KENYA STANDARD **DKS 2941-4**

Management of Persons with Substance Use Disorders

Part 4: Recovery Management

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TECHNICAL COMMITTEE REPRESENTATION

The following organizations were represented on the Technical Committee:

1. The National Authority for the Campaign Against Alcohol and Drug Abuse
2. Retreat Treatment Center
3. Ministry of health- Public health and sanitation
4. The Kenya Medical Supplies Authority (KEMSA)
5. Kenyatta University
6. Aga Khan University Hospital
7. Total Wellness East Africa Limited
8. Ministry of Health-Division of Mental Health & Substance Use management
9. Kenya Bureau of Standards

REVISION OF KENYA STANDARDS

In order to keep abreast of progress in industry, Kenya Standards shall be regularly reviewed. Suggestions for improvements to published standards, addressed to the Managing Director, Kenya Bureau of Standards, are welcome.

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ICS

Management of Persons with Substance Use Disorders

Part 4: Recovery Management

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ICS

Foreword

Treatment and rehabilitation centers for persons with substance use disorders in Kenya have recently grown exponentially in the private and public sector. This can be attributed to the increase in alcohol and drug abuse (NACADA 2019, Masinde Muliro University, 2009).

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

These guidelines provide the minimum standards to be met within treatment and rehabilitation centers in Kenya while offering services at the different levels of care for persons with substance use disorders. These include rights and responsibilities of clients, levels of treatment, treatment center management, infrastructural setting, staff training and competence.

These standards aim to provide evidence-based standardized service delivery approach that assures effective and quality care across the private and public sector.

Management of Persons with Substance Use Disorders

Part 1: Treatment and Rehabilitation Centers Management

1 Scope

This standard covers the minimum requirements needed when setting up a treatment and rehabilitation center in regards to the environment, space and structural layout, equipment, human resource and administrative management.

2. Terms and Definitions

2.1 Abuse

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

2.2 Addiction

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

2.3 Addiction counsellor

An accredited lay counsellor (i.e. a non-health or social services professional) who has demonstrated proficiency in core addiction counselling competencies and has been duly accredited and registered by a recognized training and registration body.

2.4 Clients Persons with a substance use disorder.

2.5 Counselling

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

2.6 Inpatient also, residential client: Client who resides in a residential treatment centre for treatment**.**

2.7 Intervention

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

2.8 Levels of Care: The American Society for Addiction Medicine (ASAM) identifies five levels of care as follows:

Level 0.5 – Early intervention
Level I – Outpatient treatment
Level II – Intensive outpatient/partial hospitalization
Level III – Residential/inpatient treatment
Level IV – Medically-managed intensive inpatient treatment

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

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

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

2.12 Recovery management, also known as "after-care", or social support represents a long-term recovery-oriented model of care for patients with drug use disorders that follows stabilization of abstinence achieved during outpatient or residential treatment.

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

2.14 Substance Use Disorder (SUD) as per the DSM-5: A maladaptive pattern of substance use, leading to clinically significant impairment or distress.

2.15 Therapy Treatment provided by professional staff can either be a medical treatment or a talk therapy.

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

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

3.0 Recovery Management

This shall include long-term pharmacological, psychosocial, economic and environmental treatment strategies to maximize chances of improvements across a range of outcomes, including substance use, physical and mental health, criminal behavior, risk-taking, and social functioning.

Recovery management is focused on stabilizing, supporting and strengthening one's recovery over the lifespan and moves the focus to the patient taking increasing personal responsibility for managing their disease building on the strengths and resilience of individuals.

3.1. Goals

The primary goal of the recovery management phase is to maintain benefits obtained in earlier phases of treatment. This includes ongoing pursuit of personal and social recovery as a part of living a drug abuse free life, improvement in self-care for physical and psychological well-being, reclaiming personal dignity, self-worth, and spiritual or religious growth.

3.2 Types of clients this setting is best suited for recovery management

The patients treated for drug use disorders shall need recovery management interventions as part of the continuum of care

For the individuals listed below, more emphasis is recommended:

a) Patients with high disease complexity
b) Low effective coping life skills
c) Patients with a clinical history of multiple relapse episodes
d) Poor family and community support
e) Financial, legal and housing problems
f) Mental health disorders

3.3 Principles of recovery management approach

Recovery-oriented care includes the Strengths-Based Case Management which views recovery as more than the achievement of abstinence from drug abuse, but to also as a means to build meaningful and satisfying lives.

This approach is characterized by:

3.4 Treatment Activities

Recovery management approach includes a variety of activities that promote and strengthen internal and external resources to help affected individuals voluntarily resolve problems related to drug use and actively manage the vulnerability to recurrence of such problems. Some of those activities are already present in patient's home, neighborhood and community contexts while other can be developed.

3.4.1 Specific Requirements

a) It shall involve an individualized aftercare treatment plan
b) Recovery management check-up shall be done
c) It shall have a regular monitoring or follow-up evaluations by a professional
d) Case management of clients

3.4.2 Criteria for program completion and indicators of effectiveness

A recovery management approach adopts a "life course" perspective that shuns terms of "discharge" or "graduation" used in more traditional treatment models. It embraces the chronic disease management approach that aims to help individuals effectively manage their own health problem with a goal of improving their well-being. Recovery management is open-ended and may continue for a lifetime.

4Termination of client from programme

a) Some behaviors are not acceptable in the aftercare program and may be grounds for the removal from the program. The use of drugs or alcohol, violence, stealing and sexual activity within the facility. Programs shall have regular toxicology screening with additional screening on returning from the pass outside the facility and when drug use is suspected.

b) Procedures to report unsafe incidents such as physical or sexual abuse should be in place. There should be clear procedures for responding to breaches of program rules and values, with differing levels of response to reflect the specific circumstances. Contact with visitors should be monitored or supervised, and possibly restricted, particularly in the early stages of treatment.

5. Residential/Inpatient services

Patients who are unlikely to maintain abstinence outside of a structured setting to improve their life quality, or to participate in health and social integration. Long-term residential programs are best suited for individuals who require intensive and continuing treatment to address the whole person, with particular focus on managing complex psychological and social problems associated with addiction, and initiating changes in multiple life domains to facilitate transition to the process of recovery.

5.1 Environment

a) All residential treatment programs must provide a safe environment to its staff and residents to assure a psychologically and physically safe living and learning environment.

b) The physical environment of the program where residents stay for many months is important. It should not look like a prison or a hospital but as a home. Abstinence from alcohol and drugs should be required and assured. However, psychoactive medications used under medical supervision to treat psychiatric or addiction disorders, such as methylphenidate, antidepressants, methadone or buprenorphine, should not be discontinued unless it is medically indicated.

c) Procedures for the dispensing and administering of prescribed medication should be in place.

5.2. Space and structural Layout

Diagram- for placement of rooms

5.2.1 Placement Rooms

a) The structures in the rehabilitation center shall be permanent or semi-permanent.

b) The height of all common rooms and bedrooms shall be at least 10 feet.

c) The windows should be at least 24 inches by 24 inches for the room

d) There shall be a special care and examination rooms for medical examination, emergencies and detox.

e) The doors and windows should open towards the outside in case of any emergency. The windows should alteast have a 10% openable area to the floor area ratio.

f) The walls shall be brightly colored.

g) The rehabilitation center should have a sitting area, a dining area and a kitchen structurally following each other with proper labelling of each room.

h) All rooms should access sunlight through windows or sky lights in addition to or in lieu of electric lighting.

i) The space shall be 1.5m per 1.5m per person floor area per occupant in the bedroom.
j) The facility should comply to the standard on occupational hazards public health act

5.2.2 Kitchen

a) The kitchen should be adequate and spacious to carry out all the activities carried there in.

b) The kitchen preparation tops shall be impervious or stainless steel material.

c) The kitchen shall have a waste storage bins with covers

d) The kitchen store room shall be adequate and have pallets for food stuffs storage. Maintenance of first in, first out rule. The store should have two segments the hard store/nonperishables and the soft store/perishable.

e) The kitchen should have adequate running water

f) The kitchen floor shall be self-draining and those with open drainage should be gritted.

g) The kitchen should have a chimney to exhaust the smoke

h) The kitchen utensils, the plates and cups shall be melamine, glass or porcelain and the cooking pans and cutlery shall be stainless steel.

i) The kitchen should have an exit door

j) Maintain general cleanliness

5.2.2.1 Equipment

Kitchen fridge- separate storage of different food items in regards to preparation and types of food

5.2.2.2 Human resource

Kitchen staff should be periodically medically examined to ascertain fitness to handle food for human consumption.

5.3.3 Bedrooms

a) There shall be provision of high density mattresses, warm blankets and beddings, mosquito nets, safe and secure storage areas.

b) There shall be provision of litter bins in all bedrooms

c) The bedrooms should be well ventilated

d) There shall be a space of 0.9meters from one bed to another.

e) The room X * 4.2 + 1.2m2. x is the number of people.

5.4 Water

The facility shall have clean water as evidenced by the certificate of conformity from local authorities as stipulated in the public health act. The water shall be protected from contamination. There shall be extra water reservoirs that are treated. The storage tanks shall be washed regularly.

5.5 Toilets

There shall be provision of a toilet and bathroom in the facility; one toilet for the first 25 males and one toilet for the first 20 females. There should be provision of a urinal in the male toilets, one urinal for every three toilets. Each toilet shall have a wash basin. The female toilets shall have sanitary bins. There shall be adequate provision of disinfectants, cleaning equipment and moth balls.

5.6. Vector and Vermin

a) The compound should have adequate rat proof
b) The area should be free of vector and vermin infestation. There shall be no breeding grounds for mosquitos and mosquito screened windows.

5.7 Waste Disposal

a) The yard shall be kept free from full or broken bottles.
b) Cess pits shall be covered
c) Gutters shall be perforated

6. Non- residential treatment programs

Non-residential treatment programs shall provide a safe environment to its staff and residents to assure a psychologically and physically safe living and learning environment.

The location of the nonresidential treatment centers shall be accessible by the target population where hygiene and security are guaranteed.

7.0 Documentation

Written or electronic records of all assessments should be confidentially kept in a secure location, only available to the staff directly involved in the treatment. Proper documentation should include at minimum:

a. Signed consent to treatment and agreement on programme rules
b. Signed confidentiality and ethics policy
c. Appropriate treatment and management plans for each resident
d. Regular updates with details of treatment, progress and any changes to the original goals
e. A completion summary at the end of the programme (informing the resident of its contents)

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