Provincial Addictions Treatment Standards

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Introduction

The Service System in Newfoundland and Labrador

The province of Newfoundland and Labrador (NL) provides a continuum of services and supports for individuals and families with addictions concerns throughout four regional health authorities (RHAs). This continuum includes community services such as: health promotion and prevention, youth outreach, community-based counselling, and day treatment for youth (Eastern RHA only). The continuum also includes withdrawal management services and a residential treatment program for adults (Western RHA). This continuum continues to grow with the opening of two new provincial residential treatment centres for youth in 2014. One centre for youth with complex mental health needs (which may also include addictions concerns) is located in Paradise. The other is for youth with addictions concerns, located in Grand Falls-Windsor. Planning and development are also underway for another provincial adult residential treatment centre in Harbour Grace. Information about services can be found on the Department of Health and Community Services website.

Over the past decade the system of services and supports for addictions and mental health in Newfoundland and Labrador has become increasingly "integrated". What once were historically two independent program areas have become integrated under a common provincial leadership and structure. This leadership structure is mirrored in each of the four RHAs. While it continues to evolve this broad "system level integration" has also resulted in increased service level integration in many locations characterized by such elements as: colocation of services, common referral and intake processes, shared staff, common clinical information systems, and increased opportunities for collaboration and shared care. It is expected that integration of mental health and addictions services will continue to evolve to include increased integration with primary care and other sectors.

The National Treatment Strategy and a Tiered Model of Services and Supports

Both the development of this document and enhancements to our continuum of care have been informed by the *Recommendations for a National Treatment Strategy* (National Treatment Standards Working Group, 2008). The National Treatment Strategy provides recommendations for improving quality, accessibility and range of services, and supports to address risks and harms associated with substance abuse. One key recommendation from the National Treatment Strategy Working Group (2008) is the building of capacity across a continuum of services and supports by using a "tiered model" corresponding to the acuity, chronicity and complexity of the harms associated with substance abuse. The model arranges services and supports in a pyramid fashion with the largest clustering at the bottom (primary care, health promotion) and the smallest at the peak (specialized addictions programs). A key underlying principle of this model is that all levels of services/supports are person-centred and are calibrated to the level of intensity and specialization needed to address the severity of the presenting problem.

In Newfoundland and Labrador we continue to strive to conceptualize and align our system of services and supports with the concepts and components of the recommended "tiered model". In doing so it is recognized that in some aspects of the model there are gaps, such as the building of capacity for screening and brief interventions in primary care settings and other self-management resources found in tier two. Strengths are also highlighted such as the integration of mental health and addictions services in the province and how this has facilitated increased access, choice, collaboration, coordination, and communication.

The use of the tiered model is not fixed and various jurisdictions have adapted the original model presented in the *Recommendations for a National Treatment Strategy* (National Treatment Standards Working Group, 2008). For the purposes of depicting the tiered model in this document we have chosen the Centre for Addiction and Mental Health (CAMH) modified model (Rush, 2010; Rush & Nadeau, 2011).

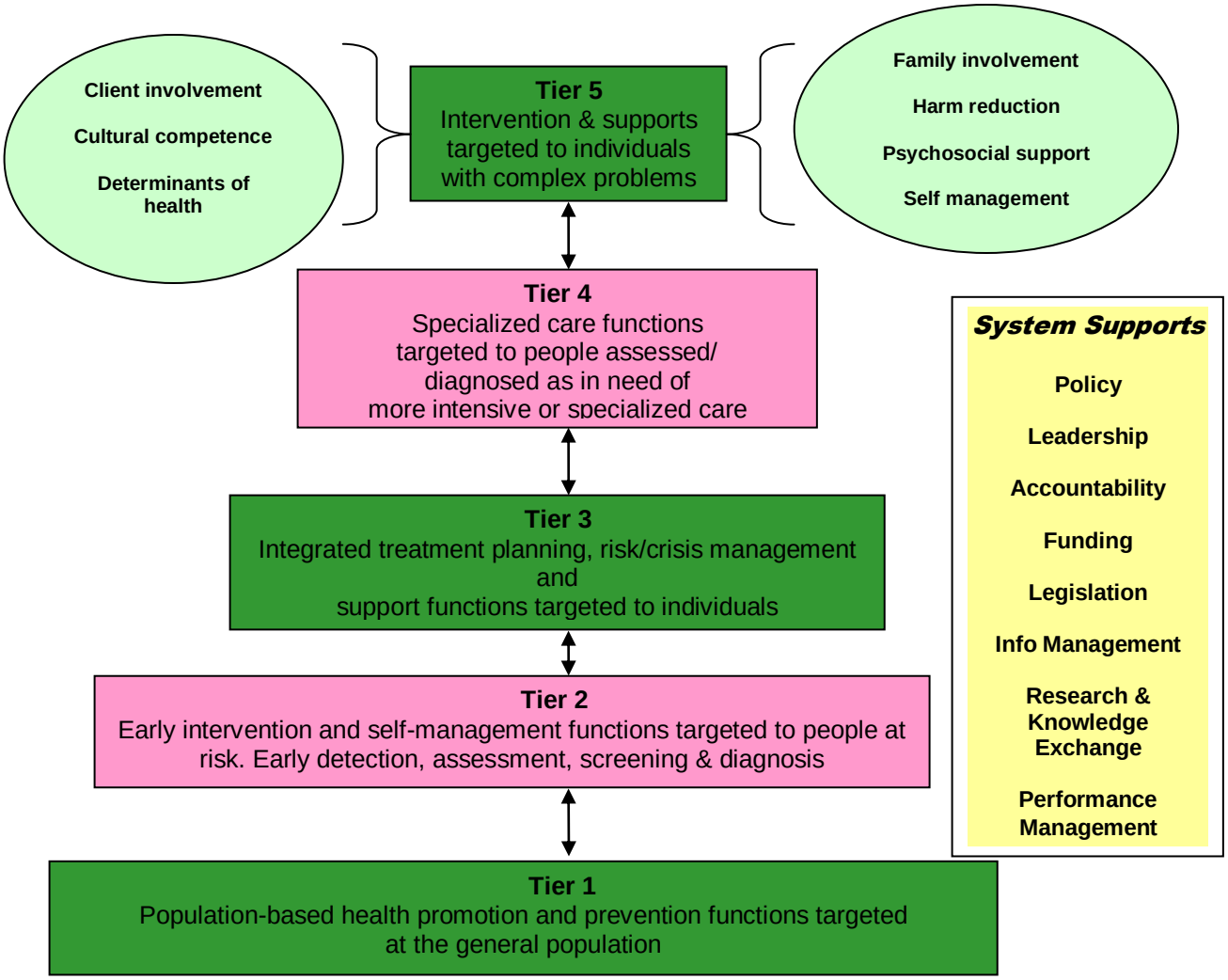

Figure 1: A 5-Tiered model of or organizing a system of services and supports (Rush, 2010; Rush & Nadeau, 2011).

The National Treatment Strategy Working Group (2008) identified the following eight guiding concepts of the tiered model which are applicable to the system in this province:

1. ***No wrong door*** – Individuals seeking treatment can access the full continuum by entry at any level and be linked to services and support that fit his or her needs.

2. ***Availability and Accessibility*** – Services and supports are available and accessible within a reasonable distance and travel time. Taking advantage of available services the moment people are ready for treatment is critical. Potential clients can be lost if treatment is not immediately available or accessible. The earlier treatment is offered, the greater the likelihood of positive outcomes.

3. ***Matching*** – No single treatment is appropriate for everyone. Matching treatment settings, interventions, and services to an individual's problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

4. ***Choice and Eligibility*** – Individuals may select among options should there be more than one available that meets his or her needs.

5. ***Flexibility and Responsiveness*** – Individuals should be moved upward and downward through tiers as needed.

6. ***Responsiveness*** - Effective treatment should ultimately help individuals to move to lower tiers as their needs change.

7. ***Collaboration*** – There should be collaboration between all levels of services to ensure quality treatment and facilitate the different tiers.

8. ***Coordination*** – There should be easy sharing of information between systems.

Standards Development

Background & Process

The development of this *Addictions Treatment Standards* document was made possible through funding provided by Health Canada's Drug Treatment Funding Program (DTFP) – Strengthening Treatment Systems component. In 2008 a three – pronged proposal was submitted to Health Canada and funding was successfully obtained targeting the following three investment areas:

1. Evidence-Informed Practice
2. Evaluation and Performance Measurement
3. Linkage and Exchange

An Addictions Treatment Consultant funded through the DTFP, based at the Department of Health and Community Services, provided overall leadership to investment areas 1 and 3 of this project. The development and implementation of this core set of provincial addictions treatment standards was the key foundational part of evidence-informed practice. Investment area 1 also included subsequent development of two sets of best practice clinical guidelines: one for withdrawal management and the other for concurrent disorders (mental health and substance abuse). The provincial based Addictions Treatment Consultant collaborated on the standards development with a provincial working group made up of knowledge exchange facilitators, clinicians, and managers from the RHAs. Through a process of reviewing relevant literature, discussion, consensus building, ongoing feedback, input, and revisions a draft set of standards was developed. Editing was provided by the provincial Division of Mental Health and Addictions and the RHAs were given an opportunity to review and provide comments on the final version of the standards.

Investment area 2 of the DTFP proposal focused on evaluation and performance measurement. An Addictions Application Specialist was hired to lead this project which included two key areas:

- Enhancing the capability and maximizing the usefulness of the provincial Client Referral Management System (CRMS) data base for evidence-based decision-making within addiction services.
- Developing and implementing a provincial outcome monitoring system (OMS) – which is reflected in the content of standard seventeen of this document.

Implementation of investment areas 1 and 2 was supported by investment area 3, Linkage and Exchange, which saw the hiring of four Knowledge Exchange Facilitators; one based in each RHA.

Scope and Target Audience

This core addictions treatment standards document is meant to be a foundation of provincial treatment standards which can be updated over time. The standards have been developed primarily for RHA based services that provide health promotion and prevention programs and care and treatment programs for addictions concerns. The standards are general in nature and

are intended to be applicable across program areas. In the future - additional program specific standards may be developed building on this foundation.

The standards are targeted to the front line staff and clinical managers working in these programs, however given the nature of system and service integration in this province they are also targeted towards mental health staff and managers. Our provincial reality is that in many cases these are the same staff. All standards may not necessarily be applicable to all staff as certain topics may not be within the function, job description or scope of practice of all positions. We use the term ***staff*** throughout this document to be inclusive of the various mental health and addictions positions. A determination will need to be made, in consultation with clinical managers, if a particular standard is not to be considered relevant.

The standards are inclusive of the fact that problematic substance abuse occurs along a spectrum of no use to dependence. We have used the broad term ***addictions concerns*** throughout this document so as to be inclusive of this spectrum of substance abuse patterns, concurrent disorders, as well as gambling addictions.

The standards are broadly applicable and relevant to both programs that provide services to clients with addictions related concerns only or to those who have concurrent disorders. In reality most of these standards represent the expected professional and clinical practices that are also applicable to services which are mental health specific.

Purpose

The main purposes of these standards are to:

1. To standardize and improve clinical practice

2. To enhance the quality of care available to clients

3. To improve provider and client outcomes

These standards align with the key strategic issues and matching outcomes identified in the Department of Health and Community Services Strategic Plan for 2014-17 (Government of Newfoundland and Labrador, 2014):

1. Population Health: Strengthened population health and healthy living.

2. Access: Improved accessibility to programs and services meeting the current and future needs of individuals, families and communities, particularly those most vulnerable.

3. An Accountable, Sustainable, Quality Health and Community Services System: Improved performance and efficiency in the health and community services system to provide quality services that are affordable and sustainable.

The standards are also reflective of the key policy directions included in our provincial policy framework for mental health and addictions services (Government of Newfoundland and Labrador, 2005):

1. Prevention and early intervention
2. Consumers and significant others
3. Bridges for better access
4. Quality mental health and addictions services
5. Demonstrating accountability and measuring progress

Important Notes:

1. **Each set of standards statements represents activities, practices, and services that in most cases staff and RHAs are already meeting or that can be implemented without additional resources.**

2. **These standards are not meant to replace RHA operational policies which may support the implementation of these standards. However, RHAs should examine current policies to ensure they can support the provision of services as outlined in the standards. Routine practice of policy review is imperative to ensure the RHA's policies are current, as the evidence-base and practice resources evolve.**

3. **These standards require competent and knowledgeable professional staff to uphold them. It is the responsibility of RHA's to ensure they are hiring, recruiting, and retaining competent professional staff. Supporting staff in orientation, training, and clinical supervision are important practices to support the standards.**

4. **It is the expectation that these standards are implemented under the direction of provincial legislation governing the delivery of health and community services in Newfoundland and Labrador.**

The Standards

Construction of Standards Sections and Statements

It is important to differentiate between Standards and Guidelines. **Standards** define a minimum expectation of professional and ethical behavior. A standard reflects a required course of action.

Guidelines are sets of best practices developed through systematic review of available evidence on a topic (National Research Council, 2011). A practitioner may use guidelines to select options or guide a course of action. Standards outline minimum requirements whereas guidelines provide recommendations.

The standards in this document are organized into broad categories. Within each category there is:

1. **A brief description or preamble**: This information is not intended to be comprehensive but rather to provide sufficient information to orient the reader to the standards - especially newcomers to the field. ***It is the expectation that staff and managers will seek out additional literature and resources pertaining to meeting a particular standard area when and where necessary.**

2. **Objective(s)**: Brief statements which outline the intended outcome/s of a particular category of standards.

3. **Standards**: The required elements within the broad standard category. These statements in most cases include the term "**shall"** to express a requirement, i.e., an action that the staff or RHA needs to perform in order to satisfy the standard; occasionally the term **"should"** may be used to express a recommendation that is advised but not required and **"may"** is used to express an option permissible within the standard. Most of the standards include "**shall"**.

Standard 1: Professional and Ethical Practice

Professional practice or professionalism is the ability of a health care professional to acquire and exude knowledge and skills in a chosen field. Knowledge and skills in professional practice are reinforced by other attributes including: accountability, workplace etiquette, communication, performance excellence, leadership, and respect. Astute professional practice or professionalism helps determine the behaviours that are generally acceptable across disciplines. It also helps integrate and standardize new guidelines and norms into a specific field. The value of professional and ethical practice in the field of addictions is significant. It is critical for staff to maintain an adequate level of professionalism in their practice if they are to succeed in the delivery of safe, quality, and competent care for their patients.

Objectives

1. To ensure astute, accountable, and prudent professional and ethical practice from mental health and addictions staff.
2. To ensure that clients receive safe, high quality, and effective addictions treatment services.

Standards

1.1 All staff working with clients that have addictions concerns in the province of Newfoundland and Labrador **shall** adhere to the following overarching standards of professional and ethical practice:
   a. Maintain an active license or registration to practice where applicable.
   b. Adhere to the professional code of conduct, standards of practice and/or their code of ethics as outlined by their professional governing bodies/associations (i.e. ARNNL, NLASW, etc).
   c. Follow the continuing educational requirements of the licensing body to ensure competence and to promote excellence in their profession and field of practice.
   d. In the absence of a professional governing body, follow their position description as outlined by their RHA as well as the organization's mandate, vision, and values.
   e. Practice within the competencies outlined by the Canadian Centre on Substance Abuse (CCSA).
   f. Uphold the beliefs, ethics, morals, and values of one's profession and/or organization.

1.2 Staff **shall** participate in regular performance appraisals, as outlined in RHA policy.

1.3 Staff **shall** practice in a clinically-efficient manner, as outlined by the RHA.

Standard 2: Cultural Competency

Cultural competency is the understanding of the interaction between culture and health behaviour and the skills to tailor interventions to reflect client's culture, needs, and preferences (Whaley & Davis, 2007). It may involve valuing differences, being open to different world views than one's own, correcting one's own false beliefs, assumptions, and stereotypes, and adapting skills and interventions accordingly (Harrison & Turner, 2011; Kohn-Wood & Hooper, 2014; Saha, Beach, & Cooper, 2008). If individuals experiencing addictions are to receive optimal, fair, and just treatment, staff need to demonstrate a sound understanding of cultural competence.

Objectives

1. To ensure that the care provided to those with addictions concerns is respectful, non-judgmental, and culturally sensitive.
2. To ensure that staff working with clients with addictions concerns practice cultural competency and demonstrate the ability to interact comfortably, and communicate effectively with people from a wide range of ethnic/cultural and linguistic backgrounds (Saha et al., 2008).

Standards

2.1 Staff working with clients who have addictions concerns **shall** understand and apply the following core concepts of cultural competence (Saha et al., 2008):

- a. Practice self-awareness of one's own cultural worldview, values, and attitude.
- b. Acquire knowledge of different cultural practices and worldviews.
- c. Display appropriate attitude and respect towards cultural differences.
- d. Recognize racism and the institutions or behaviours that contribute to racism.
- e. Engage in activities that help reframe one's thinking, allowing him/her to hear and understand others' experiences and perspectives.
- f. Be familiar with core cultural elements of the communities served, including: physical and biological variations, concepts of time, space and physical contact, styles and patterns of communication, physical and social expectations, social structures, and gender roles.
- g. Engage clients to share how their reality is similar to, or different from, what they have learned about their core cultural elements. Unique experiences and histories will result in differences in behaviours, values, and needs.
- h. Know how different cultures define, name and understand disease and treatment. Engage clients to share how they define, name, and understand their ailments.
- i. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
- j. When and where necessary, mental health and addictions publications should be made available in a population's most common and appropriate languages.
- k. Create a welcoming environment that reflects the diverse communities served.
- l. Use language translators and make other adaptations if and when the need arises.

Standard 3: Stigma and Discrimination

Stigma and discrimination can prevent clients from seeking help and treatment when they need it most. While progress is being made with respect to addressing the stigma and discrimination of mental illnesses in general; it is still a significant issue in society today, so much so that it can impact detrimentally on one's health and well-being. Education and awareness are key components of demystifying stigma and discrimination around mental illness and addictions (CAMH, 2012a).

Objectives

1. To help remove and eradicate stigma and discrimination against those living with mental health and addictions concerns.
2. To ensure that those living with mental health and addictions concerns receive respectful and non-judgmental care.

Standards

3.1 Staff working with clients with addictions and mental health concerns **shall** do the following in regards to issues of stigma and discrimination:

a. Encourage clients to seek help for their concern and support them in such a manner that they believe they are both worthy of treatment and that recovery is possible.
b. Treat clients with respect, courtesy, and dignity and ensure their human rights are upheld, promoted, supported, and advocated for.
c. Be self aware of stigma-prone behaviors and aware of the impact stigma and discrimination have on the lives of clients.
d. Remain cognizant of how they interact with others. Accurate, appropriate, and sensitive language **shall** be used when talking about people with mental health and substance use issues. For example, speak about "a person with an addiction" rather than "an addict" or about "a person with schizophrenia" instead of "a schizophrenic".
e. Take opportunities to educate others about addictions concerns, challenge behaviors that relate to stigma and discrimination and role model appropriate attitudes and behavior.
f. Advocate for other services and supports as required for clients - especially when issues of stigma and discrimination are identified as potential barriers to the receipt of such services or supports.

Standard 4: Client-Centred Care

Client-centred care represents "an active partnership between the person receiving care and providers of care" (CAMH, 2012b). A model focused on providing client-centred care takes a holistic approach to care, considering the needs of the client across several domains including the social, physical, psychological, and spiritual needs. Care is provided such that the client is actively engaged in their care and in informed decision making (CAMH, 2012b).

Objective

1. To ensure that the client is the most important focus during the provision of care and treatment to clients with addictions concerns.

Standards

4.1 Staff working with clients who have addictions and mental health concerns **shall** abide by the following key principles underlying client-centred care:

a. Understand and respect the client's goals and support the client in achieving them.
b. Facilitate an environment that promotes healing and recovery.
c. Develop partnerships with other service providers to ensure that care is comprehensive, coordinated, and delivered in the appropriate environment.
d. Integrate the client's preferences, needs, cultural beliefs, and practices into the provision of care.
e. Incorporate involvement of significant others at the client's request into the client's care plan.

Standard 5: Involvement of Family, Caregivers, and Friends

Family-centred care is an evidence-based practice which recognizes the contribution of families in the care of people with mental illness and substance use problems (National Institute on Drug Abuse [NIDA], 2009) and in the promotion of their recovery and well-being. Families and friends can play a critical role in motivating individuals with substance use problems to enter and stay in treatment, while also extending and strengthening the benefits of treatment programs (Government of Saskatchewan, 2012; NIDA, 2009; Williams, 2007).

Objective

1. To ensure that the involvement of families and/or providing family-centred care is an integral component of the way care is provided to individuals experiencing addictions concerns.

Standards

5.1 Staff **shall** involve families and/or caregivers with the client's consent in all phases of treatment where and when deemed clinically appropriate.

5.2 Staff working with clients who have addictions and mental health concerns **shall** follow these key principles of creating a positive family-provider relationship (CAMH, 2009):

a. Provide support and respect for families.
b. Listen to families' concerns and involve them with the client in the planning and delivery of treatment wherever possible.
c. Acknowledge, value, and respect family members' expertise.
d. Explore family members' expectations of the treatment program and expectations for the client.
e. Offer a variety of evidence-based interventions for families. This may include professional and peer support and education about addictions concerns.
f. Assess the family's ability (strengths and limitations) to support the client.

Standard 6: Promotion, Prevention, and Early Intervention

The social determinants of health, or the conditions in which people are born, grow, live, work, and age (World Health Organization, 2014), are critical in the promotion, prevention, and early intervention of individuals with mental health and/or addictions concerns.

These determinants help to identify for individuals what makes them healthy or not healthy. As is evident from the list provided, and given that physical and mental health share a reciprocal relationship, each determinant has the potential to impact risk for the development of mental health and/or addictions issues (Public Health Agency of Canada, 2011):

a. Income and social status
b. Social support networks
c. Education and literacy
d. Employment/Working conditions
e. Social environment
f. Physical environment
g. Personal health care practices and coping skills
h. Healthy child development
i. Biology and genetic endowment
j. Health services
k. Gender
l. Culture

Objective

1. To foster mental wellness through the promotion of positive mental health and the prevention of mental illness and addictions.

Standards

Public Policy

6.1 Staff **should** support program and policy development, which foster, protect, and promote positive mental health.

6.2 Staff **should** support the development of healthy public policy through an intersectoral approach.

6.3 Staff **should** respond in a timely manner to emerging mental health and addictions issues on provincial and local levels with accurate, current, and valid information.

6.4 Staff **should** facilitate the development of policies that enable individuals, communities and organizations to act on reducing the harms associated with substance use and gambling.

Create Supportive Environments

6.5 Staff **should** connect with community stakeholders to provide education and increased awareness of recognizing signs and symptoms of potential mental health issues and/or addictions concerns.

6.6 Staff **should** engage clients in early intervention strategies that promote early access to required services and encourage screening of various mental health and addictions concerns.

Strengthen Community Action

6.7 Staff **should** assist schools, workplaces, organizations, municipalities, and community groups in the development and delivery of prevention activities and programs.

6.8 Staff **should** support and endorse community action initiatives that set priorities and make decisions on issues that affect mental health and reduce the harms associated with substance abuse and problem gambling.

Develop Personal Skills

6.9 Staff **should** provide services that promote positive mental health such as:

a. Skill building sessions to support problem solving and emotional regulation.
b. Early childhood programs that foster social and emotional learning.
c. Programs or groups to support or enhance social connections.
d. Programs to support work-life balance.
e. Programs to support anti-violence initiatives.
f. Programs to support anti-stigma initiatives.
g. Programs to support access to economic resources.

6.10 Staff **should** educate people about addictions, mental illness, and mental well-being, and encourage lifestyle choices that lead to positive mental health.

Re-Orient Health Services

6.11 Staff **should** support the reorientation of health care services to promote a larger focus on health promotion beyond clinical practice and rehabilitation.

6.12 Staff **should** support a system transformation toward a recovery focus.

Standard 7: Outreach

Outreach is a critical component to the continuum of care in addictions services. It serves to engage individuals in their communities who may have addictions concerns and who may not know where to find help. Outreach assists with prevention and early intervention efforts, helping individuals identify options for treatment and support. It is facilitated through a multidisciplinary approach that focuses on building partnerships, educating the community, increasing awareness, and early identification (CCSA, 2010).

Outreach can help improve opportunities for engagement and access to care for both "at risk" and "difficult to reach" populations. "At risk" populations may include but are not necessarily limited to youth, those living with concurrent disorders, and individuals who are homeless. "Difficult to reach clients" may include but are not necessarily limited to those who find it challenging to access traditional office based services such as those who may be geographically isolated, have transportation issues, seniors, and caregivers.

Outreach can occur in community settings, in homes, and via electronic means.

Objective

1. To improve access for "at risk and difficult to reach" populations by ensuring that outreach is an integral component of the continuum of addictions services available in NL.

Standards

7.1 Staff **should** have the flexibility and support to complete home visits and other forms of outreach when and where required provided the resources and services such as case managers, ACT teams, counselors and community services are available.

7.2 Staff **shall** use clinical judgment in determining the appropriateness of outreach and seek supervision when necessary.

7.3 Staff **should** avail of the provincial tele-health system and other forms of telecommunication equipment to increase accessibility of services to clients with geographical and transportation related barriers.

7.4 Staff **shall** adhere to the Personal Health Information Act (2013) when using various forms of communication to interact with clients.

Standard 8: Harm Reduction Approach to Care

Harm reduction focuses on reducing or minimizing the harm associated with high risk behaviours, both for the people involved in the risky behaviour and the families, friends, and communities around them. A harm reduction approach recognizes that some people may:

a. Not be ready to change their substance use.
b. Not have a goal of abstinence.
c. Be willing to stop using one substance, but not another.
d. Be open to learning how to decrease harms of their substance use.
e. Be more likely to seek and comply with treatment if it does not require abstinence.

Some examples of harm reduction strategies to help clients achieve either abstinence and/or decreased substance use include:

a. Helping clients learn safer ways to use substances.
b. Helping clients learn how to recognize the signs of an overdose.
c. Needle exchange programs.
d. Public smoking restrictions.
e. Education and outreach programs.
f. Condom distribution programs.
g. Designated driver programs.
h. Helping to ensure clients' basic needs such as food, shelter, and medical care are met.
i. Substituting a safer drug for the one a person is using.
j. Low risk drinking guidelines.

Objective

1. To decrease the risk of harms and improve clinical outcomes for clients with addictions concerns, their families, and communities through use of a harm reduction approach.

Standards

8.1 Staff **shall** utilize a harm reduction approach, when indicated and appropriate, for providing care and treatment to individuals with addictions concerns.

8.2 Staff **shall** reach out to clients who may not be ready, willing or able to give up all substances and engage them using a harm reduction approach.

8.3 Staff **shall** integrate the use of harm reduction approaches within the context of their assessment of a clients' stage of change and process of motivational interviewing - recognizing that small improvements can help motivate clients toward making other decisions that can lead to improved outcomes.

Standard 9: Documentation

Documentation is a critical mainstay of clinical practice and reflects not only the client's progress through an illness or concern, but also reflects legal fulfillments that care was provided. Client record documentation facilitates collaborative care and ensures accountability.

Progress notes are one of the key formats used in documentation. Progress notes are the ongoing process of the client assessment and reflect the record of treatment provided. It includes recording data, issues addressed, treatment received, on-going assessment, treatment plan, and goals of treatment. It may also take the form of initial and/or closure notes.

Objectives

1. To help ensure the standardized, timely, accurate, and thorough documentation of client care and treatment progress.
2. To help ensure client health, safety, and quality of care.
3. To ensure that data collected during service delivery is kept in accordance with RHA polices surrounding file retention, privacy, and consent.

Standards

9.1 Staff **shall** follow their respective professional associations and/or health authorities/agencies' policies/protocol around clinical documentation guidelines.

9.2 Staff **shall** ensure all relevant client information and demographics are completed and recorded in accordance with RHA policy.

9.3 Documentation **shall** represent the assessment process and must reflect the record of treatment provided to any client in the form of:

- recording data
- ongoing assessment
- the treatment plan and goals of treatment
- issues addressed during contact
- the treatment received
- notes monitoring treatment goals and progress
- closure note

9.4 As proof of being completed, any intervention, consultation, collateral contact, telephone call, electronic contact, or treatment **shall** be documented in the progress notes.

9.5 Documentation for the client **shall** remain confidential, private, and only accessed and viewed if needed for reasons pertaining only to the professional care team in deciding the best course of action and/or treatment for the client. The Personal Health Information Act (2013) is expected to be followed and enforced.

9.6 All documentation **shall** automatically become part of the client chart/file and **shall** be subject to provincial standards for storage and retention and annual chart audits.

9.7 Staff **shall** ensure that screening and assessment data are attached to client files in accordance with RHA policy for storage and retention and within the required time period.

9.8 Progress notes and other forms of documentation **shall** be used to assist with the implementation of treatment recommendations.

9.9 Random chart audits **shall** be conducted in accordance with health authority policies to ensure adequate compliance. Substandard reporting **shall** be addressed on an as needed basis according to the professional's governing standards of practice and the organization's disciplinary policies and procedures.

Standard 10A: Referral and Intake

A *referral* is a process whereby a potential client requests services or is recommended for or mandated to an addictions treatment program. Referrals may take the form of a self-referral, a referral from another mental health and addictions program, or from an external source.

The *intake* process involves information exchange, triage, and engagement initiated upon formal contact with the client that helps to determine the client's immediate needs, appropriateness, and type of service/s required. The purpose of intake is to identify whether an individual does indeed have a substance use concern and to determine suitability of match with the admission criteria.

Objectives

1. To ensure timely and responsive action on referrals for service.
2. To ensure the care provided during the referral and intake stages are thorough, complete, accurate, and evidence-informed.

Standards

10.1 Staff **shall** consider all referrals as potential clients pending the completion of the intake/assessment process.

10.2 Staff **shall** initiate the intake process in accordance with RHA policy.

10.3 Staff **shall** process all referrals and intakes in accordance with RHA policy.

10.4 Staff **shall** immediately review referrals, as per RHA policy.

10.5 Staff **shall** immediately contact clients identified as 'at risk', as per RHA policies/procedures.

10.6 Staff **shall** notify all referred clients regarding their referral status in a timely manner.

10.7 Staff **shall** attempt to obtain consent from the client, to inform the referral source of the outcome of the intake assessment.

10.8 Staff **shall** educate and engage clients in making informed decisions regarding treatment.

10.9 Staff **shall** ensure there is an appropriate orientation provided to the client. Orientation **shall** include the involvement of family members/significant others, when clinically appropriate. The orientation **shall** include (Addictions Ontario, 2008):

a. A review of regulations and limitations regarding confidentiality, privacy, and informed consent.
b. Information regarding their rights and opportunities to exercise personal choice.
c. Information regarding opportunities to participate in care and treatment, including case conferences that may impact their care.
d. An explanation of the process whereby issues or concerns related to the quality of care and treatment can be addressed, including formal complaints procedure.
e. An explanation of the clients' responsibilities while engaged in treatment.

10.10 Staff **shall** identify and refer to other appropriate services, programs, and agencies when necessary.

10.11 Staff **shall** determine the need for further assessment.

10.12 Staff **shall** establish a baseline of specific areas that can be used for outcome monitoring or to measure treatment progress and recovery.

10.13 When determining the immediacy of attention and treatment needed, mental health and addictions staff **shall** use priority ranking as per RHA policy.

10.14 Staff engaging in work with clients after their file has been closed **shall** determine whether an additional intake is required by following the relevant RHA policy.

Standard 10B: Screening

Screening is a component of the intake process. It serves to recognize addictions and/or mental health concerns, issues to address in treatment, or concerns that may require additional assessment, referral, or service (Gambi & Ayim, 2006; Negrete, 2005). Accurate and timely screening helps promote the client's quality of life and self-determination through facilitating access to appropriate treatment and supports (Gambi & Ayim, 2006).

Clinical decision making in the screening process is influenced by several factors, which may include the results of clinical observations, interviews, or screening tools (Negrete, 2005). Several tools are available to assist with screening; however, there is no single screening tool for addictions concerns that is appropriate for all clients (Gambi & Ayim, 2006). Therefore, optimal treatment outcomes are achieved when tools are used as a component of the clinical decision making process (Gambi & Ayim, 2006; Negrete, 2005).

Objectives

1. To ensure that the screening process enables early detection and intervention for both addictions and mental health concerns.
2. To ensure that screening is completed in a manner that is integrated, accurate, thorough, and evidence-informed.

Standards

10.1b Staff **shall** initiate the screening process after the individual seeks out or is referred to services, as per RHA policy.

10.2b Staff **shall** recognize that understanding risk factors in the context of addictions is important in assessment and early intervention (Negrete, 2005).

10.3b Staff **shall** use screening methods that are brief, valid, and reliable, with increased specificity and sensitivity.

10.4b Staff **shall** use evidence-informed tools as a component of the screening process, as supported by the RHA.

10.5b Staff **shall** screen for addictions and mental health concerns from an integrated approach (Rush, 2011).

10.6b Staff **shall** administer screening tools using techniques that help motivate and engage the client in the treatment plan (Rush, 2011).

10.7b Staff **shall** utilize evidence-based interviewing techniques while providing timely and appropriate feedback on the results of the screening process.

10.8b Staff **shall** seek consultation and clinical supervision if a mental health concern is identified and treatment for that concern is beyond their scope of practice.

Standard 11: Assessment

The assessment process begins at first contact and continues throughout the treatment process. The notion of assessment as an ongoing process is essential, as the information shared by the client may change as the therapeutic relationship develops and/or the client stabilizes. The process focuses on gathering information to determine the severity of the addictions concern and appropriate treatment plan. It involves a comprehensive overview of the clients' risk factors, protective factors, and treatment preferences. It may involve the completion of standardized tools, gathering collateral information, and obtaining the clients' perspective on the issue. When tools are used in the assessment, the results are combined with other information gathered during the assessment process to aid in clinical decision making. Assessing across a variety of domains and using methods that are appropriate for the client, may help counselors gain a better understanding of the client and more effectively engage them in treatment (Erford, 2013).

Objectives

1. To ensure an ethical and standardized approach to assessment.
2. To ensure the process of assessment is evidence-informed and conducted in a timely, integrated, and competent manner.

Standards

11.1 All clients **shall** have an assessment completed by an appropriate and competent staff person designated by the RHA, within the required time period as identified in each RHA policy.

11.2 Staff **shall** complete an integrated mental health and addictions assessment in a format that is in accordance with RHA policy.

11.3 Staff **shall** recognize that cognitive difficulties such as memory, concentration, and executive functioning must not exclude or jeopardize the degree of assessment and treatment that a client with an addictions concern receives.

11.4 Staff **shall** engage appropriate healthcare services if medical or physical illness are observed during the assessment process and the client wishes to seek treatment for their illness.

11.5 Staff **shall** assess motivation and stage of change with the understanding that they may fluctuate and vary over time.

11.6 Staff **shall** incorporate information from collateral sources, family members, and/or treatment history into the assessment process, while adhering to policies around client consent and privacy.

Standard 12: Treatment Process

The treatment process may involve enhancing protective factors, reducing risk factors, developing coping strategies, reducing harm, exploring relapse triggers, and increasing the clients' quality of life. With goals for treatment established with the client, the objective is to develop an appropriate plan to help the client effectively meet their goals. Monitoring the plan is imperative to support the client's treatment progress. The process of outcomes evaluation should be established with the client at treatment onset to help measure therapeutic progress (CCSA, 2010).

Objectives

1. To provide treatment for addictions concerns that is timely, specific, collaborative, and evidence-informed.
2. To foster optimal opportunities for recovery and improved quality of life.

Standards

12.1 Staff **shall** ensure that every client has an individualized treatment plan developed and on file that is tailored to their own specific needs and goals for recovery.

12.2 The treatment plan **shall** include the input and support of families and caregivers whenever appropriate.

12.3 Treatment goals **shall** be specific, measurable, and have an anticipated time frame for attainment.

12.4 Staff **shall** provide treatment that is collaborative with other resources within mental health and addictions services as well as other sectors (such as housing, employment, education, child protection services, and income support).

12.5 Staff **shall** use a case management approach for coordinating and monitoring the treatment plan, as well as connecting and supporting clients in linking with additional services.

12.6 When appropriate, staff **shall** provide information, education, and support to individuals such as the client's family members, caregivers, and friends who are affected by the client's addictions.

12.7 The decision to offer treatment support and intervention in either residential or non-residential settings **shall** consider such factors as: client preferences, needs, circumstances, prior treatment experiences, and the severity of problems.

12.8 The treatment process **should** involve some of the following therapeutic components:

a. Empowering clients to regain control of their lives by instilling a belief and hope that they have the ability and the strength to make changes and maintain a contented recovery and/or significant harm reduction.
b. Providing education, tools, and processes to express and explore the issues that are vital to their recovery.
c. Assisting the client to connect the impact of their personal life experiences on their physical, cognitive, emotional, and spiritual well-being.
d. Assisting clients to understand their individualized substance use behavior patterns by reviewing the various factors that are serving to maintain problematic substance abuse
e. Assisting clients to identify, develop, and enhance personal coping skills required to change problematic substance abuse behaviors.
f. Assisting clients to identify and make the necessary lifestyle changes for recovery including entry/re-entry into healthy social, community, self-help, employment, vocational, and personal networks.
g. Where possible and clinically appropriate, providing choice and opportunities (i.e. treatment groups) for clients to connect with others who have similar experiences, thoughts, and patterns of behaviors.

Standard 13: Evidence-Based Practice

Evidence-based practice is critical to the assessment and treatment of addictions concerns. There are several theoretical approaches used in practice, however, evidence-based approaches are those which include "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (American Psychological Association, 2006, p. 273). As the knowledge base grows for addictions treatment, evidence-based practice will evolve. It is imperative that those practicing in the field of addictions seek clinical supervision, consult academic literature, and engage in professional development to remain current and competent in the field.

Objectives

1. To provide effective evidence-based treatment for addictions concerns.
2. To ensure that the selection of the theoretical approach to treatment is based on the client's needs, preferences, and competency of staff.

Standards

13.1 Staff **shall** utilize evidence-based approaches that are consistent with their respective discipline's professional standards, scope of practice, education, level of competency, and the program philosophy.

13.2 Where clinically appropriate, staff **shall** use approaches which are least intrusive and most efficient.

13.3 Staff **shall** select the treatment approach in partnership with the client as part of the treatment planning process.

13.4 Staff **shall** clearly document the evidence-based approach to be used in the client's treatment plan.

13.5 Staff **shall** continuously monitor and evaluate the treatment approach and clinical outcomes, making adjustments to the approach as required.

13.6 Staff **shall** remain current with evidence-based practices by adhering to their respective disciplines' policies on continuing education, developing professional development goals, seeking clinical supervision, and seeking opportunities for learning.

Standard 14: Trauma-Informed Care

Many people who experience addictions concerns also have experienced trauma (Poole, 2012). The literature suggests there is a relationship between the experience of trauma and the development of addictions and outlines the importance of services to be trauma-informed (Hopper, Bassuk, & Olivet, 2010; Poole, 2012). The disclosure of trauma is not required to implement practices which are trauma-informed; rather the framework and principles of trauma-informed practice can benefit all clients who are engaged in services (Arthur et al., 2013; Poole, 2012).

There are key principles to implementing trauma-informed care, which include: increasing trauma awareness, emphasizing safety, supporting client choice and control, and focussing on resilience and recovery (Arthur et al., 2013; Poole, 2012; Hopper et al., 2010).

Objectives

1. To ensure that staff recognize the relationship between trauma and addictions concerns.
2. To ensure that staff are able to provide the appropriate intervention and support to clients who have experienced trauma.

Standards

14.1 Staff **shall** consider and support the physical and psychological safety of clients accessing services.

14.2 Staff **shall** consider the importance of their own self-care, psychological safety, and vicarious trauma in their work with clients.

14.3 Staff **shall** incorporate the following trauma-informed practices in the provision of services (Arthur et al., 2013; Poole, 2012):

a. Helping clients understand the connection between their experience of trauma and their current coping strategies, substance use, and mental health.
b. Establishing safety and trustworthiness by ensuring informed consent, providing clear information, engaging in crisis planning, and demonstrating consistency and transparency.
c. Ensuring clients have ability to identify treatment preferences.
d. Approaching work with clients collaboratively, addressing power imbalances, and promoting self-determination.
e. Developing new coping skills, focussing on resiliency, and building on strengths.
f. Promoting engagement during the screening and assessment processes by emphasizing the client's autonomy and choice.

14.4 Staff **shall** understand how diversity interacts to increase vulnerabilities related to trauma and work to deliver appropriate responses.

14.5 Staff **shall** carefully and professionally ask clients of addictions services about issues of trauma in the assessment process, as clinically appropriate.

14.6 Staff **shall** continually pay attention for indications of trauma as disclosure may occur once a client develops trust in the therapeutic relationship.

14.7 Staff **shall** explore available treatment options with clients who identify trauma and support the client's choice in the planning process.

14.8 If during the assessment or treatment process, it is determined that the complexity of issue requires a specialized trauma approach that is beyond the scope of practice and/or not within the competency of available staff, staff **shall** advocate for and refer to specialized trauma services.

Standard 15: Recovery, Relapse Prevention, and Aftercare

Recovery is a critical component of care for individuals who have addictions concerns. The Substance Abuse and Mental Health Administration (SAMSHA, 2011) defines recovery as "the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential". A client in recovery may still have symptoms and struggle with concerns relating to addictions beyond their discharge from service or treatment. Relapse of the addiction and/or mental health concerns can be a part of the recovery process.

Although goal setting in recovery is individualized, there are four domains that have been identified as important to recovery, which include: establishing or managing physical and mental health, accessing safe and stable housing, establishing positive social connections, and engaging in meaningful activities (SAMSHA, 2011).

Relapse prevention is important to the recovery process and a plan needs to be developed prior to the completion of treatment. During treatment, counselors assist clients to gain insight into their patterns of substance use, anticipate challenges they may face in recovery, and develop a plan to cope with these challenges. The goals of relapse prevention are (Hendershot, Witkiewitz, George, & Marlatt, 2010):

a. To increase awareness of negative thinking patterns and behaviours.
b. To develop coping skills, strengths, and supports.
c. To identify environments and social supports that promote a healthy lifestyle and recovery.

Aftercare is also a component of recovery and relapse prevention. The aftercare plan identifies and addresses the need for ongoing services and supports that some clients may require (Sheedy & Whitter, 2009). Clients who require further support may benefit from services such as transitional housing, support programs, vocational rehabilitation, etc. Recovery Monitoring Checkups can support aftercare of clients through contact at regular intervals post-treatment. Through Recovery Monitoring Checkups a return to treatment can be facilitated.

<u>Objectives</u>

1. To ensure that all clients being discharged from an addictions program have goals for recovery, a relapse prevention plan, and any aftercare needs addressed.
2. To promote and foster an optimal recovery for all clients receiving addictions services.

<u>Standards</u>

15.1 Staff **shall** help clients develop goals for their recovery, a personalized relapse prevention plan, and an aftercare plan.

15.2 Staff **shall** recognize that family members can play an important role in recovery and be encouraged to participate when it is considered beneficial for the client.

15.3 Staff **shall** advise clients of the availability and benefits of self-help to recovery.

15.4 Staff, or in some cases a third party provider, **should** administer Recovery Monitoring Checkups at regular intervals post-treatment to support treatment re-entry if required.

Standard 16: Discharge and File Closure

Discharge planning begins at the onset of treatment. Planning for the end of treatment helps instill hope and promotes recovery. It provides clear expectations for the client and provides information regarding options for aftercare. Discharge from services/programs and file closure occurs at the completion of treatment, or when a client voluntarily or involuntarily leaves treatment.

Objectives

1. To ensure the discharge of clients from an addictions program or service is open, transparent, and collaborative.
2. To ensure that the transition to discharge is planned to promote optimal client recovery.

Standards

16.1 Staff **shall** develop an overall discharge plan with the client prior to service completion.

16.2 Staff **shall** document the reason for discharge, discharge plan, goals for recovery, relapse prevention, and aftercare plans.

16.3 In the discharge plan for clients accessing inpatient services, staff **shall** include a referral to community based outpatient services and any other appropriate community resources.

16.4 Staff **shall** inform any client who is discharged early from addictions services the reasons for and the date of discharge.

16.5 Staff **shall** notify designated next of kin, contact person, or other appropriate person if the client's health and safety are suspected to be at risk at the time of discharge.

16.6 Staff **shall** inform the client of the process for reconnecting with addictions services/programs if required in the future.

Standard 17: Monitoring and Evaluation

Monitoring client progress and evaluating the treatment process is an integral part of competent and ethical clinical practice. Monitoring and evaluating clinical outcomes and programs are essential to inform quality improvement initiatives. These measures ensure accountable, sustainable, and efficient service delivery. High quality data from evaluation is required to make evidence-informed decisions, relevant to the local context, both regionally and provincially.

Objectives

1. To ensure the availability of high quality data to inform program evaluation and decision making.
2. To ensure that clinical monitoring is integrated as part of regular clinical practice.
3. To ensure program evaluation includes opportunities to incorporate feedback from service users and their family/social supports.

Standards

A. Data Quality

17.1 Staff **shall** consistently input data within the electronic documentation system, as per RHA policy.

B. Client Level Monitoring

17.2 Staff or a third party provider **shall** administer baseline measure instruments including assessments and/or surveys for new and returning clients.

17.3 Staff **shall** practice ongoing monitoring of clinical outcomes and evaluation of the treatment process, in consultation with the client.

17.4 Staff or a third party provider **shall** administer assessments and/or surveys during treatment or post-treatment to help determine clinical outcomes.

C. Program Level Evaluation

17.5 Staff **shall** refer to evidence-based outcomes when making clinical, program planning, and policy decisions.

17.6 Staff **shall** practice compliance with provincial evaluation requirements and participate in program evaluation as required.

17.7 Staff **shall** obtain client and family feedback to help support and inform program evaluation, in accordance with RHA policy.

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