programme.
- Educational programmes that address specifically non-commercial alcohol.

### 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

Identify high risk group and intervene timeously to prevent them from becoming addicted to substances.

#### 4.1.2 Outcome

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

#### 4.1.3 Programme practice

- **Pre-admission:** It involves screening all the documents required prior to admission. Screening panels participate fully in terms of admission process.
- **Admission :** The applicant go through an administrative or clinical procedure by which a suitable applicant is admitted in the centre
- **Assessment :**The centre administer an assessment tool and offer intervention.
- **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.
- **Special programmes for early intervention:** Education programme specifically for those serving and selling substances. Education programme of professionals eg Health workers and educators.  
Educational programmes specifically for parents.  
Prevention programme for drinking and driving

#### 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 assessment process involves the following:

- a) Brief social history.
  - b) Biomedical problems.
  - c) Identify a need for detoxification.
  - d) Motivation or lack of motivation for treatment and recovery
  - e) Evidence or lack of support system
  - f) Identify strength and weakness.
- **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 abuse persons.

#### 5.1.2 Outcome

Substance-dependent persons are admitted to out-patient treatment centres according to statutory process.

#### 5.1.3 Programme practice

The Prevention and Treatment of substance abuse Bill makes provision for referrals, admission, treatment and release of service users.

- Substance-dependent persons committed to an out-patient treatment centres in terms of section 41 of the Substance Abuse Bill are accompanied by a court order.
- Voluntary patients/clients admitted in terms of section 40 of the Bill should be accompanied by a voluntary admissions form.
- All admissions of service users to out-patient 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.
- Child justice Bill 2003 makes provision for referral of young offenders who undergo through a diversion programme

#### 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 and treatment

#### 6.1.1 Standards statement

All service users 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 and treatment 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 screening and assessment is undertaken by a medical practitioner within 48 hours.
- **Comprehensive assessment:** A comprehensive assessment is undertaken in a timely manner by qualified and experienced professionals.

The assessment process involves the following:

- g) Brief social history.
  - h) Biomedical problems.
  - i) Identify a need for detoxification.
  - j) Motivation or lack of motivation for treatment and recovery
  - k) Evidence or lack of support system
  - l) Identify strength and weakness.
- **Psychiatric diagnosis:** Identified service users 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 or the multidisciplinary team.
  - **Specialist and team review:** The results of each service user comprehensive assessment are reviewed by a case manager and the centre's multidisciplinary team.
  - **Documentation:** The assessments are recorded in a service users '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.
  - **Service users feedback:** Service users receive feedback during the assessment process on the results of the process.
  - **On review of progress:** A formal review of the service users' treatment progress (including psychiatric status) is done weekly by the

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 to support monitor and regulate the assessment and review process.

Service users 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 service users 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 service users have a documented, individualized treatment plan that encourages their participation, motivation and recovery.

### 6.2.2 Outcome

**Treatment plan:** All service users have an individualized treatment plan/programme.

### 6.2.3 Programme practice

- **Informed consent and information:** Informed consent is sought from all service users prior to the onset of any treatment. They 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.
- **Individual treatment selection:** Treatment is selected for all service users 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. Treatment programme must be age sensitive
- **Care plan:** Based on the comprehensive assessment, a written individual treatment plan or provisional development treatment plan is developed in consultation with the service users and recorded. The plan contains the following:
  - a) Clear and concise statement of the service users' current strengths and needs.
  - b) Clear and concise statements of the short- and long-term goals the service users are attempting to achieve.
  - c) Type and frequency of therapeutic activities and treatment programme in which the service users will be participating.
  - d) Staff responsible for the service users' treatment and their individual counsellor.
  - e) The service users' responsibilities and commitment to the rehabilitation process.
  - f) The plan is dated and signed by the individual counsellor and the service users a copy of the plan is given to the patient/client.
- **Participation:** As far as possible, service users (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 service users are still in the treatment programme.

#### 6.2.4 Management actions

- **Treatment standards:** All treatment offered is safe and evidence based and reflects national and 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. Basic requirements here are the following:
  - a) The individual counsellor is responsible for assisting service provider 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 service users for a minimum of 45 minutes.
  - c) The individual counsellor is reasonably accessible to service users 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 – the ratio is 1:10 for short-term treatment programmes and 1:15 for long-term treatment.
  - e) Duration of short term treatment programme minimum 6 sessions, Long term programme 12 sessions
  - f) Therapeutic group sessions minimum 1 hour
  - g) Education and awareness groups sessions minimum 45 minutes facilitated by addiction counsellor, Social auxiliary worker, Child and Youth care worker as well as Health professionals.

### 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 service users' 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 component:** Some out patient centres have in- house medical facilities whilst others need to refer to outside facilities. Where a referral is made to an outside facility it must be appropriate and a registered medical facility. Where a service user is referred for a detoxification to the provincial hospital there must be a written agreement that all service users who are referred for detoxification must provide proof of completing detoxification when returning to the centre for treatment services. It must be recorded if the service user does not return .A service user will not be re-admitted if he /she does not return immediately after the detoxification period has lapsed. This must be a communicated to the service users and confirmed in writing.
  
- Should there be an in house medical facility the patient will be required to have a medical examination .It must be determined from the examination, as well as the history taken, whether the service user is a suitable candidate for out-patient treatment of withdrawal .withdrawal may be categorized as mild, moderate.  
The medical examination must be carried out by a registered medical practitioner and the necessary medication prescribed. The minimum amount of medicines should be prescribed, but with the maximum effects, for the shortest time and it must be cost-effective.  
Medication needs to be age appropriate. It should be established whether a service user is fit to control his/her medication or whether it should be dispensed by a registered nursing sister with a dispensing license.
  
- **Clinical/Case record:** A medication record, with appropriate signatures, is kept in the service users 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.

- **Drug Testing /Breathalysing**  
Drug testing and breathalysing are essential elements of the treatment process, This aspect must form part of the initial contract between the client and the treatment centre, whereby the client specifically consents to undergo drug testing and breathalysing procedures during treatment process.

- **Medicine-related monitoring:** Service users 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 service users' 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 service users.

*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 service users' 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 service users receive an initial intake assessment (i.e. face-to-face examination) by a medical doctor or psychiatrist before any medicines are prescribed

- **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.
- **Continuity of care:** No service users 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) An up-to-date list of staff qualified and authorized to prescribe and administer drugs.
  - d) Medicine administration, including timing, venues and supervision.
  - e) Storage, control, accountability, inspection and documentation of medicines (according to statutory and professional requirements).
  - f) Monitoring of adverse reactions and medication errors.
  - g) Documented policies and procedures for drug testing and breathalysing.
  - h) Voluntary withdrawal.

**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

*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

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- 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) Service users 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) Service users 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 service users individual needs and preferences and the centre's capacities;
- h) a safe, quiet and comfortable space for the detoxification process;
- i) adequate monitoring and supportive care;
- j) pharmacotherapy (as per protocol for medicated detoxification) including adequate, individual-specific, prescribed medicines;
- k) emergency care and equipment, including referral to hospital, if required;
- l) feedback and support to family and caregivers, if appropriate.

## 6.4 Structured treatment programmes and daily activities

### 6.4.1 Standard statement

Service users 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 service users 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 national and internationally accepted standards.

*Notes and examples: The treatment and rehabilitation programme describes structured weekly and daily activities, individual and group counselling/therapy; and in a time-limited programme*

- **Programme content:** The structured programme consists:
  - a) Individual sessions, youth therapy and family therapy.
  - b) Life and social skills.
  - c) Psycho educational groups.
  - d) Recreational and creative activities
  - e) Spiritual counselling (optional).

*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 psycho educational (e.g. drug information and relapse prevention).*

- **Programme duration:** The duration of the short term treatment programme minimum of six sessions, while the long term minimum of 12 sessions, which includes therapeutic/counselling sessions.

*Notes and examples: This can take place as a component of the structured treatment programme (e.g. psycho educational 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 service users (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 service users' community.

*Notes and examples: This can include orientation information, posters and regular staff/ service users 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.
- **Meals:**
  - a) Service users can be provided with refreshments when necessary.
  - 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

- Service users 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.
- Service user has granted another opportunity as relapse is part of treatment process can be granted.
- After care contributed towards successful maintaining of sobriety.

### 6.5.2 Outcome

Service users who are fully prepared to participate in after care programmes within their communities.

Successful completion of the treatment programme.

### 6.5.3 Programme practice

- **Discharge assessment and review:** All patients/clients are assessed and reviewed by the multidisciplinary 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 leaving the centre. A copy of this report is kept in the service users' case records. The summary includes:
  - a) Service users' 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 service users to their original referral social workers, local community services and self-help groups.  
A service users will be linked to a self help group /support e.g. NA, AA
- **Release information:** Release information is provided for all service user 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.

- **Relapse prevention:** Prior to release, the service users, 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 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 programme due to serious violation of rules and regulations (e.g. possession of harmful substances or weapons, sexual harassment, violence or repeated threats of violence.
- c) The release and transfer of patients deemed to be unsuitable for the programme

- **Expulsion:** The criteria and procedures for expelling service users are clearly communicated to patients/clients and their families/caregivers. Service users 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. Regional /Provincial representatives will convene appeal committee meeting and take a decision regarding expulsion.
- **Transfer and referral:** Defined and documented criteria and procedures exist for referring service users in need of alternative services (e.g. in-patient treatment) for further intervention.
- **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.
- **Release planning:** The release plans are developed and reviewed in collaboration with service users and with the service users' informed consent and that of their families and caregivers. A copy of these plans is kept in the service users' case records.
- **Readmission:** The centre has policies and procedures to support the readmission of appropriate service users. The treatment goals and programme for readmitted service users is clearly stipulated in accordance with their treatment needs.

## MANAGEMENT AND GOOD GOVERNANCE

7.1 Management structure should consist of a board of Directors responsible for development of policies while the centres management committee is responsible for implementation of policies.

### 7.2 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:** Management employ only professional 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 and the South African Council for Social Services.*

**7.1.2 Support staff:** Addiction counsellors, Social auxiliary worker, Child and youth care are regarded as support staff. They assist in conducting support groups and awareness programme under the supervision of professionals.

**7.1.3 Core competencies:** Professionals endeavour to have the skills and competencies to undertake the following in individual and group therapy. These competencies are the minimum requirements for professional health and social services.

- a) Screening to establish whether the service users is appropriate for the programme.
- b) Intake – Administrative and initial assessment procedures.
- c) Orientation of the service users.
- 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 service user's needs are not being addressed by the programme.
- k) Reports and record keeping.
- l) Consultation with other professionals on treatment services.

**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 service users or recently released service users becomes involved in the counselling or treatment of other service users.

**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 adheres 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.

**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 and trauma counselling.
- d) Counselling skills development.
- e) Service users confidentiality
- f) Service user's rights and treatment ethics.
- g) HIV/AIDS, tuberculosis and other related medical conditions.
- h) Common mental health problems (e.g. depression, suicide, psychoses, eating disorders).
- i) Crisis management, including managing aggression and disturbed/intoxicated patients/clients.

- j) Sensitivity towards and skills in responding to sexual abuse/incest and harassment.
- k) Cultural sensitivity and racial diversity.
- l) Gangs.
- m) Training on behaviour management (minimum norms and standards for child and youth care)

**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:** Professional staff require regular, skilled clinical/case supervision provided by a more experienced or skilled professional person.

**7.1.11 Employment assistance programme:** 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 and their own personal problems.*

**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 service users their informed consent is essential. Research is not conducted on an involuntary/uninformed basis (e.g. "drug trials").

## 7.2 Environment and amenities

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

**7.2.1 Legislation:** The centre ensures that its amenities and physical environment comply with environmental health, 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 :out-patient 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. service users, 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.

**7.2.7 Special care and examination facilities:** Rest rooms are provided as special care and examination rooms for medical procedures/examinations, emergencies and detoxification. The rest room 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
- 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 service users to relax.

**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 service users' consent. Safeguards to protect service users' rights cover the following:

- a) Whenever possible, all searching of service users' private belongings and parcels occurs only in the presence of the patients/clients, and only by professional designated staff.
- b) Service users are informed of such searching practices and consent to them as part of their orientation at the centre.
- c) The bodily integrity of service users is not violated by routine or unauthorized bodily searches

**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 service users and staff against crime and theft.

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

- a) Clean, well-ventilated, adequately heated, well-lit treatment and therapy area

- b) Adequate security against theft and crime, such as perimeter fencing and burglar bars.
- c) Toilets and showers/baths in good repair.
- d) Sufficient bathrooms and toilet facilities: at least 1 toilet to every 8 service users and 1 bath and shower to every 12 service users.

### **7.3 Family support and involvement**

The centre encourages the support and participation of the service users' 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 service users' 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 home visit.

*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 service users 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 service users, 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 service user's recovery.
- d) Support for families and caregivers to cope with co-dependency.
- 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 services-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.

#### 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:** Service users have their own permanent, separate service user's 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 service users.

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

**7.4.4 Comprehensive records:** Case records are a comprehensive factual and sequential record of service users' condition and the treatment and support offered.

- a) Entries are signed legibly (clear name and professional designation) and dated.
- b) The diagnosis given to service users is clearly indicated in the records.
- c) Details are provided of all service users 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, ongoing progress and release planning.
- d) Notes are taken of multidisciplinary case conferences, consultations and feedback on participation in group treatment programmes.
- e) Daily nursing care records are kept and included in the case records.

**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 service user to determine patient/staff ratios and occupancy rates.
- c) Critical incidents.
- d) Number of detoxifications
- e) Length of stay.
- f) Service user's 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 support staff) 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 out patient 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 for children in treatment centres:** 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) receive an assessment of their developmental needs, which are addressed in individualized care;
- e) receive family-centred interventions that seek to strengthen family development;
- f) 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;
- g) have access to education and vocational information and guidance, appropriate to their age, aptitude and ability;
- h) have access to basic health care, including confidential access to health promotion and prevention (e.g. HIV/AIDS, sexuality and reproduction);
- i) 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 relevant legislation and service users' 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) participation of families in the comprehensive assessment and release planning;
- b) attendance at family therapy/counselling and family support groups;
- c) 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 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);

**7.5.8 Education:** Adolescents continue to receive educational inputs while they are in treatment. Educational activities do not interfere, however, with prescribed treatment programme activities.

**7.5.9 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 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 service users.
- 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**

**7.5.10 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.

**7.5.11 Risk assessment.** An assessment of HIV-risk behaviours is part of all service users' 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.

**7.5.12 HIV and AIDS testing:** The centre ensures that voluntary HIV/AIDS diagnostic testing and counselling is readily available to all service users 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).

**7.5.13 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 .

**7.5.14 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.

**7.5.15 Ongoing support and counselling:** Service users 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**

**7.5.16 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).

**7.5.17 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).

**7.5.18 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 referred 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).

## 8. PROCEDURE FOR TREATMENT CENTRES MANAGEMENT

- 8.1 Appropriate placement:** The centre admits and retains only service users according to its current Scope of Practice and its treatment and resident capacities. Appropriate referrals are made for service users considered unsuitable for treatment at the centre.
- 8.2 Incident reporting and monitoring:** Every death, injury and neglect of a service user is 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).
- 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 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.
- 8.5 Centre rules:** service users, their families and caregivers are supported in complying with the behavioural expectations of the centre.

*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 service users community with a view to developing further criteria on this issue.*

- 8.6 Behaviour management:** Service users 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.

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

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

**8.8 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.*

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

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

**8.10 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.*

**8.11 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.

**8.12 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.

**8.13 Law enforcement and treatment status:** Service users 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.

#### **8.14 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.

#### **8.15 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 addiction counsellors.

- a) A medical doctor and psychiatrist are employed on a sessional basis and for emergencies.
- b) The minimum multidisciplinary team consists of a professional staff member (a social worker or clinical/counselling psychologist, support staff and a part-time professional nurse).

**Staff numbers and coverage:** The centre has adequate staff to render a holistic treatment programme.

- a) The staffing norm is one professional staff member for every 10 service user while the norm for the support staff is one staff member for every five service users.

**8.16 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.

**8.17 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
- 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