KENYA STANDARD **DKS 2941-2**

Management of Persons with Substance Use Disorders

Part 3: Residential treatment

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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.

KENYA STANDARD

DKS 2941-2
ICS

Management of Persons with Substance Use Disorders

Part 3: Residential Treatment

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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 3: Residential Treatment

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 use of illegal or legal substances including alcohol and prescription drugs in a harmful way, excessively or for purposes they were not intended for.

2.2 Addiction

Addiction is a brain disorder characterized by inability to control or stop the use of legal or illegal mind-altering drugs despite negative consequences often associated with physical and/ or psychological dependence on the substance

2.3 Clients Persons with a substance use disorder.

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

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 Critical incident

Any abnormal or unusual occurrence that threatens the safety or well-being of clients and staff.

2.7 Drug

Any substance, legal or illegal, that when consumed alters the functioning of the brain either by changing feelings, perceptions, thoughts, and/ or behaviour of an individual.

2.8 **Inpatient/ residential center:**

Client who resides in treatment centre for purposes of the therapy / prescribed treatment**.**

2.9 Intervention

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

2.10 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

2.11 Outpatient/Non-Residential Center : the client 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.

2.12 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.

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

2.14 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.

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

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 and treatment goals, i.e. physical, psychological, social, vocational, spiritual, interpersonal and lifestyle needs.

2.17 Treatment plan
An individualized written document that serves as a road map to the recovery process that reflects a mutual agreement between the client and therapist regarding a client's personal goal for treatment with measurable, time specific steps towards achieving these goals. It should be reviewed periodically as the client progresses through the stages of treatment

3 Short-Term In-Patient or Residential Treatment

a) The short-term inpatient (or residential) treatment setting is an environment in which 24-hour care is available. This is at an intensity capable of managing the symptoms and potential complications likely to occur in the days and initial weeks following the cessation of drug use including the drug withdrawal syndrome.

b) Short-term inpatient treatment provides an opportunity to cease drug use with minimal discomfort and risk to health and offers both a temporary reprieve from the environmental stressors in a person's life, and an opportunity to receive some psychosocial support which may become the start of an ongoing treatment process either long term inpatient or outpatient treatment.

c) The length of stay varies from 1 to 4 weeks according to the local practices and the clinical situation. Given that the drug withdrawal syndrome and its treatment can pose significant health risks, short-term residential treatment requires a higher degree of medical supervision than long-term residential treatment, which follows the acute withdrawal phase.

3.1 Goals

The goals of short-term residential treatment are to facilitate the initial cessation of drug use, assist the client manage withdrawal symptoms with minimal discomfort and to motivate patients to engage into some further treatment that may be psychological, sociological, and/ or pharmacological.

3.2 Target population

The typical target population are people with substance use disorders likely to experience significant withdrawal symptoms upon cessation of their drug use. Short-term residential treatment can also be used to commence medically assisted therapies.

The following criteria should be considered when deciding whether a short-term residential treatment or another treatment level is applicable:

a. Type of drug being used
b. Likelihood of withdrawal syndrome
c. Severity of drug dependence
d. Related health and social problems
e. Co-occurring medical and psychiatric problems

3.3 Treatment models and methods used

a) Achieving the therapeutic goals of short-term residential treatment typically requires a combination of interventions such as psycho-education on drug-effects, motivational counselling, pharmacotherapy and support through drug withdrawal.

b) Other interventions which can be initiated may include introduction to cognitive behavioral therapy, orientation to self-help groups, social services, and appropriate referrals for follow-up care after discharge.

c) The specific types and the duration of these interventions differ depending upon the nature, complexity and patterns of drug use, as well as the presence of co-occurring medical and psychiatric problems.

3.4 Treatment activities

Short-term residential treatment programmes for drug use disorders should include the following activities:

a. Comprehensive medical and psychosocial assessment
b. Treatment plan which best addresses individual needs and goals
c. Medication-assisted detoxification where indicated
d. Initiation of maintenance medication where indicated
e. Strategy to foster patients' motivation for change
f. Contact with individuals that are of significance in patient's social network to engage them in the treatment plan
g. Initiation of behavioral treatment strategies for the treatment of drug use disorders
h. Initiation of treatment for co-occurring medical and psychiatric disorders, if time and resources permit
i. Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the programme
j. Discharge planning with relapse prevention and continuing care strategies for the

period after residential treatment, including maintenance medication if indicated, an appropriate level of psychosocial treatment, and ongoing treatment for co-occurring medical and psychiatric problems.

k. Proper documentation

3.5 Long Term Residential Treatment

a) Residential treatment for drug use disorders exists in a variety of forms, having developed independently in a variety of settings.
b) Long–term residential treatment can take place in a hospital environment, typically a psychiatric hospital, or other accredited SUD's rehabilitation facilities
c) Other models of long-term residential treatment have been developed to deal more specifically with co-occurring mental health disorders, and have characteristics of psychiatric and medical clinics with integrated psychotherapy, family therapy and pharmacological interventions.

d) Residential treatment which intends to promote therapeutic change must be distinguished from supported accommodation that primarily functions as a housing intervention that is not providing active treatment.

e) Staying long-term in a residential setting allows patients to be removed from the chaotic and stressful environment that might have contributed to their drug use. In a therapeutic environment that is free of drugs and alcohol, patients are no longer exposed to the usual cues that trigger drug seeking behavior and may find it easier to maintain abstinence and work towards recovery.

3.5.1 Target population

Patients who are unlikely to maintain abstinence outside of a structured environment to improve their life quality, or to participate in health and social integration. Long-term residential programmes 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 drug use disorders, and initiating changes in multiple life domains to facilitate transition to the process of recovery.

Residential treatment services are typically indicated for individuals:

a. experiencing severe drug-related problems that affect their education, employment and social integration process
b. with a history of unsuccessful treatment, who do not respond to pharmacological and psychosocial treatment in outpatient or short-term in-patient facilities
c. affected by severe co-occurring mental health disorders that affect their health and security outside of structured environments (who usually require hospitalization)
d. with limited personal resources
e. with social and family problems and limited social supports
f. who are socially isolated or marginalized or with difficulties in interrupting their affiliation to criminal groups and drug dealing networks
g. who recognize the need and are prepared to significantly change life-style and acquire new skills.

3.5.2 Goals

The primary goals of long-term residential treatment for patients are:

a. to reduce the risk of a return to active drug use
b. to treat psychiatric and substance/ drug use disorders using medication and

psychosocial therapy
c. to develop skills to cope with cravings and life stressors without drugs
d. to improve personal health and the family and work environment and social functioning
e. to develop effective interpersonal relationships with other patients and staff while acquiring new social skills, gaining self-confidence and receiving appreciation for positive behaviors
f. to develop interpersonal and communication skills to build a network of friends who are abstinent
g. to acquire a healthier lifestyle e.g. good nutrition, a stable sleep/wake routine, routine health monitoring and adherence to treatment
h. to complete their education and develop vocational skills to progressively become able to regain control over their life once they return to the general community

3.5.3 Treatment approaches
Long-term treatment programmes may differ in their applied approaches. Treatment may begin with a detoxification period, or this may occur prior to admission. Interventions offered vary significantly and can be based on the 12-step facilitation, Therapeutic Community, Minnesota, recovery coaching, structured psychosocial approaches such as Cognitive Behavioral Therapy, Motivation Interviewing or eclectic model.

3.5.4 Length of Treatment
A sufficient duration and intensity of treatment increases the chance that any behavioral change will be consolidated and internalized, and that clients will be sufficiently prepared to live a drug-free life in their communities. The duration of treatment necessary to reach this point varies for each client, however residents who stay at least 3 months in treatment usually have better outcomes.

3.5.5 Specific programme requirements
Programmes offering long-term residential treatment for people with drug use disorders should include the following components:
a. Comprehensive medical and psychosocial assessment on admission
b. Treatment plan which best addresses individual needs, and is revised appropriately as treatment progresses
c. Programme rules that cover clear procedures for admission, discharge and consequences for negative behavior
d. Treatment contract which clearly outlines all treatment procedures, services and other policies and regulations as well as programme's expectations of the patient
e. Ongoing evaluation of patient's progress in treatment, and continuous clinical assessment that is built into the programme
f. Relapse prevention and discharge strategies for continuous care after residential treatment
g. A clear structure of activities and responsibilities

3.7 Discharge, Aftercare, and Referral

a) Discharge planning is essential for a client preparing for life after leaving outpatient rehabilitation. The discharge shall aim at relapse prevention, self-monitoring, and emotional regulation in order to live a healthy and independent life in recovery.

b) Involuntary discharge of the client from treatment is justified to ensure the safety of staff and other patients, but noncompliance with the programme rules alone should not

generally be a reason for involuntary discharge of the client. Before involuntary discharge of the client, reasonable measures to improve the situation should have been taken, including re-evaluation of the treatment approach used.

c) There are defined criteria for the management of specific risk situations (e.g., intoxication, suicide risk).

d) Care plans are explored which map out alternative pathways which might be followed in the event of partial or complete failure of the original plan, or premature termination from drug treatment services.

4. 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 recovery environment.

b) The physical environment of the program where residents stay for the duration of treatment is important, it should be a controlled environment that meets the treatment needs, ensures their safety and respects the human rights of the clients. 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 and provided within the existing legislation that govern the prescription and dispensing of these medication.

4.1 Space and structural Layout

Diagram- for placement of rooms

4.1.2 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

4.1.3 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

4.1.3.1 Equipment

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

4.1.3.2 Human resource

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

4.2 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.

4.3 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.

4.4 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.

4.5 Compound

The outdoor play area shall be determined by the public health act and the physical planning act.

4.5.1 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.

4.6 Waste Disposal
The facilities that offer residential treatment shall ensure compliance with public health on waste disposal.

4.4 Recreation area
There shall be provision of a safe recreational area that is sufficiently equipped and ensure accessibility of all persons.
a)

4.7 Medical and pharmaceutical commodities
Prescription

a. To help treat certain types of addiction, a person may be prescribed treatment drugs that diminish cravings and withdrawal, counter the intoxicating effects of a drug. A client may also be on medication that address any co-occurring medical or mental health conditions. These medications shall be prescribed by a registered clinician as per the existing laws.
b. Certain basic medical procedures such as monitoring of vital signs like blood pressure, temperature, pulse shall be necessary during inpatient stay in treatment facility. The facility shall ensure that where needed the equipment's are available in the facility, in good functioning state and used by a trained medical personnel.
c. Often clients will require basic laboratory tests such as drug screening, HIV test, Hepatitis test etc to monitor their health and treatment progress. These tests should be conducted by a trained and certified medical staff or at a facility registered to conduct such test and within the availed regulation
d. A first aid kit shall be available in the facility for purposes of handling emergencies

Storage

a. Storage areas should be designed or adapted to
b. should be in accordance with PPB)
c. and where special storage conditions are required on the medicine label (e.g. temperature,), these shall be provided and monitored.

d. Materials and pharmaceutical products shall be stored off the floor and suitably spaced.
e. Psychoactive medications as well as substances presenting special risks of abuse and other hazardous, sensitive and/or dangerous materials shall be stored in a dedicated area that is subject to appropriate additional safety and security measures. Precautions must be taken to prevent unauthorized persons from entering storage areas. (should be in accordance with PPB)

f. Narcotic drugs shall be stored in compliance with international conventions, and national laws and regulations on narcotics.

g. Medical materials and pharmaceutical products shall be handled and stored in such a manner as to prevent contamination, mix-ups and cross-contamination with proper labeling.

Disposal

a. Disposal of any contaminated and non-contaminated medical equipment and material, expired pharmaceutical products shall be done in compliance with the regulations provided in the public health act.

5. 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)

6 Food operations

All outpatient treatment facilities shall serve at least three nutritionally balanced meals per day. In particular, organizations providing 24-hour care that have therapeutic goals relating to nutritional needs and who have services for individuals who require special nutrition considerations should develop written policies and procedures to address all aspects of nutrition and food services.All nutrition and food service providers on site shall be expected to observe applicable statutory regulations concerning hygiene and sanitation. In addition, facilities shall be required to have a written statement of policy for their food services including;

a) food purchasing, storage and handling
b) adequate spacing, equipment and supplies
c) Maintenance of food services in a hygienic and sanitary manner.

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

9.6.6 Space: The treatment centre must provide adequate and appropriate space for treatment activities, relaxation, solitude, recreation and exercise.

7 Provision of recreational services

Every treatment facility shall provide a planned, diversified program of recreational activities that allow clients to participate in individual or group basis.

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

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

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