



Addiction Services
Standards and Best Practices

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PREAMBLE

■ ADDICTION SERVICE STANDARDS

Addiction Services

The development of Service Standards and the corresponding Best Practices in Addiction Services emerged from the broader trend in health care to improve client services, ensure consistency of care, monitor client outcomes and manage associated costs (Health Canada, 2001). Service standards and best practices foster quality of service in communities while facilitating ongoing monitoring and tracking of overall system performance. As well, they ensure the safety and welfare of clients and staff working in the field. Standards and best practice guidelines are usually voluntary. In other words, there are no laws that require organizations to apply them. However, governments may make some standards mandatory by referencing them in legislation or regulations (Standards Council of Canada (SCC), 2002).

The Department of Health (DOH) facilitates the developmental process for Service Standards and Best Practices and plays a provincial role in monitoring and tracking system performance. Addiction Services of the District Health Authorities (DHAs), provide clinical expertise, environmental scanning, and best practice synthesis. Developed through key expert consultation and consensus with the field, provincial service standards ensure services are consistent and accessible to all Nova Scotians. Addiction Services of the District Health Authorities demonstrate adherence to provincial standards through the accreditation of their programs, district reporting, and outcome monitoring activities.

■ Definitions

"A standard is a document, established by consensus and approved by a recognized body, that provides, for common and repeated use, rules, guidelines, or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context (SCC, 1999, p. 5). The Standards Council of Canada (1999) notes that standards should be based on the consolidated results of science, technology, and experience, and aimed at the promotion of optimum community benefits.

Best practices guidelines are generally developed using a combination of methods that "takes the best information from published research studies and combines some form of expert review and consensus development" (Lomas, 1991 cited in Health Canada, 2001, p. 24). Serving to guide the implementation of service standards, best practices are continually evolving and must be consistent with the mission and values of a particular organization (Centre for Health Promotion, 1999). The development of best practices is limited to the resources available and allocated to the review of the literature and key expert involvement.

■ Guiding Principles for Service Standards and Best Practices Development

Province-wide Service Standards and Best Practices should:

- Reflect the mission and values of DOH, DHAs, and Addiction Services to reduce the harms associated with substance use and/or gambling;
- Be consistent with the strategic priorities of the DOH, DHAs, and Addiction Services. As new priorities (i.e., nicotine addiction treatment, enhanced services for rural women and youth, etc.) emerge, new Service Standards and Best Practices should be developed;
- Be based on existing standards and best practices commonly used to reduce the harms associated with substance use and/or gambling (Health Canada Best Practices, Health Act, Hospitals Act, accreditation process);
- Focus on the system as a whole and on those areas of program management that should not show variation between DHAs; and
- Be based on best available evidence and key expert consensus.

Service Standards comprise of (1) an operational definition, (2) objectives and (3) standard measurements specific to a section of the continuum of Addiction Service or a specific practice in support of services. Service Standards have been developed for:

Intake, Assessment, Enhanced Assessment, Case Noting
Withdrawal Management: Residential Component
Withdrawal Management: Day Component
Addiction Education Program
Structured Treatment Program
Community Based (Outpatient) Services
Prevention and Community Education
Driving While Impaired Programs
Outcome Monitoring
Adolescent Service Standards
Women Service Standards
Methadone Maintenance Service Standards
Nicotine Treatment Service Standards
Recovery Homes
Long Term Recovery Homes

Best Practices are based on the Service Standards and provide clinical direction for the delivery of the service. Best Practices are being developed for each area of the Service Standards.

Addiction Services of the DHAs within the shared service areas (Districts 1, 2, & 3; Districts 4, 5, & 6; Districts 7 & 8; District 9) are developing a process to consistently measure the Service Standards. However, resource limitations and historical differences in Addiction Services of the DHAs within the shared service areas may limit the extent to which a particular Service Standard is met. As a result, Addiction Services in the DHAs will initially assess the impact of the Service Standards by determining whether or not a particular standard has been met, partially met, or not met. The results of this initial assessment will assist the Directors of Addiction Services in determining strategic direction and business planning. The Directors will determine what resources will be required to meet the Service Standards in the future. Finally, the implementation of Service Standards will allow each shared service area to benchmark their service delivery as well as to provide the province with an accurate composite of system performance.

■ References

Health Canada. (2001). *Best Practices: Concurrent Mental Health and Substance Use Disorders*. Ottawa: Minister of Public Works and Government Services Canada. [WWW Document]. URL: <http://www.cds-scas.com>.

Standards Council of Canada. (December 1999). *Accreditation of Standards-Development Organizations*. [WWW Document]. URL: <http://www.scc.ca/publicat/canp/1d.pdf>.

Standards Council of Canada. (2002). *Standards: Getting Started*. [WWW Document]. URL: http://www.scc.ca/standards/starting_e.html.

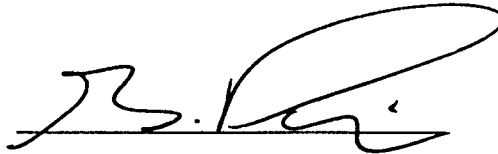
Centre for Health Promotion. (1999). *CHP's Best Practices Work Group*. Ontario Health Promotion Email Bulletin #55.1. [WWW Document]. URL: <http://www.ohpe.ca>

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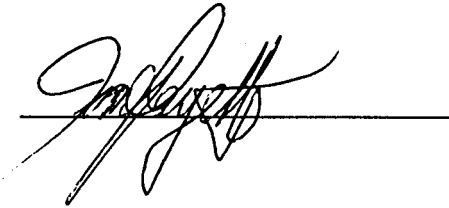
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INTAKE, ASSESSMENT, ENHANCED ASSESSMENT, CASE NOTING

■ INTAKE

Intake* is the process of information exchange, triage, and engagement initiated upon formal contact with the client (* defined in Best Practices).

■ Objectives

- 1 To determine the appropriateness of services provided by Addiction Services to meet identified needs of the client.
- 2 To promote client engagement.
- 3 To provide relevant information/client education.
- 4 To identify and refer to appropriate services, programs, and agencies.
- 5 To determine assignment of priority level.
- 6 To determine the need for further assessment.
- 7 To establish a base line of specific problem areas that can be used during treatment to evaluate a client's progress.

■ Standard Measurements (As measured through annual file audits)

- 1 90% of all potential clients who consent to participate will have an Intake completed within one working day.
- 2 100% of all potential clients who consent to participate will have a Client Information Form completed and recorded to file. Their Intake will be recorded to file at this time.
- 3 100% of clients returning for service after case closure will have an Intake completed and recorded to file.
- 4 100% of clients identified as "at risk" (i.e., suicidal, homicidal, or rapidly de-compensating) will be immediately seen by treatment staff.

■ **ASSESSMENT**

Assessment* is the process of gathering information necessary to identify whether an individual's needs can be addressed by services provided by Addiction Services and to make appropriate bio-psycho-social treatment recommendations (* defined in Best Practices).

■ **Objectives**

- 1 To determine the appropriateness of services provided by Addiction Services to meet identified needs of the client.
- 2 To determine the client's strengths and needs.
- 3 To identify and refer to appropriate services, programs, both internal and external agencies.
- 4 To strengthen client engagement.
- 5 To determine the client's level of readiness for change.
- 6 To provide relevant information.
- 7 To determine the need for enhanced assessment.

■ **Standard Measurements** (As measured through annual file audits)

- 1 100% of all clients will have a Consent to Treatment Form explained to them and a signed copy will be attached to their file.
- 2 80% of all clients in a structured treatment program will have an Assessment completed and attached to their file prior to referral.
- 3 80% of all clients will have an Assessment completed and attached to their file within three outpatient appointments.
- 4 90% of clients who have an Assessment completed indicate that it has been reviewed with them by staff.

■ ENHANCED ASSESSMENT

Enhanced Assessment is the process of gathering additional information to supplement the information usually gathered through an Assessment when the information gathered by the Assessment is insufficient by itself to make appropriate bio-psycho-social treatment recommendations.

■ Objectives

- 1 To determine the appropriateness of services provided by Addiction Services to meet identified needs of the client and to assist in making appropriate internal and external referrals.
- 2 To assist the client in better understanding issues related to substance use/misuse/ problem gambling.
- 3 To provide supplemental information on issues detected that warrant further inquiry in order to proceed with appropriate treatment recommendations.
- 4 To meet a mandated client treatment requirement.
- 5 To assist in providing more comprehensive feedback to the client.

■ Standard Measurements (As measured through annual file audits)

- 1 90% of clients participating in an enhanced assessment will have it completed and attached to the file after five outpatient appointments.
- 2 90% of clients who have an enhanced assessment completed will have it reviewed with them by a staff member and this will be noted in the client file.

■ CASE NOTING

Case Noting is the ongoing process of client bio-psycho-social assessment and is the record of treatment provided. It includes: recording data, issues addressed, treatment received, on-going assessment, treatment plan, and goals of treatment. It may take the form of initial, progress, and closure notes.

■ Objectives

- 1 To provide accountability.
- 2 To provide a record of client progress relating to treatment goals (i.e., physical psychological health, employability, etc.).
- 3 To assist in an organized and thoughtful approach to the implementation of treatment recommendations.

■ Standard Measurements (As measured through annual file audits)

- 1 100% of initial and progress notes are recorded in the file within two business days following each session with or about the client.
- 2 100% of closure notes are recorded in the client file within five business days of closure.

Yearly random audits based on a common checklist for acceptable inclusion will be conducted. Substandard reporting will be addressed.

INTAKE, ASSESSMENT, ENHANCED ASSESSMENT, CASE NOTING

DESCRIPTION

The assessment process focuses on gathering information necessary to identify whether an individual's needs can be addressed by services provided by Addiction Services and to make appropriate bio-psycho-social treatment recommendations.

Assessment is a process of engagement, information exchange and decision-making to determine the appropriate course of action for the client. Assessment helps a client tell "his or her story". It is a collaborative effort between client and worker, not only a cornerstone, but also an integral component throughout the client's involvement with Addiction Services. It exists along the treatment continuum from initial contact to case closure. For the purposes of this document, the assessment process will be divided into four components; Intake, (Standard) Assessment, Enhanced Assessment and Ongoing Assessment. Ideally, clients move through these assessment components based upon the complexity of their service needs, allowing for appropriate case disposition at the earliest and least intrusive point. The assessment process, although dynamic in nature, should allow for initial treatment recommendations to be made at the earliest point. Successful outcomes are maximized by developing recommendations that best match client needs with the services offered them.

GUIDING PRINCIPLES

The assessment process should involve the least intrusive method necessary to make appropriate referral and treatment recommendations.

The assessment process is a collaborative process between the client and treatment staff.

The process is dynamic and continuous throughout treatment.

The process is purposeful and initiated to accomplish specific objectives.

The assessment process is contingent upon the client's fully informed consent.

The assessment process shall be in keeping with the Code of Ethics for Addiction Services and the professional code of ethics of its treatment staff.

The assessment process will assist in the identification of:

- client strengths
- resources
- risk factors
- barriers to treatment
- treatment goals
- treatment plan

Addiction Services will strive to ensure that the assessment process is conducted with the highest quality standards of ethics, process, content and instruments.

Standardized assessment instruments will be employed by qualified staff. These instruments shall have demonstrated validity, reliability and clinical relevance.

OVERVIEW OF STANDARDS

INTAKE

Intake is the process of information exchange, triage, and engagement initiated upon formal contact with the client.

Objectives

- 1 To determine the appropriateness of services provided by Addiction Services to meet identified needs of the client.
- 2 To promote client engagement.
- 3 To provide relevant information/client education.
- 4 To identify and refer to appropriate services, programs and agencies.
- 5 To determine assignment of priority level.
- 6 To determine the need for further assessment.
- 7 To establish a baseline of specific problem areas that can be used during treatment to evaluate a client's progress.

■ **Standard Measurements** (As measured through annual file audits)

- 1 90% of all potential clients who consent to participate will have an Intake completed within one working day.
- 2 100% of all potential clients who consent to participate will have a Client Information Form completed and recorded to file. Their Intake will be recorded to file at this time.
- 3 100% of clients returning for service after case closure will have an Intake completed and recorded to file.
- 4 100% of clients identified as "at risk" (i.e., suicidal, homicidal, or rapidly de-compensating) will be immediately seen by treatment staff.

■ **Staffing**

Treatment staff is required to complete all content items except Recording Data parts 1 and 2 (see below) which may be completed by either clerical or clinical staff.

■ **Content**

The Intake becomes part of the client file and is subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. It shall be legible.

Recording Data

- 1 Client's name, file number, date of birth, address, appropriate telephone numbers and permission to contact them.
- 2 Date of contact.
- 3 Treatment provider's name, profession and signature.
- 4 Attempts to contact including date, time and initials of treatment provider.
- 5 Recording of confidentiality policy and Intake process explained to client.

Presenting Problem

- 1 Brief description of client's presenting problem.
- 2 Previous treatment involvement.
- 3 Current treatment involvement including involvement with other agencies.
- 4 Present employment status.

Level of Priority

- 1 Client statement of immediacy.
- 2 Risk to harming self or others.
- 3 Statement on level of priority.

Disposition of Case

- 1 Treatment provider's recommendation.
- 2 Team's recommendation. (Case Disposition where possible will be determined through a team process.)

(STANDARD) ASSESSMENT

The (Standard) Assessment is the process of gathering information necessary to identify whether an individual's needs could be addressed by services provided by Addiction Services and to make appropriate bio-psycho-social treatment recommendations.

This portion of the assessment continuum is intended to apply to all clients making contact with Addiction Services and any service program specific additions will be noted at the end.

For Driving While Impaired Assessment (DWI) and Nicotine Assessment standards refer to the DWI standards and the Nicotine standards documents.

Objectives

- 1 To determine the appropriateness of services provided by Addiction Services to meet identified needs of the client.
- 2 To determine the client's strengths and needs.
- 3 To identify and refer to appropriate services and programs (internal and external agencies).
- 4 To strengthen client engagement.
- 5 To determine the client's level of readiness for change.
- 6 To provide relevant information.
- 7 To determine the need for enhanced assessment.

■ **Standard Measurements (As measured through annual file audits)**

- 1 100% of all clients will have a Consent to Treatment Form explained to them and a signed copy will be attached to their file.
- 2 80% of all clients in a structured treatment program will have an Assessment completed and attached to their file prior to referral.
- 3 80% of all clients will have an Assessment completed and attached to their file within three outpatient appointments.
- 4 90% of all clients who have an Assessment completed will indicate in writing that they have reviewed the treatment goals/recommendations with treatment staff.

■ **Staffing**

Only appropriately trained treatment staff can complete (Standard) Assessments.

■ **Content**

A collaborative process of exploration and decision-making (including the client's right to withdraw from the assessment process) is fostered throughout. A client shall be assessed by staff to be competent to participate in the process prior to proceeding with the assessment.

The Standard Assessment document is part of the client file and is subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. It shall be legible.

Recording Data

- 1 Client's name and file number.
- 2 Client's date of birth.
- 3 Date of client contacts and date the results of the standard assessment were reviewed with client.
- 4 Treatment provider's name, profession and signature.
- 5 Confirmation of the client's understanding of the Standard Assessment process and Consent to Treatment policy shall be recorded.

Client Interview

- 1** Description of client's presenting problem including: current symptoms, immediate needs, and client's goals of treatment.
- 2** Client's current life circumstances (living arrangements, employment status, level of support, health, etc.).
- 3** Addictions history/use and recovery history.
- 4** Benefits and consequences of client's use (physical, social, emotional, family, employment/school and legal).
- 5** Client employment readiness.
- 6** Effects of other people's use on the client (current and/or family history).
- 7** Current emotional well-being (risk to self/others, thought impairment, emotional distress, etc.).
- 8** Client's current strengths and resources.
- 9** Further exploration of items indicated during intake: involvement with mental health services (current and historical), involvement with other service providers (current and historical) and prior addictions treatment.

Approved Instruments

Assessment instruments are to be used in conjunction with information gathered throughout the assessment process. A client's level of literacy will guide the method of test administration.

- 1** The Substance Abuse Subtle Screening Inventory (SASSI 3).
- 2** The South Oaks Gambling Screen (SOGS).
- 3** The Commitment to Change Questions.
- 4** Fagerström Test for Nicotine Dependence (FTND).
- 5** Research Institute on Addictions Self Inventory (RIASI) for Driving While Impaired Program.
- 6** Other assessment instruments may be used with prior approval of the appropriate Director or designate.

Case Summary

- 1** Results from assessment instruments.
- 2** Treatment provider's conclusion based upon: results of screening instruments, clinical interviews and clinical judgment.
- 3** Negotiated treatment goals.
- 4** Treatment recommendations or an indication of the need for further assessment.

■ Factors leading to referral for enhanced assessment

Reason for enhanced assessment must be recorded in the client file. Determining the need for an enhanced assessment may be influenced by a number of factors including but not limited to the following:

- 1** Based on client request, further assessment is negotiated and seen as appropriate and useful for the recovery process.
- 2** The client is mandated to receive an enhanced assessment.
- 3** Data from the (Standard) Assessment is inconclusive.
- 4** Other issues are detected that warrant further inquiry in order to proceed with appropriate treatment (e.g. depression, family violence, abuse history).

■ ENHANCED ASSESSMENT

Enhanced Assessment is the process of gathering additional information to supplement the information usually gathered through the (Standard) Assessment when the information gathered by the (Standard) Assessment is insufficient by itself to make appropriate bio-psycho-social treatment recommendations.

■ Objectives

- 1 To determine the appropriateness of services provided by Addiction Services to meet the identified needs of the client and to assist in making appropriate internal and external referrals.
- 2 To assist the client in better understanding issues related to substance use/misuse/ problem gambling.
- 3 To provide supplemental information on issues detected that warrant further inquiry in order to proceed with appropriate treatment recommendations.
- 4 To meet a mandated client treatment requirement.
- 5 To assist in providing more comprehensive feedback to the client.

■ Standard Measurements (As measured through annual file audits)

- 1 90% of clients participating in an Enhanced Assessment have it completed and attached to the file after five outpatient appointments.
- 2 90% of clients who have an Enhanced Assessment completed have it reviewed with them by a staff member and this will be noted in the client file.

■ Staffing

Clinical therapists, who have completed the appropriate training, are to complete the Enhanced Assessment.

■ Content

A collaborative process of exploration and decision-making (including the client's right to withdraw from the assessment process) is fostered throughout. A client shall be assessed by staff to be competent to participate in the process prior to proceeding with the assessment.

The Enhanced Assessment is part of the client file and is subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. It shall be legible.

Recording Data

- 1** Client's name and file number.
- 2** Client's date of birth.
- 3** Date of client contacts and date the results of the Enhanced Assessment were reviewed with client.
- 4** Treatment provider's name, profession and signature.
- 5** Consent to treatment policy shall be recorded.

Client Interview

- 1** Description of client's presenting problem including: current symptoms, immediate needs and client goals of treatment.
- 2** Client's current life circumstances (living arrangements, employment status, level of support, health, etc.).
- 3** Addictions history/use and recovery history.
- 4** Benefits and consequences of client's use (physical, social, emotional, family, employment/school and legal).
- 5** Client employment readiness.
- 6** Effects of other people's use on the client (current and/or family history).
- 7** Current emotional well-being (risk to self/others, thought impairment, emotional distress, etc.).
- 8** Client's current strengths and resources.
- 9** Further exploration of items indicated during the intake: involvement with mental health services (current and historical), involvement with other service providers (current and historical), and prior addictions treatment.

Approved Instruments

- 1** The Substance Abuse Subtle Screening Inventory (SASS3).
- 2** The South Oaks Gambling Screen (SOGS).
- 3** The Commitment to Change Questions.
- 4** The NEEDS/JASAE.
- 5** The Inventory of Drug Taking Situations 50 (IDTS 50).
- 6** Fagerström Test for Nicotine Dependence (FTND).
- 7** Research Institute on Addictions Self Inventory (RIASI) for Driving While Impaired Program.
- 8** Other assessment instruments may be used with prior approval of the appropriate Director or designate.

Collateral Information

- 1** Information gathered from relevant third parties (significant other, employer, parents, etc.).
- 2** Existing client records (drivers abstract, probation reports, etc.).
- 3** Client behavioural data (inconsistencies between client's presentation and information during interview).

Case Summary

- 1** Results from assessment instruments.
- 2** Treatment provider's conclusions based upon: results of screening instruments, clinical interviews and clinical judgment.
- 3** Negotiated treatment goals.
- 4** Treatment recommendations.

■ **CASE NOTING**

Case Noting is the ongoing process of client bio-psycho-social assessment and is the record of treatment provided. It includes: recording data, issues addressed, treatment received, on-going assessment, treatment plan and goals of treatment. It may take the form of initial, progress and/or closure notes.

■ **Objectives**

- 1 To provide accountability.
- 2 To provide a record of client progress relating to treatment goals (physical and psychological health, employability, etc.).
- 3 To assist in an organized and thoughtful approach to the implementation of treatment recommendations.

■ **Standard Measurements (As measured through annual file audits)**

- 1 100% of initial and progress notes are recorded in the file within two business days following each session with or about the client.
- 2 100% of closure notes are recorded in the client file within five business days of closure.

Yearly random audits based on a common checklist for acceptable inclusion will be conducted. Substandard reporting will be addressed.

■ **Staffing**

All treatment staff are required to maintain case notes.

Content (Initial Note)

An Initial Note or a dependency assessment shall be recorded in the client file within 24 hours of client contact. An Initial Note is part of the client file and is subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. It shall be legible.

Recording Data

- 1 Client's name and file number.
- 2 Date of client contact and date of note.
- 3 Treatment provider's name, profession and signature.

Issues Addressed

Outline of issues addressed.

Treatment Received

Outline of treatment approaches or interventions used.

Ongoing Assessment

- 1 Preliminary appraisal of problem(s).
- 2 Initial notes will also include a brief assessment of danger to self and to/from others.

Treatment Plan

As appropriate.

Content (Progress Notes)

Progress Notes are part of the client file and are subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. Progress notes shall be legible.

Recording Data

- 1 Client's name and file number.
- 2 Date of client contact and date of note.
- 3 Treatment provider's name, profession and signature.

Issues Addressed

Outline of issues addressed.

Treatment Received

Outline of treatment approaches or interventions used.

Ongoing Assessment

- 1 Statement of client's present functioning.
- 2 Statement of client's progress in achieving treatment goals.
- 3 Progress notes will also include a brief assessment of danger to self and to/from others.

Goals of Treatment

- 1 A clear statement of client's treatment goals.
- 2 Statements concerning additional treatment goals or renegotiated treatment goals.

Content (Closure Notes)

Closure notes are part of the client file and are subject to provincial Service Standards as well as District Standards for storage and retention, and shall be subject to annual file audits. Closure notes shall be legible. A case shall be considered closed following: the achievement of the original treatment goals, mutual consent with client, or 60 days of inactivity.

Recording Data

- 1 Client's name and file number.
- 2 Date of client contact and date of note.
- 3 Treatment provider's name, profession and signature.

Assessment

- 1 Brief statement of client's present problems.
- 2 Assessment: Diagnosis or Formulation of treatment issue/s.

Treatment Received

Summary of treatment provided and interventions used.

Progress

Progress at time of closure.

CONSENT TO TREATMENT FORM

Client Name: _____ File No.: _____

Consent to Treatment

I, hereby consent to working with my treatment provider towards achieving collaboratively established treatment goals. By signing this form, I understand that I am indicating that my participation in treatment is voluntary. I further understand that all treatment options deemed necessary for diagnosis and treatment will be fully explained to me by treatment staff for my consent prior to implementation or in the event they need to be modified or changed. I understand that treatment is client directed and I have the right to end treatment at any time of my choosing. I have had the opportunity to discuss the nature of the treatment

as well as the associated risks

and alternatives

with my treatment provider. I am aware that my treatment provider will further discuss these issues at my request at any time. I understand that it is my responsibility to give notice to cancel or reschedule appointments if I am unable to attend and that my treatment provider will provide me with the same courtesy.

* In the case of an individual who is mentally or physically challenged to such a degree as to be incapable of giving consent, the next-of-kin or legal guardian may authorize appropriate treatment.

Client or Representative _____

Witness _____ Date _____

Limits to Confidentiality

Every client has the right to have information he or she supplies maintained in the strictest confidence. To that end, we do not release any information to outside agencies or individuals without the direct consent of each individual client. Information will be shared on a need-to-know basis with other Addiction Services treatment staff.

However, there are some situations where we are required to breach confidentiality without client consent.

In general, the situations where we are required to act are:

- 1 If the worker has any indication that you are planning to injure or kill anyone.
- 2 If the worker has any indication that you are planning to injure or kill yourself.
- 3 If there is any indication whatsoever of child or elder abuse.
- 4 If the worker and/or the agency's files are required by law (ie. subpoena, court order, ombudsman, etc.).

I have read (or have had read to me) and understand the above.

Client or Representative _____

Witness _____ Date _____

INTAKE FORM

Intake Form

File # _____

Addiction Services

Date of Intake _____

DHAs 4, 5, 6

Health Card # _____

Nova Scotia

call made within one business day

Name _____ **DOB** _____

Address _____

Phone / Home _____ c m **Work** _____ c m

Referral Source self other _____

Contact person _____ **Phone** _____

THIS SECTION TO BE COMPLETED BY ADDICTIONS / INTAKE WORKER

Confidentiality policy explained

Intake process explained

Reason for Call (how can we help you today?)

Last use or gamble _____

Previous treatment history _____

Mandatory referral?

no

probation / parole

DWI

school

Children's Aid

other

Other agency involved

Mental Health

Children's Aid

probation/parole

EAP

Other - _____

Charges pending?

no

yes - detail _____

Employment Status

full-time

part-time

seasonal

unemployed

homemaker

Income Ass.

disability

student

Family Physician _____ aware of referral yes no

Risk Assessment

Thoughts of self harm yes no

Previous history of self harm yes no

Risk of harm to others yes no

If any 'yes' – *make aware of emergency/ interim resources* **done**

Client's view of urgency _____

Referral to other agency/resource yes no

detail _____

Level of Priority

- Emergency** – suicidal, homicidal, rapidly decompensating. To be seen and / or referred that day.
- Urgent** – highly motivated, self-referred, first time seeking treatment. To be seen within one week if possible.
- General** – All other clients - to be seen within three week quality standard.

Intake Worker's Signature _____

Date Completed _____

Intake completed within one business day yes no

Team Disposition

Assigned to _____ Date reviewed _____

Appt. date and time _____ Client notified of appt. yes

Attempts to contact client

Notes

Family Structure (marital status, children, family history)

Family of Origin (childhood, inter-family relations, education, work history)

Medical History (major surgery, hospitalization, medications, allergy, OTC use)

Strengths, Resources, Supports (family, community, groups, activities, hobbies)

INITIAL INTERVIEW NOTE

Name: _____ File No: _____

Date of Contact: _____ Date of Note: _____

Focus

Assessment

Treatment

Goals

Homework

Staff's Signature _____

PROGRESS NOTE

Name: _____ File No: _____

Date of Contact: _____ Date of Note: _____

Focus

Assessment

Treatment

Goals

Homework

Staff's Signature _____

CLOSURE NOTE

Name: _____ File No: _____

Date of Contact: _____ Date of Note: _____

Focus

Assessment

Treatment

Goals

Homework

Staff's Signature _____

COST BENEFIT ANALYSIS

Name: _____

Date: _____

Benefits of Alcohol/Drug

Benefits of Not using Alcohol/ Drugs

Costs of Alcohol/Drug

Costs of Not using Alcohol/Drugs

STAGES OF CHANGE QUESTIONS

Please circle the statement that best fits you:

- "I don't want to change and don't need to change"
- "I'd like to change. Maybe I will one day."
- "I want to change but I haven't decided how to go about it."
- "I'm changing my behaviour and replacing it with activities that are better for me."
- "I'm keeping up my changed behaviour and lifestyle."
- "I'm changed for good."
- "Oops, I slipped up for a while."

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WITHDRAWAL MANAGEMENT: RESIDENTIAL COMPONENT

Withdrawal Management Services is comprised of both residential and day components. These two components do not necessarily operate independent of each other and there is fluidity between the two services based on assessment of client needs.

The residential component of Withdrawal Management Services is designed to meet the needs of individuals requiring inpatient treatment. It is a process designed to optimize the health of individuals harmfully involved with alcohol, drugs and/or gambling through the provision of a comprehensive range of integrated bio-psycho-social treatment services. These services include, but are not limited to: assessment, medically-managed detoxification, treatment planning, therapeutic counselling and support, education, vocational and employability counselling, family counselling and support, and referrals.

■ Objectives

- 1 To provide safe, effective, and efficient withdrawal management in an environment conducive to the addiction treatment and recovery process in a timely manner.
- 2 To respond appropriately to the client's immediate needs and social pressures through situational and/or crisis counselling.
- 3 To raise the client's awareness of his/her condition through the educational process.
- 4 To motivate the client to continue in the recovery process by encouraging the client's active participation in developing and acknowledging the importance of the treatment plan.

■ Standard Measurements

1 Safety

Addiction Services clients are detoxified safely from alcohol and other drugs and gambling as indicated by the following:

- 0% mortality rate
- <2% seizure rate
- 0% delirium tremens rate.

2 Accessibility

Addiction Services ensures a timely provision of withdrawal management to clients who meet admission criteria as indicated by:

80% of clients meeting admission criteria are offered services within five business days from the first contact (that is by telephone or face to face meeting).

3 Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete the withdrawal management process and are connected to other Addiction Services as indicated by:

80% of clients admitted to the withdrawal management complete the process and are discharged with consent,

50% of clients discharged with consent from withdrawal management continue the recovery process as a client of Addiction Services (measured one year following detoxification admission based on a client profile report).

4 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

85% of clients will have a treatment plan recorded on their chart at discharge.

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of withdrawal management.

WITHDRAWAL MANAGEMENT RESIDENTIAL COMPONENT

■ DESCRIPTION

Withdrawal Management Services are comprised of both residential and day components. These two components do not necessarily operate independent of each other. There is fluidity between the two services based on assessment of client needs.

The residential component of Withdrawal Management Services is designed to meet the needs of individuals requiring inpatient treatment. It is a process designed to optimize the health of individuals harmfully involved with alcohol, drugs and/or gambling through the provision of a comprehensive range of integrated bio-psycho-social treatment services. These services include but are not limited to: assessment, medically-managed detoxification, treatment planning, therapeutic counselling and support, education, vocational and employability counselling, family counselling and support, and referrals.

The provision of Withdrawal Management Services is a cost-effective and unique specialty within the Health Care System. However, detoxification alone does not constitute adequate treatment for an addiction(s). Detoxification is one component of a comprehensive treatment strategy offered by Addiction Services. Withdrawal Management should be part of a comprehensive, integrated service delivery system. Additionally, the environment in which Withdrawal Management Service are offered should take into consideration the following components:

- An environment that is safe, secure, supportive and conducive to the recovery process.
- Accessible and community-based.
- Employs a non-judgmental approach by staff trained in treating addiction(s) and the associated medical and psychiatric problems.
- Utilizes a holistic, addiction-focused treatment approach.

■ GUIDING PRINCIPLES

Initial assessments must include evaluation of predicted withdrawal severity, medical and psychiatric co-morbidity.

Initial assessments must facilitate the selection of an appropriate level of care for detoxification.

Every means possible must be used to ameliorate the client's withdrawal signs and symptoms.

The duration of detoxification is not a clearly defined, discrete period of time.

Clients may have prolonged withdrawal signs or symptoms, or a protracted withdrawal syndrome.

There are two general strategies for the pharmacological management of withdrawal:

- Suppression of withdrawal by using a cross-tolerant medication.
- Decreasing signs and symptoms of withdrawal by alteration of another neuro-pharmacological process.

Detoxification alone does not constitute adequate treatment. Detoxification is one component of a comprehensive treatment strategy.

Many individuals undergo detoxification more than once; some do so many times.

After detoxification, the physiological function of the brain gradually returns to its pre-dependent state. However, the neurons may not be exactly the same as they were before the onset of dependence.

Source: Adapted from the American Society of Addiction Medicine, 1998

■ OVERVIEW OF STANDARDS

■ Objectives

- 1 To provide safe, effective and efficient withdrawal management in a timely manner in an environment conducive to the addiction treatment and recovery process.
- 2 To respond appropriately to the client's immediate needs and social pressures through situational and/or crisis counselling.
- 3 To raise the client's awareness of his/her condition through the educational process.
- 4 To motivate the client to continue in the recovery process by encouraging the client's active participation in developing and acknowledging the importance of the treatment plan.

■ Standard Measurements

Safety

Addiction Services clients are detoxified safely from alcohol and other drugs and gambling as indicated by the following:

0% mortality rate
<2% seizure rate
0% delirium tremens rate.

Accessibility

Addiction Services ensures a timely provision of withdrawal management to clients who meet admission criteria as indicated by:

80% of clients meeting admission criteria are offered services within five business days from the first contact (by telephone or face to face meeting).

Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete the withdrawal management process and are connected to other Addiction Services as indicated by:

80% of clients admitted to withdrawal management complete the process and are discharged with consent.

50% of clients discharged with consent from withdrawal management continue the recovery process as a client of Addiction Services (measured one year following detoxification admission based on a client profile report).

Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

- 85% of clients have a treatment plan recorded on their chart at discharge.
- 90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of withdrawal management.

SPECIFIC GUIDING PRINCIPLES

Staffing

The Head Nurse/Nurse Team Leader is responsible for the supervision and management of all activities related to Withdrawal Management Services. The staffing complement must include:

- at least one Registered Nurse.
- at least one additional staff person.

Target Population

Clients who require:

- management of mild to severe withdrawal.
- management of the acute phase of the detoxification process.
- assessment and crisis intervention.
- management of concurrent disorders.

Admission Criteria

- intoxicated, in withdrawal, at risk for relapse and/or gamblers in crisis
- medically manageable
- psychiatrically manageable
- voluntary
- cooperative
- conscious
- capable of self-care

Criteria for Early Dismissal

- physical and/or verbal violence/abuse against clients and/or staff
- drug possession and/or use on the unit
- theft
- destruction of property
- clear violation of the unit's posted rules and regulations
- sexual activity on the unit
- deterioration leading to physical or psychiatric unmanageability

■ COMMON PROVINCIAL PRACTICES

The following sections represent the minimum practice for the delivery of withdrawal management.

■ Withdrawal Protocols and Treatment Guidelines

The Provincial Addiction Services Withdrawal Management Advisory Committee has approved the utilization of the following Drug Withdrawal Protocols and Guidelines in the Detoxification Units of Addiction Services of Nova Scotia:

- Alcohol Withdrawal Protocol.
- Benzodiazepine Withdrawal Protocol.
- Cocaine Withdrawal Protocol.
- Methadone Stabilization Protocol.
- Nicotine Withdrawal Protocol.
- Opiate Withdrawal Protocol.
- Treatment Standards and Guidelines.

■ Intake Assessment

The objective of the intake assessment is designed to gather relevant information to:

- determine if the individual meets the admission criteria.
- based upon nursing assessment, individuals will be referred to the appropriate service, program or agency (emergency, mental health or other Addiction Services) if not offered admission.

The components of the intake assessment are:

- personal information (including but not limited to: client name, file number, date of birth, address, telephone number, health card number, family physician, psychiatrist).
- substance abuse/misuse and gambling history.
- health history (medical/psychiatric).
- current health status including prescribed medications.
- current/previous addiction treatment history.
- risk assessment (medical, homicidal, violence, suicidal, etc.).
- psychosocial needs (childcare, housing, etc.).
- last use of alcohol and/or drug(s).
- referral source.
- self-help connection (if any).
- treatment recommendation.

■ Triage

The objective of triage is to establish the most effective utilization of resources to meet the needs of the client.

Priority for admission is given to:

- the level of need based upon intake assessment.
- first time for treatment.
- referrals from Addiction Services staff and emergency departments.
- withdrawal demands and drug use history.
- demographics of the current clientele on the unit.
- safety of current living situation.

■ Interview Assessment

In some circumstances it may be necessary to have a face-to-face interview with an individual to gather more in-depth information, clarify for the client what the services can provide and/or determine the appropriateness of admission. It may include, but is not limited to:

- restricted clients.
- third party referrals.
- minors with guardian.
- long-term Benzodiazepine withdrawal.
- methadone maintenance treatment services.

■ Admission Procedure

An initial comprehensive assessment is used to gather in-depth information in order to provide quality care. Given the importance of this information, it must be completed and documented in a timely fashion.

Upon arrival to the Unit, the minimum amount of information must include:

- personal information (client name, file number, date of birth, address, telephone numbers, health card numbers, family physician, psychiatrists, next of kin).
- substance(s) used and abused.
- Allergies.
- prescription medications and medical conditions.
- assessment of health status.
- pregnancy status.
- seizure history.
- vital signs (TPR, blood pressure, blood alcohol reading, additional information as deemed important).

The complete admission procedure must be completed within the first 24 hours including:

- substance use/abuse history.
- health history.
- medical (especially seizure status and allergy) history.
- psychiatric history.
- current health status (must include any prescription medications).
- current substance use status.
- potential risk factors (medical, homicidal, suicidal, violence, etc.).
- previous addiction treatment history.
- psychosocial needs (childcare, transportation, employment).
- vital signs / alcometer reading.
- current withdrawal or intoxication status determined.
- collateral information.
- client tour/orientation to the unit (fire evacuation plan).
- client informed of the unit's rules, regulations and guidelines.
- all pertinent documentation completed (nursing/observation notes, etc).
- supervised urine (optional).
- search of belongings and person.

■ Ongoing Assessment, Evaluation and Treatment

Ongoing assessment, evaluation and treatment planning are not confined to the individual client. Where appropriate, the family and/or significant others may be part of this process. The objectives of the process are:

- to ensure continuous, cost-effective quality of care.
- to respond and change the treatment based upon the complexity of their service needs.
- to collaborate with the client's family physician/psychiatrist and other agencies to provide comprehensive and holistic treatment.
- to provide clients with the basic tools to begin the recovery process.
- to retain and/or achieve employment.
- to present strategies to address the determinants of health which are adversely impacting upon their health.

The components of ongoing assessment, evaluation and treatment are:

- management of withdrawal signs and symptoms.
- case conferencing utilizing a collaborative and/or multidisciplinary approach.
- shift reports, ongoing communication amongst Addiction Services staff.
- treatment modalities may include one-to-one counselling, self-help educational videos and group discussions, acupuncture.
- referrals to support services and appropriate consults.
- assessment tools (e.g. bio-psycho-social assessment tools, SASSI, SOGS, ASI, BECK Inventory).
- ordering of appropriate and pertinent laboratory and diagnostic tests such as communicable disease testing, glucose tolerance, liver enzymes, etc.

■ Recovery Planning

The objective of recovery planning is to provide the client with the resources and information necessary to assist them in developing their own recovery plan. The recovery plan must be appropriately recorded.

Information and resource material in recovery planning includes:

- important contact numbers.
- realistic client goals.
- family physicians/psychiatrist.
- appointments within Addiction Services.
- self-help.
- pharmacotherapies (Antabuse, Revia).
- other agencies.

■ Discharge Summary

The discharge summary is designed to present an overview of key treatment issues. It must include:

- discharge status (against medical advice, ambulatory, accompanied by significant other, etc.).
- response to treatment.
- recovery plan (see Recovery Planning above).

■ Performance Measures

The Statistical Information System (StatIS), organizationally developed questionnaires and other tools will be employed to measure performance. The following targets (to be reviewed on an annual basis) have been established:

85% of clients have access to information on life issues (employment, housing, legal, financial, etc.).

90% of clients participate in education components.

90% of clients report satisfaction with the service.

25% report maintenance or improvement in their employability status after discharge.

85% of clients have a recovery plan before discharge.

30% of clients participate in other Addiction Services after discharge.

80% of clients successfully complete the withdrawal process.

70% of clients do not require readmission 6 months after discharge.

70% of clients are normally discharged.

15% of individuals with concurrent disorders resume treatment with mental health and/or Addiction Services (these are from the day, not the residential component).

■ SUPPORTING DOCUMENTS AND FORMS

■ Terms of Reference

Provincial Addiction Services Withdrawal Management Advisory Committee

Mandate

The Provincial Addiction Services Withdrawal Management Advisory Committee shall report to Addiction Services Directors' Committee through one of the Regional Directors who acts as the liaison. The Directors shall assign issues to the committee and receive reports and recommendations for action related to withdrawal management.

Functions

Within its mandate, the Committee shall fulfill the following functions:

- Review and approve recommended medical protocols.
- Acts as provincial review for delegating medical functions in Addiction Services.
- Provide feedback and approve all alternative withdrawal management modality pilots (clinical trials).

Responsibilities

Within its mandate, the Committee shall fulfill the following responsibilities:

- The physicians are responsible for providing professional medical guidance to the withdrawal management process and to liaise where possible with their colleagues in their respective regions.
- The chair is responsible for the facilitation and development of drafts for recommended medical withdrawal protocols and delegated medical functions. All medical withdrawal protocols and delegated medical functions are to be reviewed every three years.
- A management person or designate for each region is responsible for the development of a regional status report on the trends of presenting clients.
- The development and presentations of pilots and new withdrawal service delivery models are the responsibility of the region and should be shared with the committee by the regional delegates.

Membership

Membership on the Committee will be the Pharmacologist (Chair), one physician designated by each region (4), a management person or designate from each region (4), a Regional Director to act as a liaison, and the Director of Addiction Services, Department of Health, Office of Health Promotion. An additional physician and/or regional person can participate at a region's discretion. Delegates will be appointed by the organizations as required.

Accountability

The Committee shall be accountable through the Directors' Liaison to the members of the Addictions Services Directors' Committee. It is the responsibility of the Director of Addiction Services in the region to determine the implementation of the reports and recommendations for action related to withdrawal management in the region he/she represents.

Meetings

The Committee will meet once a year at the call of the chair. Agendas and minutes of the meetings are to be forwarded to the membership and the Directors. Expenses, honoraria, and travel expenses of physicians and staff are the responsibility of each region.

Approved by Directors of Addiction Services, March 19, 1999.

Practice Specific Documents**Protocols**

- Alcohol Withdrawal Protocol
- Benzodiazepine Withdrawal Protocol
- Cocaine Withdrawal Protocol
- Methadone Stabilization Protocol
- Nicotine Withdrawal Protocol
- Opiate Withdrawal Protocol
- Treatment Standards and Guidelines

■ GLOSSARY

Acute Phase of Detoxification

A period of time when psychological and physical signs and symptoms of withdrawal are present requiring medical and nursing assessment and treatment according to established withdrawal management protocols in order to ensure safe and effective detoxification. The time frame for the acute phase of detoxification will vary according to an individual's drug of choice.

Minor (Adolescent) Client

An individual under the age of majority (age 19 in Nova Scotia). Depending on the age of the individual client, living arrangements (i.e. at home with parents or living independently), cognitive abilities, may require the parent or guardian's consent to treatment.

Normal Discharge

A normal discharge occurs when an individual has completed the acute phase of detoxification, is medically/psychiatrically stable, has a recovery plan established or one has been recommended, and is, in the opinion of Withdrawal Management Services staff, ready for discharge.

Restricted Clients

Clients that have been refused admission from one or more Addiction Service for a specific period of time due to unacceptable/inappropriate behaviour and/or violation of Addiction Services rules and regulations.

Seizure Protocol

Refers to the use of Diazepam or Oxazepam (in clients with liver dysfunction) to prevent seizures associated with alcohol withdrawal (refer to Withdrawal Protocols for specific information regarding dosing).

Third Party Referrals

Referrals from agencies outside of the district or shared service catchment area.

■ REFERENCES AND BIBLIOGRAPHY

Kasser, C.L, Geller, A., Howell, E., & Wartenberg, A.(1998). Principles of Detoxification. In W. Graham & T. Schultz (Eds.), *Principles of Addiction Medicine*. Chevy Chase, Maryland: American Society of Addiction Medicine.

WITHDRAWAL MANAGEMENT: DAY COMPONENT

The day component of Withdrawal Management Services is designed to meet the needs of individuals not requiring residential service. The Day Component allows clients to function in their own environment while medically managing their withdrawal. It is a process designed to optimize the health of individuals harmfully involved with alcohol, drugs, and/or gambling through the provision of a comprehensive range of integrated bio-psycho-social treatment services. These services include, but are not limited to: assessment, medically-managed detoxification, treatment planning, therapeutic counselling and support, education, vocational and employability counselling, family counselling and support, and referrals.

■ Objectives

- 1 To provide safe, effective and efficient withdrawal management in an environment conducive to the addiction treatment and recovery process in a timely manner.
- 2 To respond appropriately to the client's immediate needs and social pressures through situational and/or crisis counselling.
- 3 To raise the client's awareness of his/her condition through the educational process.
- 4 To motivate the client to continue in the recovery process by encouraging the client's active participation in developing and acknowledging the importance of the treatment plan.
- 5 To provide withdrawal management to individuals who do not require residential service.

■ Standard Measurements

1 Safety

Addiction Services clients are detoxified safely from alcohol and other drugs and gambling as indicated by the following:

- 0% mortality rate
- <2% seizure rate
- 0% delirium tremens rate.

2 Accessibility

Addiction Services ensures a timely provision of withdrawal management to clients who meet day detoxification admission criteria as indicated by:

90% of clients meeting admission criteria are offered services within five business days from the first contact (that is by telephone or face to face meeting).

3 Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete the day withdrawal management and are connected to other Addiction Services as indicated by:

75% of clients admitted to the withdrawal management services complete the process and are discharged with consent,

60% of clients discharged with consent from withdrawal management continue the recovery process as a client of Addiction Services (measured one year following detoxification admission based on a client profile report).

4 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

85% of clients have a treatment plan recorded on their chart at discharge.

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of withdrawal management.

WITHDRAWAL MANAGEMENT: DAY COMPONENT

■ DESCRIPTION

Withdrawal Management Services are comprised of both residential and day components. These two components do not necessarily operate independent of each other. There is fluidity between the two services based on assessment of client needs.

The Day Component of Withdrawal Management Services is designed to meet the needs of individuals not requiring residential service. The Day Component allows clients to function in their own environment while medically managing their withdrawal. It is a process designed to optimize the health of individuals harmfully involved with alcohol, drugs, and/or gambling through the provision of a comprehensive range of integrated bio-psycho-social treatment services. These services include but are not limited to: assessment, medically-managed detoxification, treatment planning, therapeutic counselling and support, education, vocational and employability counselling, family counselling and support and referrals.

The Day Component of Withdrawal Management Services is an effective and efficient means to expand the treatment options available while maintaining quality care in a fiscally responsible manner. The Day Component provides an environment conducive to the treatment and recovery process. This "environment" consists of both the support system within the Withdrawal Management and the client's own support system(s) (i.e., home, family, friends, self-help, etc.).

The provision of Withdrawal Management Services is a cost-effective and unique specialty within the Health Care System. However, detoxification alone does not constitute adequate treatment for an addiction(s). Detoxification is one component of a comprehensive treatment strategy offered by Addiction Services. Withdrawal Management should be part of a comprehensive, integrated service delivery system. Additionally, the environment in which Withdrawal Management Service are offered should take into consideration the following components:

- An environment that is safe, secure, supportive and conducive to the recovery process.
- Accessible and community-based.
- Employs a non-judgmental approach by staff trained in treating addiction(s) and the associated medical and psychiatric problems.
- Utilizes an holistic, addiction-focused treatment approach.

■ GUIDING PRINCIPLES

Initial assessments should include evaluation of predicted withdrawal severity, medical and psychiatric co-morbidity.

Initial assessments must facilitate the selection of an appropriate level of care for detoxification.

Every means possible must be used to ameliorate the client's withdrawal signs and symptoms.

The duration of detoxification is not a clearly defined, discrete period of time.

Clients may have prolonged withdrawal signs or symptoms, or a protracted withdrawal syndrome.

There are two general strategies for the pharmacological management of withdrawal:

- Suppression of withdrawal by using a cross-tolerant medication.
- Decreasing signs and symptoms of withdrawal by alteration of another neuro-pharmacological process.

Detoxification alone does not constitute adequate treatment. Detoxification is one component of a comprehensive treatment strategy.

Many individuals undergo detoxification more than once, and some do so many times.

After detoxification, the physiological function of the brain gradually returns to its pre-dependent state. However, the neurons may not be exactly the same as they were before the onset of dependence.

Source: Adapted from the American Society of Addiction Medicine, 1998

■ OVERVIEW OF STANDARDS

■ Objectives

- 1 To provide safe effective and efficient withdrawal management in a timely manner in an environment conducive to the addiction treatment and recovery process.
- 2 To respond appropriately to the client's immediate needs and social pressures through situational and/or crisis counselling.
- 3 To raise the client's awareness of his/her condition through the educational process.
- 4 To motivate the client to continue in the recovery process by encouraging the client's active participation in developing and acknowledging the importance of the treatment plan.
- 5 To provide withdrawal management to individuals who do not require residential service.

■ Standard Measurements

Safety

Addiction Services clients are detoxified safely from alcohol and other drugs and gambling as indicated by the following:

- 0% mortality rate
- <2% seizure rate
- 0% delirium tremens rate.

Accessibility

Addiction Services ensures a timely provision of withdrawal management to clients who meet day detoxification admission criteria as indicated by:

- 90% of clients meeting admission criteria are offered services within five business days from the first contact (by telephone or face to face meeting).

Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete the day withdrawal management and are connected to other Addiction Services as indicated by:

- 75% of clients admitted to withdrawal management services complete the process and are discharged with consent.
- 60% of clients discharged with consent from withdrawal management continue the recovery process as a client of Addiction Services (measured one year following detoxification admission based on a client profile report).

Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

- 85% of clients have a treatment plan recorded on their chart at discharge.
- 90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of withdrawal management.

■ **SPECIFIC GUIDING PRINCIPLES**

■ **Staffing**

The Head Nurse/Nurse Team Leader is responsible for the supervision and management of all activities related to Withdrawal Management Services.

The staffing complement must include:

- at least one Registered Nurse.
- at least one additional staff person.

■ **Target Group**

Clients who require:

- management of mild to moderate withdrawal.
- longer management of the detoxification process.
- more individual and small group work.
- management of concurrent disorders.

■ **Admission Criteria**

- intoxicated, in mild to moderate withdrawal, at risk for relapse and/or gamblers in crisis
- clients whose withdrawal can be managed on a day basis
- medically manageable
- psychiatrically manageable
- voluntary
- cooperative
- conscious
- capable of self-care
- appropriate shelter
- access to safe transportation

■ **Criteria for Early Dismissal**

- physical and/or verbal violence/abuse against clients and/or staff
- drug possession and/or use on the unit
- theft
- positive urine test or breathalyser results
- destruction of property
- clear violation of the unit's posted rules and regulations
- sexual activity on the unit

■ COMMON PROVINCIAL PRACTICES

The following sections represent the minimum practice for the delivery of withdrawal management.

■ Withdrawal Protocols and Treatment Guidelines

The Provincial Addiction Services Withdrawal Management Advisory Committee has approved the utilization of the following Drug Withdrawal Protocols and Guidelines in the Detoxification Units of Addiction Services in the province of Nova Scotia:

- Alcohol Withdrawal Protocol.
- Benzodiazepine Withdrawal Protocol.
- Cocaine Withdrawal Protocol.
- Methadone Stabilization Protocol.
- Nicotine Withdrawal Protocol.
- Opiate Withdrawal Protocol.
- Treatment Standards and Guidelines.

■ Intake Assessment

The objective of the intake assessment is designed to gather relevant information to:

- determine if the individual meets the admission criteria.
- refer individuals to the appropriate service, program or agency (Emergency, mental health or other Addiction Services).

The components of the intake assessment are:

- personal information (including but not limited to, client name, file number, date of birth, address, telephone number, health card number, family physician, psychiatrist).
- substance abuse/misuse and gambling history.
- health history (medical/psychiatric).
- current health status including prescribed medications.
- current/previous addiction treatment history.
- risk assessment (medical, homicidal, violence, suicidal, etc.).
- psychosocial needs (childcare, housing, etc.).
- last use of alcohol and/or drug(s).
- referral source.
- self-help connection (if any).
- treatment recommendation.

■ Triage

The objective of triage is to establish the most effective utilization of resources to meet the needs of the client.

Priority for admission is given to:

- the level of need based upon intake assessment.
- first time for treatment.
- referrals from Addiction Services staff, mental health and emergency departments.
- withdrawal demands and drug use history.
- demographics of the current clientele on the unit.

■ Interview Assessment

In some circumstances it may be necessary to have a face-to-face interview with an individual to gather more in-depth information, clarify for the client what the service can provide and/or determine the appropriateness of admission. Interview assessments may include, but are not limited to:

- restricted clients.
- third party referrals.
- minors with guardian.
- long-term Benzodiazepine withdrawal.
- methadone maintenance treatment services.

■ Admission Procedure

An initial comprehensive assessment is used to gather in-depth information in order to provide quality care. Given the importance of this information, it must be completed and documented in a timely fashion.

Upon arrival to the Unit, the minimum information must include:

- personal information (client name, file number, date of birth, address, telephone numbers, health card numbers, family physician, psychiatrists, next of kin).
- substance(s) used and abused.
- allergies.
- prescription medications and medical conditions.
- assessment of health status.
- pregnancy status.
- seizure history.
- vital signs (TPR, blood pressure, blood alcohol reading, etc.).
- referrals to support services and appropriate consults.
- assessment tools (bio-psycho-social assessment tools, SASSI, SOGS, ASI, BECK Inventory).
- ordering of appropriate and pertinent laboratory and diagnostic tests, such as communicable disease testing, glucose tolerance, liver enzymes, etc.

The complete admission procedure must be completed within the first 24 hours including:

- substance use/abuse history.
- health history.
- medical history (especially seizure status and allergy history).
- psychiatric history.
- current health status (must include any prescription medications),
- current substance use status.
- potential risk factors (medical, homicidal, suicidal, violence, etc.).
- previous addiction treatment history.
- psychosocial needs (childcare, transportation, employment).
- vital signs / alcometer reading.
- current withdrawal or intoxication status determined.
- collateral information.
- client orientation to the Day Detoxification unit (i.e. fire evacuation plan).
- client informed of the unit's rules, regulations and guidelines.
- all pertinent documentation completed (nursing/observation notes, etc).
- supervised urine (optional).
- search of belongings and/or person (optional).

■ **Ongoing Assessment, Evaluation and Treatment**

Ongoing assessment, evaluation and treatment are not confined to the individual client. Where appropriate, the family and/or significant others may be part of this process. The objectives of the process are:

- to ensure continuous, cost-effective quality of care.
- to respond and change the treatment based upon the complexity of the service needs.
- to collaborate with the client's family physician/psychiatrist and other agencies to provide comprehensive and holistic treatment.
- to provide clients with the basic tools to begin the recovery process.
- to retain and/or achieve employment.
- to present strategies to address the determinants of health which are adversely impacting upon their health.

The components of ongoing assessment, evaluation and treatment are:

- management of withdrawal signs and symptoms (may include transfer to the inpatient component).
- case conferencing utilizing a collaborative and/or multidisciplinary approach.
- ongoing communication amongst Addiction Services staff.
- treatment modalities may include one to one counselling, self help, educational videos and group discussions, acupuncture.
- referrals to support services and appropriate consults.
- assessment tools (biopsychosocial assessment tools, SASSI, SOGS, ASI, BECK Inventory).
- ordering of appropriate and pertinent laboratory and diagnostic tests such as communicable disease testing, glucose tolerance, liver enzymes, etc.

Recovery Planning

The objective of recovery planning is to provide the client with the resources and information necessary to assist them in developing their own recovery plan. The recovery plan must be appropriately recorded.

Information and resource material in recovery planning includes:

- important contact numbers.
- realistic client goals.
- family physicians/psychiatrist.
- appointments within Addiction Services (i.e. Clinical Therapist, AEP, Structured Treatment, CORE, residential component of Detoxification Services, Community Based Outpatient Services, etc.).
- self-help.
- future pharmacotherapies (Antabuse, Revia).
- other agencies.

Discharge Summary

A discharge summary is designed to present an overview of key treatment issues. It must include:

- discharge status (against medical advice, ambulatory, accompanied by significant other, etc.).
- response to treatment.
- recovery plan (see Recovery Planning, above).

Performance Measures

The Statistical Information System (StatIS), organizationally developed questionnaires and other tools will be employed to measure performance. The following targets (to be reviewed on an annual basis) have been established:

- 85% of clients have access to information on life issues (employment, housing, legal, financial, etc.).
- 90% of clients participate in education components.
- 70% of clients are normally discharged.
- 90% of clients report satisfaction with the service.
- 25% report maintenance or improvement in their employability status after discharge.
- 85% of clients have a recovery plan before discharge.
- 30% of clients participate in other Addiction Services after discharge.
- 15% of individuals with concurrent disorders resume treatment with mental health and/or Addiction Services.
- 75% of clients receiving acupuncture in the Day Component, report satisfaction.
- 50% of clients do not require readmission 6 months after discharge.
- 80% of clients successfully complete the withdrawal process- this is from the residential component and was not listed here.

■ SUPPORTING DOCUMENTS AND FORMS

■ Terms of Reference

Provincial Addiction Services Withdrawal Management Advisory Committee

Mandate

The Provincial Addiction Services Withdrawal Management Advisory Committee shall report to Addiction Services Directors' Committee through one of the Regional Directors who acts as the liaison. The Directors shall assign issues to the committee and receive reports and recommendations for action related to withdrawal management.

Functions

Within its mandate, the Committee shall fulfill the following functions:

- Review and approve recommended medical protocols.
- Acts as provincial review for delegating medical functions in Addiction Services.
- Provide feedback and approve all alternative withdrawal management modality pilots (clinical trials).

Responsibilities

Within its mandate, the Committee shall fulfill the following responsibilities:

- The physicians are responsible for providing professional medical guidance to the withdrawal management process and to liaise where possible with their colleagues in their respective regions.
- The chair is responsible for the facilitation and development of drafts for recommended medical withdrawal protocols and delegated medical functions. All medical withdrawal protocols and delegated medical functions are to be reviewed every three years.
- A management person or designate for each region is responsible for the development of a regional status report on the trends of presenting clients.
- The development and presentations of pilots and new withdrawal service delivery models are the responsibility of the region and should be shared with the committee by the regional delegates.

Membership

Membership on the Committee will be the Pharmacologist (Chair), one physician designated by each region (4), a management person or designate from each region (4), a Regional Director to act as a liaison, and the Director of Addiction Services, Department of Health, Office of Health Promotion. An additional physician and/or regional person can participate at a region's discretion. Delegates will be appointed by the organizations as required.

Accountability

The Committee shall be accountable through the Directors' Liaison to the members of the Addictions Services Directors' Committee. It is the responsibility of the Director of Addiction Services in the region to determine the implementation of the reports and recommendations for action related to withdrawal management in the region he/she represents.

Meetings

The Committee will meet once a year at the call of the chair. Agendas and minutes of the meetings are to be forwarded to the membership and the Directors. Expenses, honoraria, and travel expenses of physicians and staff are the responsibility of each region.

Approved by Directors of Addiction Services, March 19, 1999.

■ **Practice Specific Documents**

Protocols

- Alcohol Withdrawal Protocol
- Benzodiazepine Withdrawal Protocol
- Cocaine Withdrawal Protocol
- Methadone Stabilization Protocol
- Nicotine Withdrawal Protocol
- Opiate Withdrawal Protocol
- Treatment Standards and Guidelines

■ GLOSSARY

Acute Phase of Detoxification

A period of time when psychological and physical signs and symptoms of withdrawal are present requiring medical and nursing assessment and treatment according to established withdrawal management protocols in order to ensure safe and effective detoxification. The time frame for the acute phase of detoxification will vary according to an individual's drug of choice.

Minor (Adolescent) Client

An individual under the age of majority (age 19 in Nova Scotia). Depending on the age of the individual client, living arrangements (i.e. at home with parents or living independently), cognitive abilities, may require the parent or guardian's consent to treatment.

Normal Discharge

A normal discharge occurs when an individual has completed the acute phase of detoxification, is medically/psychiatrically stable, has a recovery plan established or one has been recommended, and is, in the opinion of Withdrawal Management Services staff, ready for discharge.

Restricted Clients

Clients that have been refused admission from one or more Addiction Services for a specific period of time due to unacceptable/inappropriate behaviour and/or violation of Addiction Services rules and regulations.

Seizure Protocol

Refers to the use of diazepam or Oxazepam (in clients with liver dysfunction) to prevent seizures associated with alcohol withdrawal (refer to Withdrawal Protocols for specific information regarding dosing).

Third Party Referrals

Referrals from agencies outside of the district or shared service catchment area.

■ REFERENCES

Kasser, C.L, Geller, A., Howell, E., & Wartenberg, A.(1998). *Principles of Detoxification*. In W. Graham & T. Schultz (Eds.), *Principles of Addiction Medicine*. Chevy Chase, Maryland: American Society of Addiction Medicine.

ADDICTION EDUCATION PROGRAM

Addiction Education Program (AEP) is a service for individuals at risk for developing and/or maintaining harmful involvement with addictive substances and/or behaviours by providing specialized bio-psycho-social addiction information, education, and support for recovery delivered in a residential or non-residential day-patient basis.

■ Objectives

- 1** To provide access to an AEP within a 15 working-day waiting period of an interview documenting client need.
- 2** To improve the health of clients by promoting healthier lifestyles: including reduction in the harm associated with addictive substances and behaviours and to assist clients to address employability. The continuum of harm reduction includes abstinence.
- 3** To motivate the client to continue in the recovery process by increasing the client's knowledge of addiction recovery and support for a personal treatment plan.
- 4** To provide common group experiences for clients facing similar recovery issues.
- 5** To promote a pro-active link between the AEP and Community-Based (Outpatient) Services.

■ **Standard Measurements**

1 Accessibility

Addiction Services ensures a timely provision of AEP to clients who meet admission criteria as indicated by:

90% of clients meeting admission criteria are offered AEP within 15 business days from intake.

2 Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete AEP and are connected to other Addiction Services as indicated by:

80% of clients admitted to the AEP complete the process and are discharged with consent.

70% of clients discharged with consent from AEP continue the recovery process as a client of Addiction Services (measured one year following AEP admission based on a client profile report).

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

80% of clients completing AEP have at least 3 treatment tasks which support their recovery goals documented in their chart.

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of AEP.

ADDICTION EDUCATION PROGRAM

■ DESCRIPTION

Addiction Education Program (AEP) is a short-term educational group designed for individuals at risk for developing and/or maintaining harmful involvement with addictive substances and/or behaviours. AEP provides specialized bio-psycho-social addiction information, education, and support for recovery, delivered in a residential or non-residential setting. AEP is especially helpful for those who have limited time available and/or those not ready for longer-term programs.

Overall, the goal is to provide basic information on addiction, including its physical, emotional, cognitive, and spiritual effects. Further goals include strengthening the client's personal coping skills and self-efficacy for recovery. Links are established with other addiction treatment/educational programs, vocational/employability training and other community resources as needed.

■ GUIDING PRINCIPLES

AEP will provide education about the process of addiction and recovery, relapse prevention and tools of recovery.

Program content will be consistent with evidenced-based practice in the field of addictions.

Program delivery will be consistent with the principles of adult education.

Program staff will have an appropriate combination of skills, knowledge, academic training and experience required to meet the goals of the program.

Clients must meet admission criteria prior to entry into an AEP.

Delivery of AEP shall be in keeping with the Code of Ethics for Addiction Services and the professional codes of ethics of its treatment staff.

Gender and culturally sensitive practices will provide the context for the delivery of program content.

■ OVERVIEW OF STANDARDS

■ Objectives

- 1 To provide access to an AEP within a 15 business day waiting period of an interview documenting client need.
- 2 To improve the health of clients by promoting healthier lifestyles: including reduction in the harm associated with addictive substances and behaviours and to assist clients to address employability. The continuum of harm reduction includes abstinence.
- 3 To motivate the client to continue in the recovery process by increasing the client's knowledge of addiction recovery and support for a personal treatment plan.
- 4 To provide common group experiences for clients facing similar recovery issues.
- 5 To promote a pro-active link between the AEP and Community-based Services.

■ Standard Measurements

Accessibility

Addiction Services ensures a timely provision of AEP to clients who meet admission criteria as indicated by:

- 90% of clients meeting admission criteria are offered AEP within 15 business days from intake.

Retention and connection to the continuum of care supporting recovery

Addiction Services clients successfully complete AEP and are connected to other Addiction Services as indicated by:

- 80% of clients admitted to the AEP complete the process and are discharged with consent.
- 70% of clients discharged with consent from AEP continue the recovery process as a client of Addiction Services (measured one year following AEP admission based on a client profile report).

Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

- 80% of clients completing AEP have at least 3 treatment tasks that support their recovery goals documented in their chart.
- 90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of AEP.

■ **SPECIFIC GUIDING PRINCIPLES**

■ **Staffing**

Each program will ensure that the staff complement for the Addiction Education Program (AEP) includes an appropriate combination of skills, knowledge and experience required to meet goals and objectives of the program. Recognizing the importance and value of a multi-disciplinary team approach to treatment, the staffing combination may include a Clinical Therapist, a Community Health Worker, Counsellor Attendant, and Nurse Rehabilitation Counsellor. Specific roles and responsibilities for delivering AEP will be assigned on the basis of academic education/ training, experience and skill. Staff skills and competencies will provide a comprehensive range of services.

Necessary skill sets to ensure maximum service impact will include: group facilitation and co-facilitation skills, extensive knowledge of group dynamics, a working knowledge of adult education principles, knowledge of gender specific issues in addiction and recovery, good communication skills, enhanced relationship-building skills, as well as sound empathic abilities. Assessment, crisis intervention, and decision-making skills are required. Specific qualifications and duties will be based on position descriptions.

Each district will ensure that each AEP is staffed at a level appropriate to the needs of the program. Female staff should facilitate women's gender specific educational component of AEP.

■ **Target Group**

Persons 16 years of age and older who are at risk for developing and/or maintaining harmful involvement with addictive substances and/or behaviours.

Clients may be offered AEP on a residential basis when distance from home would be a barrier to treatment, commuting would not be a viable option, or their home situation would not be conducive to recovery.

■ **Admission Criteria**

Clients include those who:

- need an improved understanding of the addiction experience.
- benefit from a focused education program over a specific time period.
- may benefit from receiving AEP as an inpatient in a safe environment.
- have not participated in AEP within the past twelve months or who, based on assessment by addiction staff, would benefit from an education refresher or as a relapse prevention and coping tool.
- have limited time available for addiction education.

Clients must:

- volunteer to participate.
- be medically and psychiatrically manageable.
- be willing to participate in an interview/assessment/screening process to determine suitability/appropriateness for admission to AEP.
- be able to maintain self-care.
- demonstrate a willingness and ability to work in a group setting and participate in all aspects of the program.
- be willing to respect the posted guidelines/policies of the specific AEP.
- be clean and sober for a minimum of five (5) days and be abstinent during the program.

■ **Regular Discharge**

A discharge plan will be formulated and negotiated with the client upon completion of the AEP.

A discharge plan may include a referral to Community-based Services and other appropriate community resources.

A discharge plan including a treatment follow-up plan and recommendations will be documented on the client chart.

■ **Criteria for Early Dismissal**

Early dismissal is based upon:

- failure of the client to adhere to the posted guidelines/policies of the specific AEP.
- deteriorating psychological or physical health.
- departing without the consent of staff is considered to be an early dismissal.
- compassionate or emergency reasons may result in premature discharge (e.g. death of a family member).

The client will be informed of a pending discharge and the reasons for the discharge. The details of the discharge, including the reasons for the discharge, as well as any recommendations for further treatment will be documented. If the client's health and safety is at risk at the time of discharge, a designated next of kin, contact person or appropriate person will be notified. If the reason for discharge is due to the use of intoxicating substances or gambling, a referral to Withdrawal Management will be offered to the client.

■ COMMON PROVINCIAL PRACTICES

■ Assessment/Screening

Every referral must be assessed/screened to determine suitability of match with the admission criteria.

Assessment/screening shall consist of a collaborative process between the client and treatment staff including decision making to determine the appropriate treatment or course of action.

The assessment/screening process will follow the Standards and Best Practices for Assessment. The assessment/screening process should involve the least intrusive means for the client and incorporate all existing Addiction Services information so as to prevent repetitious processes.

If a client cannot be accepted into AEP, alternative treatment options will be identified and recommended.

■ Admission Process

Admission to the Addiction Education Program is by referral only. A referral is a process whereby a potential client requests admission, is recommended for, or mandated to an Addiction Education Program. All referrals will be given equal consideration.

Every individual must be assessed/screened and deemed appropriate for an Addiction Education Program. Previously completed assessments may be considered during this process.

Admission suitability will be determined by addiction treatment staff (Primary Care or Community-based).

Primary care staff will complete the AEP Intake/Booking Form in collaboration with the client and/or Community-based staff.

Primary Care staff will confirm admission time and date with the client.

Upon admission to the unit, Primary Care staff will complete the appropriate admission assessment. Guidelines/policies of the unit are explained to the client.

If a client cannot be accepted into AEP, alternative treatment options will be identified and recommended.

■ **Content and Process of Addiction Education Programs**

The content and process of an Addiction Education Program consists of a combination of education and therapeutic components, with an emphasis on the practical application of the therapeutic aspects of the program so as to maximize personal growth. Education will be facilitated by lectures, multimedia tools, assignments, focused discussions, role-plays etc.

While the delivery of content may vary slightly among Addiction Education Programs, the following areas will be addressed:

Addiction Process	Community Supports	Coping Skills and Decision Making	Employability
Gambling	Gender-Specific Issues	High Risk Behaviours	Nutrition
Personal Recovery Plan	Recovery Process	Relapse Prevention	Spirituality

Appropriately skilled staff will deliver components of AEP.

Delivery of AEP will be based on the principles of adult education.

Program content shall be consistent with “evidence-based” practice in the field of addictions.

■ **Recovery Planning**

Recovery planning will be developed on an individual basis in collaboration with clients based on their identified strengths and needs. Specific recovery goals will be identified and documented.

■ SUPPORTING DOCUMENTS AND FORMS

■ Specific Content of Addiction Education Program

The content of the Addiction Education Program supports the program objectives. The specific content may vary depending upon group needs. The specific content areas address the listed objectives, however, the areas may overlap in the actual program delivery so as to facilitate the flow.

Addiction Process

- To provide clients with information about the physical changes that occur in the brain and other body systems due to the use of mood altering substances and/or behaviours.
- To help clients explore the impact that these chemical and physical changes have on their emotions and thinking.
- To help clients explore and assess the effects their use/behaviour has had on their lives and others.

Community Supports

- To explore and identify various supports within the community. This may include exposure to self-help and other services that may aid in the recovery process.

Coping Skills and Decision Making

- To encourage clients to identify positive and negative coping skills, facilitating healthier choice.
- To acknowledge that drugs, alcohol and compulsive activity may have served a purpose in the past. It is acknowledged that clients by their participation in a program are choosing to move towards healthier coping skills.

Employability

- To help clients identify barriers to productive employment.
- To empower clients to address barriers thereby reducing issues preventing them from securing employment.

Gambling

- To educate clients regarding the commonalities between alcohol and other drug addictions and problem gambling.
- To educate clients regarding the potentially harmful effects of gambling.
- To provide a supportive milieu to examine gambling experience.

Gender-Specific Issues

- To educate female clients regarding the unique biological aspects of women's substance use, and the implications of this use on their bodies.
- To assist female clients to gain awareness of factors (individual, interpersonal and societal) that influence women's addiction experience.

High Risk Behaviours

- To help clients reduce the harm associated with high risk activities frequently associated with substance use/addictive behaviours.

Nutrition

- To educate clients about the implications of addictive behaviours on nutritional status.
- To educate clients about the essential elements of good nutrition in order to promote optimal health.

Personal Recovery Plan

- To facilitate the client's development of an individualized action plan to sustain recovery.
- To aid the transition from treatment to the community including the building of a support network (home, employment, community, Community-based Services).

Recovery Process

- To educate clients about short term and long term physical and psychological effects of ceasing harmful involvement with mood altering substances and/or behaviours.
- To help clients identify specific strategies to cope with the physical and psychological effects of ceasing harmful involvement with mood altering substances and/or behaviours.

Relapse Prevention

- To educate clients concerning the prevalence of relapse in the recovery process.
- To educate clients about potential personal relapse triggers.
- To help clients select and practice specific relapse prevention activities.

Spirituality

- To explore the concept of spirituality.
- To provide clients with the opportunity to develop their individual understanding of spirituality as it relates to their recovery.
- To explore the differences between spirituality and religion.

Intake Booking Form Addiction Education Program

F2A is an example of a booking form illustrating the minimum information required to facilitate the admission process for AEP.

INTAKE / BOOKING FORM • ADDICTION EDUCATION PROGRAM

Name: _____ M F

Case #: _____ DOB: _____

Address: _____

Home Phone: _____ Employed? yes no

Work Phone: _____

Can we identify ourselves at home? yes no At work? yes no

N.S. Health Card # _____

Referral Source _____

Court Date Pending? yes no Court Date: _____

No. Of AEPs: _____ Date of Last AEP: _____

Family Dr.: _____

Mental Health/AS/DDS Counselor : _____

Special Needs (e.g. literacy, hearing impaired, etc.): _____

Medical/Mental Health

History:

Present Medications (drug/dosage/length of use)

	Amount	Frequency	Length of Use	Last Use
Alcohol				
Benzos				
Opiates				
Cannabis				
Cocaine				
Gambling				
Other				

Reason for seeking treatment: _____

Any Self Help Connection? yes no Day client Inpatient

Referred to other service? _____

Date Program first offered: _____ Dates Program taken: _____

Staff Signature: _____ Date: _____

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STRUCTURED TREATMENT PROGRAM

Structured Treatment Program is an intensive time limited group treatment service for clients who have successfully completed a withdrawal process. It provides bio-psycho-social assessment, education, counselling, and treatment in collaboration with other components of the Addiction Services continuum. It is offered in both residential and non-residential settings.

■ Objectives

- 1** To provide an intensive therapeutic experience for clients to reflect on their life choices, create new opportunities for choice, and assist clients in achieving new goals for change and/or for sobriety.
- 2** To provide time limited group therapeutic experience which reduces the isolation and shame of the client by providing a shared opportunity to identify with others who have similar experiences, thoughts, and patterns of behaviours.
- 3** To provide individuals with a safe and supportive group forum where they are able to engage in a reciprocal sharing process facilitating increased awareness, personal growth, and empowerment.
- 4** To provide individuals with the tools and processes to express and explore problem areas and/or issues regarding personal work that is vital to their recovery.
- 5** To offer residency for the following reasons: 1) therapeutic milieu of communal living; 2) an alternative to a home situation that is not conducive to recovery; 3) transportation is not viable; and 4) other specific circumstances that create barriers to treatment.
- 6** To motivate personal recovery including involvement in other addiction treatment/ educational services, vocational development, self help community, and community resources.
- 7** To empower individuals to regain control of their lives, to instill in the client the belief that they have the ability and the strength to deal with life one day at a time, as well as the belief that they can achieve and maintain contented sobriety and/or significant harm reduction.

- 8 To assist individuals with the development and enhancement of a personal and lifestyle change, and life skills necessary for a positive and productive recovery process, including entry/re-entry into a healthy social, community, employment, vocational, and personal networks.
- 9 To provide information and support to individuals affected by a client's addiction.

■ **Standard Measurements**

1 Accessibility

Addiction Services ensures a timely provision of structured treatment services to clients who meet admission criteria as indicated by:

90% of clients meeting admission criteria are offered a structured treatment program within 60 business days of an assessment/screening indicating need.

2 Retention and Connection to continuum of care supporting recovery

Addiction Services clients successfully complete the structured treatment process and are connected to other Addiction Services as indicated by:

90% of clients admitted (to residency in CORE) complete program and are discharged with consent.

80% of clients (in residency in CORE) who complete the program and are discharged with consent, continue the recovery process as a client of Addiction Services (measured one year following admission to structured treatment based on a client profile report).

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

80% of clients completing structured treatment (residency in CORE) have completed three treatment tasks noted in their chart and have identified an additional 3 tasks to actively pursue.

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of structured treatment.

STRUCTURED TREATMENT

■ DESCRIPTION

Structured Treatment Program is an intensive time limited group treatment service for clients who have successfully completed a withdrawal process. It provides bio-psycho-social assessment, education, counselling, and treatment in collaboration with other components of the Addiction Services continuum. It is offered in both residential and non-residential settings.

The focus is on strengthening the client's personal coping skill and self efficacy by providing basic information on addiction and the physical, emotional, cognitive and spiritual effects. Feelings and attitudes are explored in a supportive environment in an effort to improve client self esteem and personal growth. Structured treatment strives to increase involvement in a personal recovery program which may include self help involvement, other addiction treatment/educational programs, vocational/employability training and other community resources.

■ GUIDING PRINCIPLES

The structured treatment program consists of a combination of educational and therapeutic components intricately woven throughout the process, with an emphasis on the therapeutic aspects of the program in an effort to maximize personal growth.

Program content is consistent with evidenced-based practice in the field of addictions.

Clients must meet admission criteria prior to entry into a structured treatment program. The assessment/screening process should involve the least intrusive means for the client.

Gender and culturally sensitive practice will provide the context for the delivery of program content.

Program staff has an appropriate combination of skills, knowledge, academic training and experience required to meet the goals of the program.

The self-help community makes a valuable contribution to the work of structured treatment programs and therefore programs may utilize their services appropriately.

■ OVERVIEW OF STANDARDS

■ Objectives

- 1 To provide an intensive therapeutic experience for clients to reflect on their life choices, create new opportunities for choice, and assist clients in achieving new goals for change and/or for sobriety.
- 2 To provide time limited group therapeutic experience which reduces the isolation and shame of the client by providing a shared opportunity to identify with others who have similar experiences, thoughts, and patterns of behaviours.
- 3 To provide individuals with a safe and supportive group forum where they are able to engage in a reciprocal sharing process facilitating increased awareness, personal growth, and empowerment.
- 4 To provide individuals with the tools and processes to express and explore problem areas and/or issues regarding personal work that is vital to their recovery.
- 5 To offer residency for the following reasons: 1) therapeutic milieu of communal living, 2) an alternative to a home situation that is not conducive to recovery; 3) transportation is not viable, and 4) other specific circumstances that create barriers to treatment.
- 6 To motivate personal recovery including involvement in other addiction treatment/ educational services, vocational development, self help community, and community resources.
- 7 To empower individuals to regain control of their lives, to instill in the client the belief that they have the ability and the strength to deal with life one day at a time, as well as the belief that they can achieve and maintain contented sobriety and/or significant harm reduction.
- 8 To assist individuals with the development and enhancement of a personal and lifestyle change, and life skills necessary for a positive and productive recovery process, including entry/re-entry into healthy social, community, employment, vocational, and personal networks.
- 9 To provide information and support to individuals affected by a client's addiction.

■ Standard Measurements

Accessibility

Addiction Services ensures a timely provision of structured treatment services to clients who meet admission criteria as indicated by:

- 90% of clients meeting admission criteria are offered a structured treatment program within 60 business days of an assessment/screening indicating need.

Retention and Connection to continuum of care supporting recovery

Addiction Services clients successfully complete the structured treatment process and are connected to other Addiction Services as indicated by:

- 90% of clients admitted (to residency in CORE) complete program and are discharged with consent.
- 80% of clients (in residency in CORE) who complete the program and are discharged with consent, continue the recovery process as a client of Addiction Services (measured one year following admission to structured treatment based on a client profile report).

Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

- 80% of clients completing structured treatment (residency in CORE) have completed 3 treatment tasks noted in their chart and have identified an additional 3 tasks to actively pursue.
- 90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of structured treatment.

■ SPECIFIC GUIDING PRINCIPLES

■ Staffing

Each program will ensure that the staff compliment includes an appropriate combination of skills, knowledge and experience required to meet the goals and objectives of the program. Recognizing the importance and value of a multi-disciplinary team approach to treatment, the staffing combination may include a Clinical Therapist, a Community Health Worker, and Counselor Attendant. Specific duties/responsibilities within the program will be assigned on the basis of academic education/ training, experience and skill. Staff experiences and competencies will provide a comprehensive range of services.

Necessary skill sets to ensure maximum service impact include: group facilitation and co-facilitation skills, extensive knowledge of group dynamics, a working knowledge of adult education principles, good communication skills, enhanced relationship building skills, as well as sound empathic abilities. Assessment, crisis intervention, and decision-making skills are required. Specific qualifications, skills and duties are based on position descriptions (see Typical Staff Competencies F.1).

■ Target Group

Persons 16 years of age and older, addicted to or harmfully involved with alcohol and/or drugs and gambling, who require extensive treatment beyond their own environment to interrupt the addictive/potentially destructive process.

- While age is not a strict criteria, it will be considered when composing groups.
- The residential and non-residential programs provide an opportunity for more intensive treatment/education and exploration of personal issues to assist in motivating clients to continue the recovery process.
- Some programs may also provide services to those affected by another's addiction or harmful involvement.
- In addition to mixed treatment groups, some facilities will offer gender specific and adolescent programming.
- The residential component is offered to clients based on distance to their home, a home situation not conducive to recovery, or commuting is not a viable option.

■ Admission Criteria

Clients must:

- be voluntary,
- be medically and psychiatrically manageable,
- be willing to participate in an interview/assessment/screening process to determine suitability/appropriateness for admission to the structured treatment program,.
- demonstrate a willingness and ability to work in a group setting and participate in all aspects of the program,
- be willing to respect the posted guidelines/policies of the specific structured treatment program,
- demonstrate appropriate behaviour, abstinence during program.

■ **Regular Discharge**

A discharge plan will be formulated and negotiated with the client upon completion of the program.

The discharge plan will include a referral to Community-Based (Outpatient) Services and other appropriate community resources.

A discharge plan including a treatment follow-up plan and recommendations will be documented.

■ **Criteria for Early Dismissal**

Early dismissal is based upon:

- failure of the client to adhere to the posted guidelines/policies of the specific structured treatment program.
- deteriorating psychological or physical health.

The client will be informed of a pending discharge and the reasons for the discharge. The details of the discharge will be documented including the reasons and recommendations for further treatment. If the client's health and safety are at risk at the time of discharge, a designated next of kin, contact person, or other appropriate person will be notified. If the reason for discharge is due to the use of intoxicating substances or gambling, a referral to Withdrawal Management will be offered to the client.

■ COMMON PROVINCIAL PRACTICES

■ Admission Process

Admission to a Structured Treatment Program is by referral only. A referral is a process whereby a potential client requests admission or is recommended for, or mandated to a structured treatment program. All referrals will be given equal consideration.

- Referrals may be a self-referral, or from an Addiction Services staff, or from an external source.
- All referrals will be considered potential clients pending the completion of the assessment/screening process to determine suitability of match with the admission criteria.
- Previously completed assessments will be forwarded by Addiction Services staff to support a client referral to Structured Treatment.
- Potential clients referred by a mandatory process must meet all program admission criteria and be appropriate for the service being offered.
- Referral sources will be informed, (with the client's consent where necessary) of the outcome of the admission assessment.
- All referred clients will be notified regarding their admission status in a timely manner.
- If a client cannot be accepted to a structured treatment program, a recommendation for further treatment will be provided by program staff.

■ Assessment/Screening

Every referral must be assessed/screened to determine suitability of match with the admission criteria. Previously completed client assessments will be considered during this process.

- Assessment/screening shall consist of a collaborative process between the client and treatment staff, including decision making to determine the appropriate treatment or course of action.
- The assessment/screening process should involve the least intrusive means for the client, and incorporate all existing Addiction Services information so as to prevent repetitious processes.
- The recognized assessment tools may be utilized. The completed assessment is part of the client's file.

The clinical interpretation of the assessment/screening process is the responsibility of the structured treatment program staff and is based on the admission criteria.

■ Client Complaint

Staff recognizes and appreciates the right of individuals to file a complaint with respect to the service they received, and to appeal decisions related to their treatment that may include but is not limited to, admission to a structured treatment program. It is recommended that:

- staff inform clients at admission of their right to appeal and/or file a complaint and the process to follow to register a complaint,
- the manager or team coordinator will be notified by staff of a client's wish to file a complaint,
- the complaint will be addressed in accordance with program/district policy.

■ Content and Process of Structured Treatment Programs

The content and process of Structured Treatment Programs consists of a combination of education and therapeutic components, with an emphasis on the practical application of the therapeutic aspects of the program so as to maximize personal growth. The education components are designed to provide information on addictions and the specific content may include communication, stress management, assertiveness, self esteem and life skills, and to provide an opportunity to promote awareness and insight serving as a preparatory phase for more intensive therapeutic components.

While the delivery of content may vary slightly among structured treatment programs, the following areas will be addressed (see F.2 for a more complete list and objectives):

Communication	Self Concept	Stress Management
Coping/Decision Making	Change	Personal Recovery Plan
Spirituality	Family of Origin	Emotions
Boundaries	Unresolved Anger	Guilt/Shame
Gambling	Relationships	Power/Control
Values	Self Help Meetings	Daily Dairies
Relapse	Journaling	

Therapeutic components focus on personal experiences of the client and seek to assist the client to connect their life experiences and the impact of the life experiences on their physical, cognitive, emotional, and spiritual well being. The therapeutic components focus on the "processing" of the client experiences in a way that is both promoting and empowering for the client. A clinical therapist processes client disclosures and experiences in a therapeutic manner for the client and group members.

Appropriately trained staff will deliver specific components of the structured treatment program.

Program content and process shall be consistent with addictions evidence-based practice. Delivery of program content will be based on adult learning theory and maximize the benefits of the group process thereby reducing the feelings of isolation and shame.

■ Drug Screens

During a structured treatment program, staff may administer random drug screens which may include a breathalyser, urinalysis and other appropriate measures.

- In the best interests of clients and staff and supporting program objectives, an alcohol/drug free environment is required. Therefore, random drug screens may be administered.
- Client refusal to participate in a screening may result in a discharge from the program.
- Random screens will be administered respecting the dignity of the client.
- Results from a screen will be discussed with the client in a timely manner.
- A positive screen may result in a client's discharge from the program. Rationale for discharge will be documented on the client's file.

■ Intimacy

Intimate and/or romantic relationships between clients participating in a structured program will not be tolerated. Such behaviour is counter-productive to, and interferes with the treatment process. To pro-actively address the issue, staff will:

- prior to accepting individuals into a program explore if the client is intimately involved with another potential candidate for the same program.
- advise all clients at the outset of the program that intimate and/or romantic relationships will not be tolerated.
- monitor the development of any such relationships.

■ Medical/Psychiatric Incidences

Medical/psychiatric incidents may occur during the course of a structured treatment program. Such incidents will be dealt with immediately. The following process is recommended:

- ambulatory clients will be referred to medical staff for assessment and treatment, if necessary.
- non-ambulatory clients will be transported immediately by ambulance to the nearest medical hospital.
- should the incident result in a disruption to a client's continued involvement in the program, a re-booking for a later date will be offered to the client, appropriate documentation including an incident report will be completed.

■ **Psychiatric Illness**

Structured treatment programs recognize some clients requiring addiction treatment may also suffer from a psychiatric illness. In order to facilitate the process:

- all dual diagnosis patients must be psychiatrically managed prior to admission.
- a letter/summary from the client's psychiatrist will be part of the assessment/screening process and is part of the client's file.
- the client must agree to continue with medications prescribed by his/her psychiatrist.
- re-occurrence of psychiatric symptoms or deterioration in mental health will result in an assessment by a mental health professional and pending the results, a possible termination in the client's participation in the program.
- treatment goals will include both diagnosis.

■ **Safe Environment- Alcohol and Other Drugs**

Structured treatment programs promote drug free participation but realize that some clients may require ongoing or temporary medication regimes to deal with medical or minor psychiatric problems. In support of a safe environment:

- all prescribed and over the counter (OTC) medications in the client's possession on admission must be turned over to staff.
- medication will be kept in a secure cabinet while the client is on the premises.
- medication will be self-administered under the supervision of staff.

Structured treatment programs promote an alcohol and drug free safe environment and reserve the right to conduct a search of a client's room and/or belongings. The following process is recommended:

- staff may request that all residents gather in a central location.
- a staff person will remain with the group in the central location.
- a second staff person will accompany the client to his/her room for the purposes of the search.
- the client will be present during the search of his/her room and or belongings.
- the client will be asked to empty pocket contents, luggage, purses, drawers, etc., and to spread all contents out for staff to observe,
- if contraband is discovered, the client may be discharged from the program.
- if a weapon is found in a client's possession, the client will be discharged from the program.
- the disposal of contraband will be in keeping with District policy,
- body searches of clients are not permitted.

■ **Safe Environment- Personal**

Structured treatment programs are committed to ensuring safe and respectful environments for staff and clientele. Safe and respectful environments can be threatened by behaviours which could be deemed abusive. If the environment is compromised the following process is recommended:

- staff are empowered to suspend program activities in response to abusive behaviour on the part of a client toward a staff member or another client.
- staff have the right to request an abusive client leave the premises and should the client refuse to comply with the request, staff will contact appropriate authorities for assistance.
- such an incident must be documented on the client's file.

■ **Visits**

Program staff encourages visiting while clients are engaged in a program. However, in respect of the confidentiality and dignity of all clients, visits will be organized and monitored by program staff. Common guidelines include:

- visits can not interfere with program activities or meal times.
- times will be determined by each site and may vary in frequency and duration.
- visitors will be permitted in spaces designated by staff.
- a visitor assessed to have brought contraband to a client will be asked by staff to leave the premises, failing such, the appropriate authorities will be notified.
- clients are responsible for their visitor's behaviour.

■ **Volunteers**

Volunteers make a valuable contribution to structured treatment programs. Volunteer services must compliment service delivery. The following process is recommended:

- volunteers must complete an application process and provide references.
- volunteers must be interviewed by the program manager.
- volunteers must sign a release of information form permitting management and/or human resources to conduct a child abuse registry check and a criminal record check.
- volunteers must complete a program orientation including policies and procedures prior to any program involvement.
- recovering volunteers must have achieved at least 1 year sobriety and demonstrate a healthy lifestyle.

■ SUPPORTING DOCUMENTS AND FORMS

■ Typical Staff Competencies

Clinical Therapist

(Masters Degree in Social Work/Psychology or related Counselling Profession)

- A demonstrated and clinical knowledge base, effective integration of personal and professional qualities, a knowledge base and comprehensive range of clinical skills appropriate to the field of addictions are essential.
- To ensure a treatment team that is able to competently address the needs of all target populations, the required clinical knowledge and skill base may at times need to be more specific and or specialized i.e.; adolescents, seniors, women, and first nations people.
- Well-developed and demonstrated ability to work cooperatively and collaboratively with other professionals, para-professionals and lay people is essential.
- A sound understanding of a community health approach and community service delivery systems is necessary.
- Strong leadership abilities and an ability to function effectively as a clinical reference for other team members.

Community Health Worker (Grade 12 & 2 yrs related experience)

- Should be a recovering person with 5 years of demonstrated quality recovery.
- A good working knowledge of community resources, organizations and services.
- Experience in individual counselling and rehabilitative services as well as public presentations and group work.
- Above average organizational, interpersonal, problem solving , and communication (written & verbal) skills.
- Ability to act as a bridging vehicle to the self-help community and to act as a community resource/liaison person.

Counsellor (Grade 12 plus completion of a an approved course or 2 yrs experience)

- Must possess a good understanding of the resources within the community.
- Must possess the ability to work independently and within a team environment.
- Well developed organizational, problem solving, interpersonal and communication (written & verbal) skills are essential.
- Experience in individual supportive counselling, public presentations and group work are essential.

■ Specific Content of Structured Treatment

The content of the structured treatment program supports the program objectives, the specific content may vary depending upon the group needs. The specific content areas address the listed objectives however the areas may overlap in the actual program delivery so as to facilitate the flow. Not all specific content areas are distinctly listed in Content and Process of Structured Treatment Programs (E.4).

Anger

- To facilitate understanding of anger as a healthy emotion and distinguishing between anger and violent behaviour.
- To identify causes of anger.
- To identify and express anger as it exists in the client's life.
- To suggest appropriate methods of expressing anger.

Assertiveness

- To provide clients with effective means of maintaining appropriate boundaries and responses to conflict.
- To provide clients the opportunity to understand their choices of response (unless power/abuse is an issue).
- To educate clients that assertiveness is defining boundaries and personal power and not influencing or manipulating others.

Boundaries

- To increase clients awareness of personal boundaries for self and others.
- To provide clients with the opportunity to identify and examine healthy and unhealthy boundaries in their own lives.
- To provide clients with a framework to develop and maintain healthy boundaries.

Change

- To identify the process of change.
- To empower clients to identify and make changes in their own lives.
- To explore the benefits and drawbacks to change, thereby helping clients to be prepared for the losses that can accompany changes that are necessary to improve the quality of life.
- To help clients' positive or negative change as a source of stress that must be managed.

Communication

- To educate clients regarding effective communication.
- To understand the role of effective communication in managing relationships and emotions.
- To explore barriers to effective communication and the impact on personal and employment situations, and to develop healthy and appropriate responses.

Coping and Decision Making

- To encourage clients to identify positive and negative coping skills, facilitating healthier choice.
- To acknowledge that drugs, alcohol and compulsive activity may have served a purpose in the past. It is acknowledged that clients, by their participation in a program, are choosing to move towards healthier coping skills.

Daily Diaries and Journaling

- To introduce clients to the value of journaling for personal reflection and self-awareness.
- To provide questions or issues to consider as a guideline for the journaling process to maximize the therapeutic effectiveness.
- To have clients become familiar with the experience as a helping tool that may continue following the program.

Emotions

- To educate clients about emotions and the intricate role emotions play.
- To specifically identify emotions and connect them to personal experiences.
- To provide tools for dealing with emotions such as, expressing emotions at the time you feel them, accurately naming emotions so that one can properly express them, journaling.

Employability

- To help clients address barriers to productive employment.
- To empower clients to address barriers, thereby reducing issues preventing them from securing employment.
- To provide clients with skills needed to re-enter or return to the workforce such as resume writing, how to negotiate a return to work, upgrading.

Family of Origin

- To help clients explore the influence of family of origin on their adult lives.
- To provide clients with tools to examine relationships in their family of origin for example, genogram, eco-map, lifeline.
- To reduce the isolation and shame often associated with family of origin issues.

Gambling

- To educate clients regarding the harmful effects of gambling.
- To educate clients regarding the connection between alcohol and other drug addictions and problem gambling.
- To provide a supportive milieu to examine gambling experience.

Guilt and Shame

- To understand the difference between guilt and shame and the impact on recovery.
- To reduce the isolation, by shared experiences, that accompanies feelings of guilt and shame.
- To help clients develop a personal action plan aimed at reducing guilt and shame, that is, letters, constructive confrontation, journals, ongoing therapy, meaningful activity/work/volunteering, education.

Inner Child

- To help clients understand the impact of their childhood on them as adults.
- To help clients who have experienced childhood pain and trauma acknowledge the impact.
- To provide clients with a safe environment where they may grieve lost childhoods and unmet needs.
- To stress the importance of having needs met on an ongoing basis if one is to live a happy and fulfilling life.

Personal Recovery Plan

- To aid the transition from treatment to the community, including the building of a support network (home, employment, community).
- To facilitate the client's development of a specific action plan to sustain recovery.
- To initiate internal and external referrals as required - other Addiction Services, community resources, including education/job training, employment.

Power and Control

- To educate and increase awareness of abuse of power in relationships, including physical, sexual and emotional abuse.
- To examine equality and equity in relationship to power.
- To examine gender imbalance in relationships.
- To provide information and resources for individuals who identify abuse in their relationships.

Relapse

- To increase awareness of the relapse process as opposed to simply an event.
- To help clients realize their relapse triggers so as to provide a personal safe guard.
- To normalize relapse and to situate it as one of the stages of change.
- To help clients identify high risk areas and the potential impact on their sobriety.

Relationships

- To broaden client's definition of relationships.
- To explore and identify components necessary for healthy relationships.
- To explore the personal impact of unhealthy and abusive relationships.
- To explore the impact of relationships on personal emotional reactivity.
- To empower clients to take responsibility for the relationships in their lives.

Self Concept

- To enhance a sense of self worth.
- To define self-concept, the personal impact.
- To provide tools for enhancing self concept, that is, positive self talk, identifying strengths and accomplishments, respectful treatment/environment/role modeling.

Self Help Meetings

- To provide exposure to the 12-step recovery process.
- To connect individuals to a supportive environment.
- To provide clients with the opportunity to discuss their self help experience in a safe and supportive group.

Sexuality

- To provide clients with accurate sexuality information.
- To dispel myths regarding sexuality.
- To provide clients with a safe and supportive environment where sexuality can be discussed, including sexual orientation, sexually transmitted diseases, impotence, sexual abuse.

Socialization

- To help clients understand the impact of the socialization process.
- To assist clients in understanding that traditional socialization can place limitations on both males and females.
- To explore the impact of limitations on the loss of hopes and dreams and the negative impact on the personal spirit.
- To help clients “look outside the box” to have individual needs met.

Spirituality

- To explore the impact of spirituality on self and relationships.
- To provide clients with the opportunity to connect with the spiritual self in healing and recovery.
- To explore the difference between spirituality and religion. Personal spiritual practice impacts self perception and can sustain recovery during the difficult periods.
- To facilitate skill development of spirituality practice, that is, meditation, visualization, and written reflection.

Stress Management

- To normalize the physical and emotional experience/reaction to stress.
- To provide information regarding stress.
- To provide tools for identifying and managing stress.

Values

- To explore the relationship between values and choices.
- To explore the connection between values and a personal belief system.
- To explore contributing factors to the development of a value system.
- To encourage clients to choose values that will guide their lives in a positive and healthy manner.

COMMUNITY-BASED (OUTPATIENT) SERVICES

■ Description

Community-Based (Outpatient) Services are an accessible outreach, intervention and treatment service delivered to individuals and groups who reside in their own communities. Services are based on client needs and commitment to change, and based on a bio- psycho-social assessment.

■ Objectives

- 1 To provide accessible Community-Based (Outpatient) Services. When transportation presents as a barrier to accessing service, services will be delivered in the client's home or community.
- 2 To improve the health of clients by promoting healthier lifestyles: including reduction in the harms associated with substance use and/or gambling and to assist clients to address employability. The continuum of harm reduction includes abstinence.
- 3 To motivate the client to continue in the recovery process by increasing the client's knowledge of addiction recovery and support for a personal treatment plan.
- 4 To provide common group experiences for clients facing similar recovery issues.
- 5 To be proactive in establishing and maintaining the continuum of care with clients, by establishing a link between Community-Based (Outpatient) Services and all other Addiction Services and taking the primary role in managing individual client's cases.
- 6 To provide addiction specific outreach contact and engagement that address the barriers to treatment in the community. Services may include, partnerships, community education, early identification, case finding, portable programming.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of Community-Based (Outpatient) Services to clients who require services as indicated by:

90% of persons requesting services are called back within one business day.

90% of all potential clients who consent to participate have an Intake completed within one business day.

90% of potential clients are offered service options as defined in Best Practices, within 15 business days (the date of initial contact will be recorded on the intake form as well as the date of the date of the service option offered).

2 Retention and connection to the continuum of care supporting recovery

Addiction Services clients are successfully connected to Addiction Services as indicated by:

60% of clients attending community based out patient services have three in-person clinical sessions recorded within one year.

<25% no show/cancellations for in-person clinical sessions.

>25% of clinical sessions will include significant others.

90% of clients referred from other components of Addiction Services care continuum will receive a clinical session within 10 business days.

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

60% of client cases are closed upon mutual consent after the successful completion of treatment goals.

75% of clients report a reduction in the harms associated with their addiction by the third Community-Based (Outpatient) Services appointment (excluding intake) based on an anonymous standard self report survey.

90% of clients report satisfaction with the service by the third Community-Based (Outpatient) Services appointment (excluding Intake) based on an anonymous standard self report survey.

75% of clients giving consent to participate in Outcome Monitoring System (OMS) report a reduction in the harms associated with their addiction twelve months after Intake.

COMMUNITY-BASED SERVICES BEST PRACTICES

■ DESCRIPTION

Community-Based (Outpatient) Services are an accessible outreach, intervention and treatment service delivered to individuals and groups who reside in their own communities. Services are based on client needs and commitment to change, and based on a bio-psycho-social assessment.

■ GUIDING PRINCIPLES

Community-Based Services:

- are client centered.
- support harm reduction in achieving client goals.
- provide direct access, voluntary participation, flexibility and self-determination.
- support clients in addressing the determinants of health.
- offer the least-intrusive treatment plan necessary to achieve desired outcomes.
- build on clients' strengths.
- are purposeful and designed to achieve realistic goals.
- are culturally relevant and appropriate to the diversity of communities.
- are reflective of the changing needs of the community, including the ongoing identification of under-serviced populations.
- are designed, delivered and evaluated based on current evidence-based knowledge and best practices literature.
- are cost-effective.
- function as collaborative interdisciplinary teams.
- are guided by the Provincial Code of Ethics for Addiction Services. Professional staff are also expected to abide by their respective professional codes of ethics.
- recognize and value the diversity of skill, education and life experiences of staff and volunteers.
- value continuing professional development in the field of addictions.

OVERVIEW OF STANDARDS

Objectives

- 1 To provide accessible Community-Based Services. When transportation presents as a barrier to accessing service, services will be delivered in the client's home or community.
- 2 To improve the health of clients by promoting healthier lifestyles: including reduction of harms associated with substance use and/or gambling and to assist clients to address employability. The continuum of harm reduction includes abstinence.
- 3 To motivate the client to continue in the recovery process by increasing the client's knowledge of addiction recovery and support for a personal treatment plan.
- 4 To provide common group experiences for clients facing similar recovery issues.
- 5 To be proactive in establishing and maintaining the continuum of care with clients, by establishing a link between Community-Based Services and all other Addiction Services, and by taking the primary role in managing individual client's cases.
- 6 To provide addiction specific outreach contact and engagement that addresses the barriers to treatment in the community. Services may include partnerships, community education, early identification, case finding and portable programming.

Standard Measures

1 Accessibility

Addiction Services ensures a timely provision of Community-Based Services to clients who require services as indicated by:

- 90% of persons requesting services are called back within one business day.
- 90% of all potential clients who consent to participate have an Intake completed within one business day.
- 90% of potential clients are offered service options as defined in Best Practices within 15 business days (date of initial contact will be recorded on the intake form as well as the date of the service option offered).

2 Retention and connection to the continuum of care supporting recovery

Addiction Services clients are successfully connected to Addiction Services as indicated by:

- 60% of clients attending Community-Based Services have three in-person clinical sessions recorded within one year.
- <25% no show/cancellations for in-person clinical sessions.
- >25% of clinical sessions will include significant others.
- 90% of clients referred from other components of Addiction Services care continuum will receive a clinical session within 10 business days.

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

- 60% of client cases are closed upon mutual consent after the successful completion of treatment goals.
- 75% of clients report a reduction in the harms associated with their addiction by the third Community-Based Services appointment (excluding Intake) based on an anonymous standard self-report survey.
- 90% of clients report satisfaction with the service by the third Community-Based (Outpatient) Services appointment (excluding Intake) based on an anonymous standard self report survey.
- 75% of clients giving consent to participate in Outcome Monitoring System (OMS) report a reduction in the harms associated with their addiction twelve months after Intake.

SPECIFIC GUIDING PRINCIPLES

Staffing

Clinical Therapists will:

- be registered (or candidate for registration) with a relevant legislated professional regulatory body in Nova Scotia, such as the Nova Scotia Association of Social Workers, Nova Scotia Board of Examiners in Psychology, or the College of Registered Nurses of Nova Scotia.
- have a graduate degree in a relevant field.
- have demonstrated skills in a range of treatment modalities.
- have professional training and experience in providing therapy.

Community Outreach Workers will:

- be registered (or candidate for registration) with a relevant professional regulatory body in Nova Scotia, such as the Nova Scotia Association of Social Workers, Nova Scotia Board of Examiners in Psychology, or the College of Registered Nurses of Nova Scotia.
- have an undergraduate and/or graduate degree in a relevant field.
- have demonstrated skills in a range of treatment modalities.
- have education and/or training in community development.
- have professional training in providing counseling and/or therapy.

Community Health Workers will:

- have completed a recognized college or university program (minimum two years) providing intensive, supervised counselling skills training and focused education on counselling-related issues, preferably specific to the field of addictions.
- have knowledge of addiction and recovery processes, as well as an understanding of and flexibility in using diverse treatment approaches, including harm reduction.
- have knowledge of recovery-based self-help. (Preferred)

Support Staff will:

- Have completed a recognized administrative assistant/executive assistant program/diploma/degree.
- Have a high degree of interpersonal and organizational skills.
- Have general knowledge of the field of addictions.

Clinical Hours:

For clinical staff, 75% of work hours should be devoted to providing direct counselling and/or therapy to clients (individual, couple, family, group). This may include assessment, counselling, group work.

Target Group

Individuals or families and others affected by substance use and/or problem gambling.

Admission Criteria

Refer to procedures outlined in the Intake, Assessment, Enhanced Assessment, and Case Noting Service Standards and Best Practices.

Retention Criteria

Refer to procedures outlined in the Intake, Assessment, Enhanced Assessment, and Case Noting Service Standards and Best Practices.

Guidelines for Dismissal

A client may temporarily be refused service for:

- violent or threatening behaviour towards staff and/or other clients,
- harassment,
- inappropriate sexual behaviour, or
- criminal activity onsite (theft, assault, drug dealing, etc.).

Criteria for Case Closure

- Client achieves treatment goals or upon mutual agreement.
- Three-months inactivity.
- A client voluntarily withdraws from treatment.
- Clinical staff and/or client anticipate no further benefit of treatment.
- Not the appropriate service to meet client needs (i.e., issues may not be addiction-related or other issues take priority).

Guidelines for Case Closure

- A discharge note must be entered in the client record (in keeping with the Content Standards for Closure Notes).
- Whenever possible, clinical staff should discuss closure and follow-up plan with the client.
- The client should be notified, in writing, if case closure has not been discussed with the client.
- Case closure initiated by clinical staff against a client's wishes should be discussed with the supervisor/team and noted in the client's file.

COMMON PROVINCIAL PRACTICES

Advocacy

Clinical staff advocate on behalf of clients. Advocacy may occur at a macro level for healthy public policy or micro level, such as to secure housing, employment, or facilitate access into other Addiction Services and public support systems. When advocating, clinical staff should follow appropriate Addiction Services or District Health Authority communication policies and Prevention and Community Education Service Standards and Best Practices.

■ Behavioural approaches

Several behaviour therapies are supported in the literature for the treatment of people with alcohol problems (Health Canada, 1999). These include: behavioural relapse prevention, behavioural self-control therapy for those with less severe drinking problems and the use of behavioural contracting.

■ Brief interventions

Studies indicate that for select groups brief interventions (up to eight sessions) are as effective as long-term interventions (Health Canada, 1999). Individuals with good social supports and less severe alcohol dependence are more likely to benefit from these low cost interventions.

■ Case Management

Case management refers to the coordination of addiction and community services that may be needed by a client during the course of treatment. Depending on need, case managers may adopt a variety of roles and functions including advocacy, referral, crisis intervention, coordinator, and the assessment of relapse potential (Csiernick, 1993).

Individuals with substance use and/or gambling problems may have issues that require a number of different treatment services. Providing a range of services to such clients requires coordination, which is the goal of case management. The key components of Community-Based Services case management include:

- Linking clients to the appropriate services.
- Sharing of client information among service providers within the health system as permitted by law (e.g., sharing between staff of Addiction Services and Mental Health does not require client consent), to ensure comprehensive and collaborative treatment of clients with concurrent needs.
- Monitoring and evaluating client progress through the continuum of care.
- Interceding/advocating on behalf of the client to ensure that the treatment system responds to their needs (Health and Welfare Canada, 1992).

■ Community Development

Community development is an approach where staff, and Addiction Services as an organization, are committed to broad changes in the structure of power relations in society through the support they give community groups (Minkler, 1997). This is an appropriate approach to promoting empowerment of communities and self-efficacy in relation to addiction and broader health issues (see Prevention and Community Education Service Standards and Best Practices).

■ **Community Outreach**

Community outreach is an essential component of Community-Based Services. Booth, et al.(as cited in Health Canada, 2001a) found that clients in contact with community outreach workers were more likely to enter into treatment.

■ **Community Reinforcement Approach (CRA)**

CRA is an all-inclusive approach utilizing social, recreational, family and vocational interventions to help the client overcome problems associated with addictions. There is good evidence to support the effectiveness of CRA for clients with alcohol problems (Health Canada, 1999)

■ **Couples Counseling**

Couple conflict can be the source or the result of addiction problems within a relationship (Meyers & Smith, 1995). Relationship issues should be addressed to sustain long-term effects from addiction therapy. There is good evidence indicating that providing therapy to strengthen communication, problem-solving skills, and enhance positive reinforcement between couples is beneficial in improving the relationship over the long-term (Health Canada, 1999).

■ **Culture and Spirituality Awareness**

Addiction Services recognize and respect the role that spirituality and cultural traditions play in enhancing treatment outcomes.

■ **Employability**

Clinical staff provide vocational support by engaging clients in activities with the objective of preparing for, attaining, or maintaining employment, as outlined in the client's treatment plan.

■ **Family Outreach and Support**

Outreach, education, and support are offered to family members of the client. Azrin, et al. (as cited in Meyers & Smith, 1995) found that engaging significant others in the treatment plan lead to better treatment outcomes.

■ **Family Support, Education, & Counseling**

Substance use and/or gambling problems can impact individuals, couples, and families. Whenever possible all of the key stakeholders should be involved in a client's treatment plan.

Gender-specific approaches

Where possible programs should be designed and implemented to address the gender-specific needs of clients.

Group work

Studies show that group therapy is efficacious as well as cost-effective (Health Canada, 1999). Groups also provide a venue for clients to receive support and encouragement from individuals with similar problems (Health Canada, 1999). Community-Based Services offer information, education, treatment, support, and training group sessions. Depending on the group the sessions may be open or closed.

Harm Reduction

The main goal of Addiction Services is to reduce the harm associated with/or caused by substance use/abuse. The extent to which that harm will be reduced, and the exact methods used to achieve it will be determined by the nature of the problem experienced by the individual client or community, the needs of that client or community, and the capacity of that client or community to affect change and achieve the reduction of harm. Community-Based Services work with clients at all points along the harm reduction continuum.

Key Approaches and Strategies

The key components of Community-Based Services include:

- comprehensive and ongoing assessment (see Best Practices: Intake, Assessment, Enhanced Assessment, Case Noting),
- individual treatment planning, and
- a case management approach.

Mandatory Referrals

A mandatory referral occurs when an individual is ordered by a legitimate authority (Probation Services, Family & Children's Services, employers) to contact Addiction Services for assessment, education and/or treatment. Failure to follow through with the order can result in negative consequences. These individuals always have the option of ignoring the order.

Since Addiction Services does not and cannot mandate or force any client to attend, participate in, or remain in any of their services or programs, it therefore does not have mandatory clients. The client is the individual being referred, not the organization or individual making the referral. Addiction Services therefore has no obligation to provide any particular type or amount of service or information to a referring organization. Addiction Services only provides reports or information to an outside referring organization in accordance with a request made by the client (with an accompanying written consent).

Motivational Interviewing

Empirical evidence indicates that Motivational Interviewing is an effective therapy in the treatment of addictions. Through reflection and empathy, staff guide clients into making goals and becoming aware of obstacles that interfere with lifestyle changes needed to overcome their addictive behaviour (Miller & Rollnick, as cited in Skinner, 2003).

Peer Consultation

Peer consultation is valued and encouraged as a key element of professional practice. Peer consultation can be an aid in decision-making. It can provide an opportunity for peers to review difficult cases, verify treatment, and manage cases. Peer consultation provides a venue for professional development, reviewing literature and discussing best practices and ethical issues.

Prevention and Community Education

Community-based staff participate in a range of Prevention and Community Education programs. Clinical staff should follow the Best Practices Prevention and Community Education.

Relapse Prevention/Return to Use

Based on social learning theory, structured relapse prevention counselling is an outpatient cognitive-behavioural approach designed to help clients gain control over their substance use (Annis & Davis, 1989). Relapse prevention is a key component of Community-Based Services continuum.

Self-Help

Self-help has a significant history in working with Addiction Services and in linking clients to supports in the community. Addiction Services values this resource and the role of the self-help community in supporting recovery.

Social Supports and Leisure

For many clients, social and leisure activities revolve around substance use and/or gambling. Assisting the client to partake in healthy social and recreational activities decreases the risk for relapse (Meyers & Smith, 1995). The treatment plan should include strategies devised to encourage clients to take action towards establishing healthy social and recreational activities.

■ **Stages of Change**

The Transtheoretical Model (TTM) was developed from the understanding that people use different processes of change (consciousness raising, social liberation, reward, etc.) depending on their position in the cycle of change (Prochaska et al., 1994). Change occurs over time with people moving in and out of the stages of change: precontemplation, contemplation, preparation, action, maintenance, and in some cases termination. Effective therapeutic techniques vary depending on a client's stage of change.

Although lacking empirical evidence, TTM is widely used in the addictions field. The use of TTM has led to better assessment and treatment planning by clinical staff based on the stage of a client in the addiction continuum (Skinner, 2003).

■ **Stress Management, Relaxation and Coping Skills Training**

Evidence suggests that as an integral part of therapy, stress management is effective in the treatment of individuals with addiction problems (Health Canada, 1999).

■ **Trauma**

Although lacking empirical evidence, experts recommend a concurrent integrated approach to the treatment of post-traumatic stress disorders and substance abuse (Health Canada, 2001b). An example of a recognized program of this nature is Seeking Safety (Najavits, 2002).

■ **GLOSSARY**

Clinical staff

All staff who provide direct counselling and/or therapy to clients.

Determinants of Health

The range of social, economic and environmental factors which determine the health status of individuals or populations (WHO, 1998).

GROUPS

Information

A community activity to impart information to increase knowledge of a particular topic area.

Education

The goal of an education program is to enhance knowledge and influence positive attitudes and/or behaviour – this is not therapy. It may be in single or multiple sessions

Treatment

In this process-oriented group, participants are brought together to explore, in depth, issues that affect participants' lives and recovery. The goal is to bring about change in attitude and/or behaviour through a therapeutic process. The process is emphasized over the information. Participants are registered clients and may also include significant others.

Support

The goal is to maintain progress and to encourage ongoing growth. The group focuses on recovery supports.

Training

The goal is to provide specific skill acquisition in early identification and intervention, and program delivery. Service is provided to community agencies and groups.

Open

Open groups are flexible and ongoing, with transitional participants. Open groups are best suited for education and support group formats.

Closed

Closed groups are time limited, usually therapeutic, with consistent participants. Participants are referred based on assessment. The group is considered part of the treatment plan.

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PREVENTION AND COMMUNITY EDUCATION

Prevention, health promotion and community education is community-based programming that addresses the full continuum of risks based on accurate, current information. Evidence-based, effective strategies are focused on addictions-related issues with the goals of promoting health, enhancing health and reducing/minimizing harms associated with substance use and/or gambling.

■ COMMUNICATION

Communication may be defined as the exchange and sharing of information, attitudes, ideas, or emotions. It includes a combination of media, interpersonal communication, and events used to communicate health information (University of Toronto, Health Communication Unit, 1998).

■ Objectives

- 1 To create awareness about the impact and the harms associated with substance use and or gambling, and effects on individuals, families, and communities.
- 2 To promote knowledge and awareness of available prevention and treatment programs and services.
- 3 To respond on a timely basis to emerging addiction issues on provincial and local levels with accurate, current, and valid information.

■ **Standard Measurements**

1 Accessibility

Addiction Services ensures a timely provision of service as indicated by:

- media requests are responded to within 24 hours.
- other requests are responded to within five business days.

2 Program Reach

The volume of public communication will be reported annually for each DHA:

- number of requests for information print items and the number distributed.
- number of radio exposures (broadcasts X listening audience).
- number of television exposures (broadcasts X listening audience).
- number of print media exposures (articles, news, special issues, advertisements of services {excluding employment advertisements} X circulation).
- number of Addiction Services website hits.

The District Health Authority's standard for communication will be followed.

■ FACILITATION OF LEARNING

Facilitation of learning is a key strategy that involves (a) providing accurate information about the impact and the harms associated with substance use and/or gambling, (b) exploring a range of views and opinions about the impact and the harms associated with substance use and/or gambling, and (c) developing a range of skills which help people make informed - less harmfully impacted - decisions about substance use and gambling. Because of the significant differences in service intensity and outcomes, Facilitation of Learning is structured around the concepts of Awareness Programs, Education Programs, and Skill Building Programs.

Awareness Programs increase the level of public information concerning Addiction Services.

Education Programs enhance knowledge and influence positive attitudes about substance use and/or gambling issues and the associated harms.

Skill Building Programs provide specific skill acquisition based on an effective learning process.

■ Objectives

- 1 To enhance community capacity to address substance use, abuse and/or gambling issues.
- 2 To influence attitudes about substance use and/or gambling and the associated harms.
- 3 To influence behavior change in order to reduce/minimize the harms associated with substance use and gambling.
- 4 To reinforce positive behaviors.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of programs that facilitate learning as indicated by:

all programs are scheduled within 10 business days of request(s).

2 Program Reach

Annual reports of awareness, education, and skill building programs record the number of events that have occurred and the estimated population reached for each type of program based on each DHA.

3 Positive Impact

Addiction Services clients identify a positive impact as indicated by:

10% of the **awareness** programs are evaluated utilizing a common checklist by the agency or organization requesting the program. Results are summarized annually based on each DHA.

100% of new **education** programs and 25% of existing programs are evaluated utilizing a program specific, participant self report based on a common template. An organizer's report template is utilized for external agency feedback. Results are summarized annually based on each DHA.

75% of participants report satisfaction with **education** programs as indicated by a standardized satisfaction survey at the program conclusion. Results are summarized annually based on each DHA.

100% of **skill building** programs are evaluated utilizing a program specific, participant self report based on a common template. Results are summarized annually based on each DHA.

75% of participants report satisfaction with **skill building** programs as indicated by a standardized satisfaction survey at the program conclusion. Results are summarized annually based on each DHA.

Outcome monitoring process is utilized for **skill building** programs. Results are summarized annually based on each DHA.

School settings - within the school year, at minimum of two months post program,

Health settings - minimum of three months post program,

Community settings - minimum of three months post program.

■ ENHANCING COMMUNITY HEALTH

Enhancing Community Health refers to a collection of broad Population Health activities that are:

- 1 focused on addiction-related issues and;
- 2 based on community needs and assets.

The impact of addiction on the determinants of health and on the overall health status of the population is extensive and multi-faceted. Similarly, approaches and strategies to ameliorate problems, to reduce and minimize their negative impact and more generally, to promote, maintain and restore health must be broad and comprehensive.

COMMUNITY MOBILIZATION

Community Mobilization is a common process that draws together a number of groups or organizations into collaborative actions around a specific topic, issue, or event. The purpose of community mobilization is to increase participation of communities in addiction issues by mobilizing community groups and organizations to select the issue and enhance and utilize the capacities inherent in the community.

■ Objectives

- 1 To build relationships with groups and organizations for mutually beneficial problem solving regarding substance use and gambling issues within communities.
- 2 To assess and mobilize the community's assets for sustainability of program(s) that address substance use and gambling issues.
- 3 To leverage strategies, approaches, activities and resources from outside the community to support locally defined development.
- 4 To provide accurate information to community groups and organizations about substance use and gambling.
- 5 To facilitate the development of strategies and/or policies to enable communities to take action on minimizing/reducing the harms associated with substance use and gambling.
- 6 To work closely with groups, such as Community Health Boards (CHBs), to include strategies in their health plans that minimize/reduce the harmful consequences of substance use in their communities.

■ Standard Measurements

- 1 The number of activities related to community mobilization:
Initiated,
Continued,
Concluded,
Discontinued,

will be reported each year. 80% of the activities related to community mobilization initiated will be concluded within one year.

- 2 The status (including implementation) of the activities related to community mobilization will be reported yearly, through qualitative program/staff reporting.

ADVOCACY

Advocacy involves strategies for influencing change in public policy to affect the health status of the population. It may be defined as “working for political, regulatory or organizational change on behalf of a particular interest groups or population” (Green & Kreuter, 1991). The ultimate goal of advocacy in addiction prevention and community education is to create changes in policies that improve the health of individuals, communities and organizations.

■ Objectives

- 1 To mobilize individuals, organizations, and communities to take action on substance use and gambling related issues.
- 2 To improve the health of individuals and communities impacted by substance use and gambling.
- 3 To reduce the stigma associated with substance use and gambling-related disabilities.

■ Standard Measurements

- 1 The number of activities related to advocacy:
Initiated,
Continued,
Concluded,
Discontinued,

will be reported each year. 80% of the activities related to advocacy initiated will be concluded within one year.

- 2 The status (including implementation) of the activities related to advocacy will be reported yearly, through qualitative program/staff reporting.

POLICY

A Policy is a set of principles or plan of action that guides present and future decision making. It refers to the rules that govern an organization, an administration, a community, a province or a country (Green & Kreuter, 1991; Badovinac, 1998).

■ Objectives

- 1 To create greater awareness about the impact of public policy on health (the health consequences of public and organizational policy).
- 2 To promote and support the development of healthy public policy in relation to substance use and gambling through an intersectoral approach.

■ Standard Measurements

- 1 The number and kind of policy initiatives introduced, engaged in or supported (e.g. Provincial Statutes or Policies, Municipal ByLaws, School Board Policies, etc.) will be reported each year.
- 2 80% of policy initiatives will result in positive outcomes, or the achievement of positive milestones, as identified through qualitative program/staff reporting.
- 3 Volume benchmarks will be reported annually for each DHA.
- 4 The status (including implementation) of policy initiatives will be reported yearly.

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PREVENTION & COMMUNITY EDUCATION BEST PRACTICES

DESCRIPTION

Prevention, (health promotion), and community education (P&CE) is community-based programming that addresses the full continuum of risks based on accurate, current information. Evidence-based, effective strategies are focused on addictions-related issues with the goals of promoting health, enhancing health and reducing/minimizing harms associated with substance use and/or gambling.

GUIDING PRINCIPLES

Guiding principles provide directions on how to create effective prevention programs. These principles are based on the general philosophy that guides the organization's approach to addictions.

Addiction Services has general guiding principles that guide all initiatives within the organization including strategies, target populations, resources, and staffing. Common provincial practices are specific principles guiding the implementation of each Addiction Services' program component (see Section D).

1 Strategies (Programs/Services/Policies)

- Have a rationale – clear aims & objectives.
- Fit the mission and mandate of Addiction Services.
- Have a commitment to communities served.
- Are delivered within the community.
- Are provided without charge (or are cost-recoverable).
- Are regularly evaluated.
- Are available to a wide variety of audiences including the general public, other service providers, schools, workplaces.
- Are evidence-based.
- Reflect current trends in the field of addictions.
- Are designed to be proactive and not solely reactive.

2 Audience (Population of Interest)

- Are consulted/involved in determining the nature of program to be provided/strategy to be developed or applied.
- Are referred to other agencies & community resources for assistance/information whenever appropriate.

3 Resources

- Reflect the most current information available.
- Are “balanced” in issues presented, where possible.
- Include print and electronic references.
- Are Nova Scotian and/or Canadian in content wherever possible.
- Support audience-identified learning needs and assets.

4 Staffing

Prevention and community education staff are responsible for coordinating initiatives to reduce the harm associated with addictions. Staff are required to have a minimum of Masters level education/training or comparable experience in prevention/education/health promotion. Demonstrated skills in organizational development, ability to work with diverse groups, effective communication skills both verbal and written, and project management/negotiation skills are integral to success.

Addiction Services staff should:

- Participate in professional development opportunities;
- Remain current in knowledge and best practices;
- Work collaboratively with participants and communities;
- Ensure program/service goals relate to identified priorities;
- Facilitate ongoing program evaluation; and
- Respond to requests in a timely fashion.

5 Volunteers

Volunteers are a valuable contribution to the development and the delivery of services. Their experiences and insights help to insure that programs meet the needs of various groups. Frequently, they have a personal commitment to the addictions field and are partners in the process of providing service both in prevention and in treatment.

- Are appropriately recruited.

Volunteers are recruited based on clearly designated skill levels necessary to fill a need, and the time commitment is clearly defined.

- Have a clearly defined relationship with the agency.

Volunteers need clearly articulated terms of reference which outline appropriate parameters for their activities.

- Have a meaningful role.

Volunteers must perceive that the work they are doing is relevant, valuable, and appropriate for their skill level and time commitment.

- Are appropriately screened.

Screening is an ongoing process designed to identify any individual who may harm children, youth or any other vulnerable persons. It has two main purposes: the protection of clients from potential abuse, and the reduction of liability.

- Receive a comprehensive orientation.

Volunteers need information on a variety of levels to ensure their own comfort and safety, the comfort and safety of clients, and to increase their ability to provide a service. The orientation should include knowledge specific to the position with the organization, the physical set up of the various sites, emergency procedures, as well as mandatory training.

- Are adequately supervised.

Volunteers should receive supervision that is fair, consistent, respectful, and maintains trust. The level of supervision must be determined based on the level of assignment and the skill level of the volunteer.

- Participate in regular training opportunities.

Volunteer development includes keeping information and skills training current, and identifying volunteers who want and are capable of more complex assignments.

- Are regularly evaluated (feedback).

Volunteer interest and satisfaction are increased by knowing on a timely basis whether the quality of the work they are doing is acceptable.

- Are appropriately recognized.

Volunteers need affirmation of the value of the work that they do for the organization. Recognition activities should match the volunteers needs and interests and should be designed in consultation with the volunteers.

OVERVIEW OF STANDARDS

Addiction Services designated Best Practices and Standards Task Groups to identify objectives, standards and best practices for all major program elements in the continuum of care. **Addiction Service Standards** have been published. This Best Practice document is based on the Service Standard and provides suggestions for target groups, staffing, and content for program elements.

Within Prevention and Community Education, programs fall into three general categories: communication, facilitation of learning (awareness programs, education programs, skill building programs), and enhancing community health (community mobilization, advocacy, policy). Although individual best practices have been identified for each prevention component, all objectives, standards, and guiding principles are consistent with the universal best practices which guide all operations of Prevention and Community Education. These individual components fit together to ensure that the role of prevention in the continuum of care is fulfilled in an adequate and comprehensive manner.

Communication

Communication may be defined as the exchange and sharing of information, attitudes, ideas or emotions. It includes a combination of media, interpersonal communication and events as used to communicate health information (University of Toronto, Health Communication Unit, 1998). Within prevention and community education, the purpose of communication is two-fold: 1) as a means to accomplish program goals (e.g., to create awareness, to educate), and 2) for public relations purposes. Communication tools include media collaboration/media advocacy, publications, and resources such as web sites and pamphlets (Addiction Services, Western Region, 2000).

Communication is a key strategy to inform the public about substance use, gambling, and other addictions issues, as well as to maintain important issues on the public agenda. Traditional print media, as well as other mass and multi media and other technological innovations are employed to disseminate information to the public, increase awareness of specific aspects of individual and collective health as well as importance of health in development (WHO, 1996).

Communication within Addiction Services includes formal and informal responses to meet public need/demand for accurate information that is locally applicable. Information dissemination is characterized by one-way communication from the source to the audience with limited contact between the two. This approach traditionally involves the provision of information about the nature of the drug problem, and about the physical and psychological effects of the various drugs. Although this method by itself has been shown to be ineffective (Botvin, and Botvin, 1992; Tobler, 1992), it is considered to be an important piece of a broader strategy to form a basic foundation of knowledge, and to meet public demand for this service (Youngstram, 1991).

In order to maximize the effectiveness of information dissemination, several specific approaches should be incorporated:

- **Creation of Good Information Resources:** It is necessary that current, accurate, plain language, population-specific information resources be available throughout the province. These resources should be produced and presented at a level of quality which makes them attractive to the public and promotes their use.
- **Strategic and Integrated Delivery Systems:** Dissemination of information needs to be integrated into existing systems that have the best potential to reach specific target groups. For instance, this could involve the delivery of relevant addictions-related information by mental health staff and the delivery of relevant information by physicians to adolescents (for example; information regarding FAS/FAE to pregnant teens, information regarding drugs, sex, and related harms for adolescents who are known by physicians to be sexually active).
- **Using Current Technology:** The Internet is considered an effective way to provide the public with easy access to information. Content can be continually up-dated without the expense or time delay of other methods. It also allows for the provision of more population-specific (e.g., adolescent males/females,

homosexual youth, African Nova Scotian youth, Aboriginal youth) information than is possible in the context of printing costs and logistics. This ability to target populations so specifically, even though they may be relatively small, is valuable in that culture-specific programming has been shown to be more effective than generic approaches (Botvin et al., 1995; Geronimus et al., 1993; and Winick, 1995).

- **Using Mass Media:** The use of mass media (radio and television) is one method of providing information to populations who may not be reached through other information strategies – adolescents who have dropped out of school, those who are not likely to attend community programs, and those with low literacy skills who therefore cannot make use of printed materials. Whether this is used for factual information about substances, harms, and responsible use, or for information about support or treatment services, mass media can be an effective means of delivery to this perhaps disconnected or disenfranchised population. As well, media can be a useful tool in generating public support for, and participation in other effective initiatives in the area of public policy (Stead et al., 1996; Health and Welfare Canada, 1992).

Objectives

- To create awareness about the nature and extent of the harms associated with substance use and or gambling , and effects on individuals, families, and communities.
- To promote knowledge and awareness of available prevention and treatment programs and services.
- To respond on a timely basis to emerging addiction issues on provincial and local levels with accurate, current and valid information.

Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of service as indicated by:

- media requests are responded to within 24 hours.
- other requests are responded to within five business days.

2 Program Reach

The volume of public communication will be reported annually for each DHA:

- number of requests for information print items and the number distributed.
- number of radio exposures (broadcasts X listening audience).
- number of television exposures (broadcasts X listening audience).
- number of print media exposures (articles, news, special issues, advertisements of services {excluding employment advertisements} X circulation).
- number of Addiction Services website hits.

The District Health Authority's standard for communication will be followed.

3 Specific Guidelines

- To utilize resources appropriately, minimize duplication, and ensure accuracy of information, all communication requests will be processed through the P&CE offices. P & CE staff will coordinate with clinical staff, pharmacologists, and District public relations/communications staff, as required.
- All media requests will be directed to the Director of Addiction Services or P&CE staff; each District service will designate operational procedures based on input from District public relations/communications staff, as required.
- Speaking engagement requests will be delivered by appropriately qualified staff.
- For each communications activity, a response plan will be developed with clear delineation of the process and time lines. Stakeholders (e.g., print, broadcast, and electronic media, public relations officers, volunteers) will be involved in the development of the plan.
- Mass media campaigns may be used to change substance-related knowledge, attitudes, and behaviour.
- Workplace/community programs (e.g., wellness fairs) may be used to increase community awareness of drug abuse/addictions issues.
- Public Service Announcements may be used.
- A provincial addictions web site with up-to-date accurate facts and links may be developed.
- Information provided is current, accurate and locally applicable.
- Materials will be purchased from other Canadian organizations (when necessary and available).
- Promotional items ordered will be of high quality.
- Resource materials and promotional items will be reviewed at least yearly by a pharmacologist and P&CE staff for relevancy, accuracy, and appropriateness, and those found to be inappropriate will be discarded or updated.
- A mechanism to determine process for revision or discarding is implemented and followed.
- The provincial network of P&CE staff will maintain a list of emerging issues to be prioritized for preparation of an agency-wide communications response.
- The flying star will be maintained as the logo for Addiction Services in Nova Scotia.

4 Target Group(s)

Affiliated volunteers, general public, individuals & groups (e.g., parents, youth, women, seniors, allied professionals), informal organizations (e.g., Kinsmen) and formal organizations (e.g., Children's Aid), communities, and media.

Facilitation of Learning

Facilitation of learning is a key strategy that involves (a) providing accurate information about the impact and the harms associated with substance use and/or gambling, (b) exploring a range of views and opinions about the impact and the harms associated with substance use and/or gambling, and (c) developing a range of skills which help people make informed - less harmfully impacted - decisions about substance use and gambling. Because of the significant differences in service

intensity and outcomes, Facilitation of Learning is structured around the concepts of Awareness Programs, Education Programs, and Skill Building Programs.

Awareness Programs increase the level of public information concerning Addiction Services.

Education Programs enhance knowledge and influence positive attitudes about substance use and/or gambling issues and the associated harms.

Skill Building Programs provide specific skill acquisition based on an effective learning process.

This strategy includes delivering education and/or training as indicated in current research as being most effective, and typically involves one of two approaches:

1 Direct Education

This may take the form of presentations, discussions, or skills training sessions with various audiences as well as homogeneous groups identified as having significant involvement in, or harms resulting from drug use. (NIDA, 1997)

2 Training of Allied Professionals

This strategy involves educating and training various professional groups, organizations, or individuals about how to integrate drug abuse prevention work in their interactions with clients. These groups could include teachers, guidance counselors, doctors, public health nurses, and staff or volunteers of youth centres, boys and girls clubs, treatment staff in Addiction Services. There is good reason to believe that such training of parents (NIDA, 1997), and other professionals (Botvin et al., 1990; Dusenbury & Falco, 1995) will enhance the effectiveness of addictions prevention efforts.

Training is distinct from direct education. In keeping with the mission and mandate of Addiction Services, training initiatives must consider efficiency and long-term maintenance of these important capacity-building initiatives. To provide this assurance of quality and long-term stability, it is important to integrate prevention and early intervention training into existing formal education and training programs. Such programs may include Bachelor of Education programs, Bachelor of Science in Nursing programs, etc. Addiction Services can provide or initiate and contribute to the provision of current, effective education and training in such programs. This helps to ensure that all new professionals entering the workforce in many of these relevant occupations are prepared in advance to contribute to the healthy development of their clients. In the long term, this could provide a more efficient system for training these professionals.

Addiction Services in-servicing can then be focused on more minor updates, revisions, and enhancements to the knowledge and skills already held by those individuals, and on the sharing of information and experience between those workers who are familiar with the field.

Objectives

- To enhance community capacity to address substance use, abuse and/or gambling issues.
- To influence attitudes about substance use and/or gambling and the associated harms.
- To influence behaviour change in order to reduce/minimize the harms associated with substance use and gambling.
- To reinforce positive behaviours.

Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of programs that facilitate learning as indicated by:

- all programs are scheduled within 10 business days of request(s).

2 Program Reach

Annual reports of awareness, education, and skill building programs record the number of events that have occurred and the estimated population reached for each type of program based on each District Health Authority (DHA).

3 Positive Impact

Addiction Services clients identify a positive impact as indicated by:

- 10% of the **awareness** programs are evaluated utilizing a common checklist by the agency or organization requesting the program. Results are summarized annually based on each DHA.
- 100% of new **education** programs and 25% of existing programs are evaluated utilizing a program specific, participant self-report based on a common template. An organizer's report template is utilized for external agency feedback. Results are summarized annually based on each DHA.
- 75% of participants report satisfaction with **education** programs as indicated by a standardized satisfaction survey at the program conclusion. Results are summarized annually based on each DHA.
- 100% of **skill building** programs are evaluated utilizing a program specific, participant self-report based on a common template. Results are summarized annually based on each DHA.
- 75% of participants report satisfaction with **skill building** programs as indicated by a standardized satisfaction survey at the program conclusion. Results are summarized annually based on each DHA.
- Outcome monitoring process is utilized for **skill building** programs. Results are summarized annually based on each DHA.

School settings - within the school year, at minimum of two months post program.

Health settings - minimum of three months post program.

Community settings - minimum of three months post program.

Specific Guidelines

- Evaluation measures for each type of program are clearly identified.
- All programs must have a program plan.
- All programs are designed to reflect age, gender, and/or culture of the target audience.
- Relevant stakeholders are involved in the planning process.
- A program planning model is used.
- For awareness programs, common questions for an evaluation checklist based on program objectives will be utilized.
- For education programs, the emphasis is on a systems approach (group versus individual presentations).
- A combination qualitative/quantitative self-report evaluation form, based on program objectives will be utilized for education programs.
- Skill building programs, the emphasis is on encouragement of other agencies to identify their proactive roles and continued ownership of learning initiatives.
- A concise participant satisfaction form will be utilized for skill building programs.
- Multiple learning strategies are used.
- Populations of interest are involved in the planning process.
- Resources utilized are appropriate for participants.
- Staff must be skilled/well-practiced in appropriate principles of learning for a diversity of populations and settings. Professional development opportunities will include peer-review, reflective practice, mentorship, and feedback from evaluations.
- Support of professional development for prevention and community education staff can include opportunities for peer-review, mentoring, specific skill development, etc.

Target Group(s)

- Individuals, groups, communities, organizations, and institutions where addiction issues are, or should be, a concern.

Enhancing Community Health

Enhancing Community Health refers to a collection of broad Population Health activities that are:

- focused on addiction-related issues and;
- based on community needs and assets.

The impact of addiction on the determinants of health and on the overall health status of the population is extensive and multi-faceted. Similarly, approaches and strategies to ameliorate problems, to reduce and minimize their negative impact and more generally, to promote, maintain and restore health must be broad and comprehensive.

Community Mobilization

Community mobilization is a common process that draws together a number of groups or organizations into collaborative actions around a specific topic, issue, or event. The purpose of community mobilization is to increase participation of communities in addiction issues by mobilizing community groups and organizations to select the issue and utilize the capacities inherent in the community.

Objectives

- To build relationships with groups and organizations for mutually beneficial problem solving regarding substance use and gambling issues within communities.
- To assess and mobilize the community's assets for sustainability of program(s) that address substance use and gambling issues.
- To leverage strategies, approaches, activities and resources from outside the community to support locally defined development.
- To provide accurate information to community groups and organizations about substance use and gambling.
- To facilitate the development of strategies and/ or policies to enable communities to take action on minimizing/ reducing the harms associated with substance use and gambling.
- To work closely with groups, such as Community Health Boards (CHBs), to include strategies in their health plans that minimize/reduce the harmful consequences of substance use in their communities.

Standard Measurements

1 The number of activities related to community mobilization:

- initiated,
- continued,
- concluded,
- discontinued,

will be reported each year. 80% of the activities related to community mobilization initiated will be concluded within one year.

2 The status (including implementation) of the activities related to community mobilization will be reported yearly, through qualitative program/staff reporting.

Specific Guidelines

- All groups within the community impacted by addiction related issues will be invited to participate in the process.
- When possible, resources will be made available to enable the full participation of less powerful groups.
- Community groups and organizations will explore a range of views and opinions related to addictions.

Target Groups

- Communities, organizations, groups, and institutions where addictions issues are, or should be, a concern.

Advocacy

Advocacy involves strategies for influencing change in public policy to affect the health status of the population. It may be defined as “working for political, regulatory or organizational change on behalf of a particular interest group or population” (Green & Kreuter, 1991). The ultimate goal of advocacy in addiction prevention and community education is to create changes in policies that improve the health of individuals, communities, and organizations. An example may include a media advocacy campaign to influence changes to smoking in restaurant by-laws in a small town.

Objectives

- To mobilize individuals, organizations, and communities to take action on substance use and gambling related issues.
- To improve the health of individuals and communities impacted by substance use and gambling.
- To reduce the stigma associated with substance use and gambling-related disabilities.

Standard Measurements

- The number of activities in the following areas related to advocacy:
 - initiated,
 - continued,
 - concluded,
 - discontinued,

will be reported each year. Eighty percent (80%) of the activities related to advocacy initiated will be concluded within one year.

- The status (including implementation) of the activities related to advocacy may be reported yearly through qualitative program/staff reporting.

Specific Guidelines

- Outcome measures are clearly identified (measures that indicate purpose has been achieved).
- Respects the community and enhances community capacity.
- Intersectoral collaborative action is utilized to encourage shared responsibility among policy-makers.
- Promotes health and supports social equity and justice.

- Advocacy staff may include prevention, community education and/or other agency staff, agency volunteers, agency advisory groups and relevant partners. The type of advocacy will dictate the required skill set, but all involved staff should possess above average communication, tact and diplomacy skills.

Target Groups

Advocacy is a process for changing the status quo, and may occur:

- at the level of the individual (to advance the interests of another or to push for changes in the way an individual behaves);
- to have an impact on the rules or practices operating at an institution; or
- to affect changes in public policy. (Badovinac, 1998)

Policy

A policy is a set of principles or plan of action that guides present and future decision-making. It refers to the rules that govern an organization, an administration, a community, a province or a country (Green & Kreuter, 1991; Badovinac, 1998).

Policy activities within the prevention field, for example, include working with schools and school boards to develop appropriate drug policies and supporting healthy public policy. Healthy public policy is a process in which the impact on a population's health caused by actions of sectors other than health (e.g., housing, environmental protection, agriculture) is politically recognized and non-health sectors begin to take greater accounting of how their policies affect health (Labonte, 1993). Healthy public policy includes legislation, fiscal measures, taxation and organizational change designed to promote health by supporting healthy lifestyles (e.g., smoking by-laws) and to achieve social equity and justice (e.g., reducing the risk of premature births by using social and economic policies to minimize the impact of poverty [University of Toronto, Centre for Health Promotion, 1998]).

Developing appropriate and comprehensive policies requires that everyone affected by a policy be included as a participant in the development process. This process must incorporate a strong commitment to including members of the general public, collaboration between different sectors, and an emphasis on capacity building within the community (Atlantic Health Promotion Research Center, 2001). With this approach to policy development, initiatives will be more sustainable and accepted by the community, as they feel a sense of ownership for the resulting policies.

Objectives

- To create greater awareness about the impact of public policy on health (the health consequences of public and organizational policy).
- To promote and support the development of healthy public policy in relation to substances and gambling through an intersectoral approach.

Standard Measurements

- The number and kind of policy initiatives introduced, engaged in or supported (e.g., Provincial Statutes or Policies, Municipal Bylaws, School Board Policies, etc.) will be reported each year.
- 80% of policy initiatives will result in positive outcomes, or the achievement of positive milestones, as identified through qualitative program/staff reporting.
- Volume benchmarks will be reported annually for each DHA.
- The status (including implementation) of the policies will be reported yearly.

Specific Guidelines

- Intersectoral collaborative action is imperative to encourage shared responsibility among policy-makers.
- Promotes health and supports social equity and justice.
- Respects the individual/community and enhances capacity.
- Prevention and Community Education staff should take the lead on policy initiatives, with involvement of clinical staff as required. P&CE staff must be knowledgeable about the impact of policy on health, and should have a demonstrated ability to work with diverse groups.

Target Group(s)

- Policy makers (including schools, organizations, government).

COMMON PROVINCIAL PRACTICES

Targeting Addiction Prevention & Community Education Programs

The target for any prevention program influences the type of program developed and delivered. This goes beyond age, gender or cultural considerations, although these factors also influence the type of initiatives undertaken. Using the typical primary/secondary/tertiary division of programming goals, the intended audience varies widely. Consequently, the types of programs deemed suitable also vary. For example, if primary prevention has the goal of preventing use or delaying onset of use, then the content and methodology of such a program will reflect this orientation. If the program is designated as secondary prevention, the goal should be to avoid or reduce the risks associated with involvement in substances or gambling, or help the individual return to non-use. If tertiary prevention is the purpose of the program, then the focus would be on reducing the consequences of harmful involvement.

An alternative approach to targeting prevention programs classifies interventions in terms of the intended audience, rather than the level of prevention. Using this approach, prevention programs fall into three general categories:

1 Universal prevention programs

- Programs target the entire defined population.
- All participants are assumed to share the same general risk, there is no individual assessment of risk.
- Goal is to delay or prevent the onset of use/involvement.

2 Selective prevention programs

- At-risk subgroup is identified by a number of characteristics which significantly increase their risk of substance abuse or problem gambling.
- Entire subgroup is targeted regardless of individual risk.
- Goal is to delay or prevent substance abuse.

3 Indicated prevention programs

- Target individuals experiencing early signs of substance use, abuse or related problems, but who do not have an individual assessment.
- Participants are recruited into the program.
- Goal is to halt the progression of substance abuse or problem gambling and reduce the risk of harm.

If prevention goals are established using the categories of universal, selective, and indicated programs, it may be easier to visualize the connections between addictions prevention and treatment, as the focus is the population rather than the type of service. It may also be possible to indicate staff involvement in these programs based on a required skill set rather than assignment to a particular role within the agency.

One example of the application of this classification system is the issue of adolescent substance use. The Nova Scotia Student Drug Use Survey (Poulin, C. & Wilbur, B. 2002) clearly indicated a substantial and growing number of adolescents experiencing problems with their use. However, many of these youth do not seek help. Using a selective approach to target youth, the resulting program will be designed to focus more clearly on this subgroup of youth needs. This may result in more success in reducing the harms associated with substance use in this population.

Evaluating Addiction Prevention and Community Education Programs

A comprehensive program evaluation provides an extremely useful tool to manage ongoing work, identify successes, and plan effectively for new health promotion initiatives (Health Canada, 1996). If conducted effectively, evaluation can:

- Account for what has been accomplished through project funding;
- Promote learning about which health promotion strategies work in communities and which do not;
- Provide feedback to inform decision-making;
- Contribute to the body of knowledge about health promotion;
- Assess the cost-effectiveness of different health promotion strategies;

- Position high quality projects for future funding opportunities;
- Increase the effectiveness of project and program management; and
- Contribute to policy development. (Health Canada, 1996)

Considering the multitude of benefits associated with effective evaluation, priority must be given to developing strategies and guidelines to plan appropriate evaluations in the field of addictions. Addiction Services has determined that adequate evaluation of the effectiveness of prevention activities, programs, or strategies in the field of addictions should include assessments of:

- Accessibility of services for individuals and communities;
- Participant satisfaction;
- Outputs of programs and services; and
- Outcomes (qualitative and quantitative).

Thorough evaluation should include clear outcomes in terms of knowledge, attitudes, skills, and behaviors. However, such evaluations have been virtually non-existent as a result of the complex processes and resource demands involved. Addiction Services has identified a need to increase efforts to measure clear outcomes of the services that are being offered, so as to indicate the impact on the health of a population.

A thorough evaluation combines different data types and different evaluation types. A combination of qualitative and quantitative data is necessary to identify and evaluate comprehensive goals, objectives, and outcomes. These data types should be used in combination and should include:

Process Evaluation - examines the extent to which a program or policy is achieving its goal and objectives, and reaching its intended audience.

Impact Evaluation - measures immediate changes resulting from the program or policy.

Outcome Evaluation - examines longer-term changes in health status and the determinants of health. Examples include changes in knowledge, awareness, behavior, as well as shifts in social, economic, or environmental conditions, and changes in public policy and health infrastructure. Outcome evaluation measures reductions in health status inequities between population sub-groups.

In keeping with Addiction Services' population health approach, a further need in evaluation has been identified – to move beyond the traditional focus on risks and clinical factors. In order to undertake strategies with the potential to affect entire populations, rather than only those individuals already experiencing poor health, evaluation tools must reflect this broad focus. New measures and sources of data must be explored that will provide insight on the health of populations and determinants of health, rather than just counts of diseases and treated patients.

Comprehensive evaluation of the programs and services offered by Addiction Services plays a critical role in accountability to the various audiences who are partners and have a stake in these initiatives. Addiction Services is accountable to a wide range of stakeholders, including program participants, staff, involved agencies

(e.g., schools and community groups), Community Health Boards, District Health Authorities, and the general public. Each stakeholder group may require different information and a different reporting strategy, but in all cases, Addiction Services must facilitate accountability for its initiatives and must demonstrate to stakeholders that quality programming has been provided. Evaluation which encompasses a broad range of outcome and process measures can ensure that accountability is effectively and consistently demonstrated to each stakeholder group.

Prevention

The general public often reserves the term “prevention” for interventions that occur before the initial onset of a problem. However, in the field of addictions, a much broader definition is applied to the term. Following this broad definition, prevention programs seek to minimize the effects of factors thought to support and/or encourage substance abuse and addictive behaviors. Thus, for work in the addictions field, prevention means:

- preventing or delaying onset of use;
- preventing escalation from use to harmful involvement;
- avoiding or reducing, as much as possible, the risks to health from harmful involvement; and
- helping others to identify problems of harmful involvement as early as possible and encouraging appropriate roles in support of any intervention.

Best practices literature indicates that prevention work is an ongoing process that must be constantly reassessed on the basis of results from existing strategies, as well as emerging research data. The literature also indicates that prevention goals are best accomplished through the application of multiple strategies, especially when they are used in combination. These strategies may include policy, communication, community mobilization, facilitation of learning, early identification and referral, and advocacy.

Prevention strategies must be thoroughly evaluated and analyzed, as prevention, by its very nature, is difficult to verify. If a condition or addiction is prevented, it is often impossible to prove that it would have otherwise occurred, or to demonstrate conclusively what the consequences of involvement with substances or gambling would have been. However, statistical analysis can be used to measure increases/decreases in school dropout rates or admissions to treatment, for example, which may be attributed to be the result of prevention measures.

Population Health

The concept of Population Health as an organizing model for primary health care rose to prominence during the 1990s. In 1994, the Population Health approach was officially endorsed in Canada by the Federal, Provincial and Territorial Ministers of Health in a report entitled, *Strategies for Population Health: Investing in the Health of Canadians* (Addiction Services, 2001).

Population Health is an approach to health that aims to improve the health of the entire population and to reduce inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health. These factors are known as “determinants of health”. (Addiction Services, 2001)

One aspect of this model that has implications for service delivery is the emphasis on determinants of health to address health issues at the population level. The determinants of health include income and social status, education, employment and working conditions, healthy child development and health services. If health is determined by the interaction of a number of determinants or factors, including but not limited to the health care system, then the application of a resource to remedy the health-inhibiting effects of a given factor could arise from a wide range of services and resources. A population health approach stresses the principle that health improvement goes beyond the framework of health care. It emphasizes that the health sector cannot, in and of itself, address the determinants of health, and that the determinants of health do not exist in isolation from each other. Therefore, it is essential to acknowledge the importance of mobilizing the other broad sectors that have an impact on the population’s state of health.

Within the broader field of health promotion, the population health approach must address the significant role of addiction in the framework. The relationship between addictions and health is often seen as a one-way association – addictions either cause poor health or are a result of poor health. Among those who view addiction as a determinant of health, it is often simply reduced to one of many “personal health practices” (Wynne, Wiebe, & Ah Shene, 1999). This approach fails to recognize the dynamic relationship between the determinants of health, addiction, and health outcomes (see section D2).

Health Promotion

From a health promotion point of view, health is seen as a capacity, a resource for everyday living and not merely the absence of disease. In this conceptualization, health is also seen as much more than a state determined by the healthcare system. In fostering or supporting healthcare, it is necessary to look well beyond the healthcare system.

Health promotion is the process of enabling people to increase control over their health and the conditions that determine their health (WHO, 1986). This approach also speaks to the need to examine the individual’s environment, as well as a person’s skills, attitudes and capacity for self-care, including ability to cope, as contributors to health. Health promotion is founded on a recognition that people live in and are influenced by their communities and that the health of the community can greatly influence the conditions contributing to the health of the individual.

As applied to prevention in the addictions field, a health promotion approach means a community and ecological focus, in which the “population of interest” is the community, a specific subgroup within that community or group of communities.

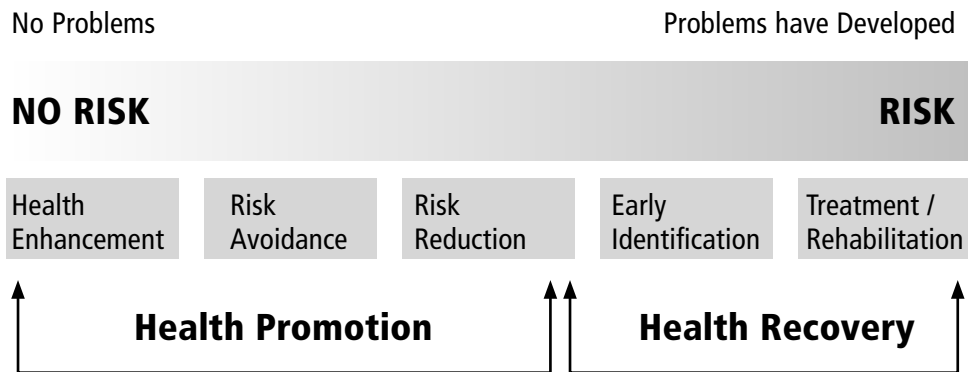
Activities incorporate a variety of methods or approaches including advocacy and policy development at the local level. Key to any approach is the involvement of the population of interest in the development and implementation of the strategy or activity.

From a health promotion perspective, an overall goal of prevention may be to foster healthy communities. In the addictions field this model may serve to focus work on either the individual or community level with specific long-term objectives of health enhancement, risk avoidance, and risk reduction.

■ The Role of Prevention in the Addictions Field

Part of Addiction Services' comprehensive approach involves providing programs and services which target individuals at all stages of the continuum of risk (Figure 1). This ranges from health enhancement for individuals who do not use substances, to treatment and rehabilitation for those individuals who are experiencing problems/harms as a result of their substance use. Within Prevention and Community Education, the focus is primarily on the left end of the risk continuum, which includes health enhancement, risk avoidance, and risk reduction. At the point of early identification of problematic use, the continuum focus is on harm reduction and health recovery.

Figure 1 **The Risk Continuum**



Adapted from the Ontario Ministry of Health: *A framework for the response to alcohol and drug problems in Ontario*, 1988.

As a result of Addiction Services' broad definition of prevention, the responsibilities of the Prevention and Community Education encompass much more than traditional primary or universal prevention programs. Staff use health promotion strategies that include initiatives to prevent the escalation of use to harmful involvement, and to reduce the harms experienced by those already involved with substance use and gambling. These strategies comprise the "Health Promotion" section of the continuum of care, while intervention and treatment/rehabilitation comprise the "Health Recovery" portion. It is important to note that the division between prevention and treatment may be much more clear on paper than in actual practice. Often in practice, the two service areas work together and may overlap, in order to provide seamless care for individuals at all stages in the risk continuum.

The field of prevention is continually evolving as the knowledge base expands and more evidence emerges from evaluations of existing prevention initiatives (CSAP, 1999). For example, critical reviews of substance use prevention initiatives have demonstrated that traditional primary prevention programs (usually consisting of dissemination of information about the physiological effects and potential harms of substance use) are largely ineffective at preventing substance abuse. Although such initiatives may lead to increased knowledge, these changes are not usually reflected in long-term assessments of attitudes or behavior (Fletcher, Stewart-Brown, & Barlow, 1997; Peters, Buijs, Kadijk, & Paulussen, 1997).

Although traditional information dissemination strategies have proven ineffective when used in isolation, there remains a place for such initiatives within the broader context of a comprehensive and multi-modal approach to prevention. Comprehensiveness in prevention programming entails utilizing a broad range of strategies which repeat and reinforce messages throughout the community and over time (Health Canada, 2001b). Broad, lower-intensity strategies such as information dissemination can be used to provide basic understanding and create increased awareness. In some cases, such strategies may also encourage certain individuals to contemplate changing risk behaviors or to seek more intensive programming (Health Canada, 2001b).

Selective programs (i.e., those targeting populations deemed at-risk) can be used to complement universal initiatives, as these programs tend to be more effective at addressing the individual needs of a population, and are more likely to elicit behavior change. Indicated prevention programs are the most intensive and targeted, and therefore the most costly. Ideally, a combination of universal, selective, and indicated prevention programs will be available in any given community, in order to effectively fulfill the role of prevention in the addictions field and address the needs of individuals across the continuum of risk.

Despite the relative lack of success demonstrated by many traditional prevention programs, evidence does exist to suggest that effective prevention initiatives can be successfully implemented in the field of addictions. The ideal approach entails the broad application of many diverse prevention strategies which complement treatment and rehabilitation efforts to provide seamless programming and service delivery throughout the continuum of care. However, the effectiveness of such an approach is likely to be the result of cumulative effects of all strategies, and may not be attributable to any one program or service (Health Canada, 2001b).

Strategic Process

Given the inevitability of resource constraints and controversy, it is essential that addiction prevention work be strategic in nature. That is, rather than being driven only by creative program ideas, political or academic preferences or ideologies, or familiarity and comfort with types of programs and services, prevention work needs to be based on specific goals. That is not to say there is no room for individual creativity, but rather that it must take place within the parameters set by a strategic approach.

Health promotion and population health can offer a broad framework that recognizes and credits the variety of aspects of prevention work in the addictions field. Specific addiction prevention strategies applied in an attempt to address various determinants of health involve multiple stakeholders within a multi-modal approach. An additional challenge emerges in developing programs that meet the Best Practices demand of the developing field of addictions in general. As a result, programs may be developed or implemented to meet increased demands for effective programming or an identified specific need. Programs can also be developed to meet a perceived gap in a comprehensive approach to prevention from a health promotion perspective.

With a strategic approach, it is necessary to first be very clear in understanding what the goals and objectives of prevention efforts are, from the level of a provincial strategy down to the objectives of a local program of service. One of the risks in this field is getting caught up in thinking that awareness and education are the ultimate goals, rather than seeing them as potential tools or objectives which can help attain the ultimate goal of improved health. This necessitates consideration of behavioural outcomes related to things such as level of consumption or harmful types of use. A strategic approach would select, create, or assign programs based on the probability that such outcomes may be attained. This approach entails assessing all existing and future programs in terms of necessity and appropriateness.

To the greatest extent possible, program and service decisions should be based on the best available empirical research at the time. In the absence of clear direction from the empirical findings, program decisions should be made on the basis of strong theoretical foundations which indicate potential to attain the stated outcomes. There is general agreement in the literature that further research is needed to refine existing prevention strategies and to identify how they achieve their effects, which types are best suited for what age group, and which are most likely to produce sustainable results over time (Jansen, 1996).

Some authors suggest that because of a lack of methodologically sound evaluations, there is insufficient evidence to assess the effectiveness of the range of approaches to substance use prevention (White & Pitts, 1998). Others suggest that enough evidence exists to support particular directions in prevention programs such as curricula based on social learning/behavioural foundations (Botvin & Botvin, 1992) and interactive teaching methods (Tobler, 1992). Still others hold a more generally positive view of the effectiveness of primary prevention curricula in the classroom (Dusenbury, Falco & Lake, 1997). There is sufficient evidence to recommend that new programs being contemplated for the classroom be thoroughly researched in order to delineate the best ingredient combinations for the particular situation in which it is applied. A body of literature can also be consulted for Best practices in such areas as community mobilization and organization or social marketing.

There is a need for clarity around these issues in order to allow for strategic prevention planning as opposed to purely opportunistic program development in response to situations that present themselves. The entire strategic planning process (which is very much akin to other concepts and terminology such as evidence-based

planning and program logic modeling) requires patience and sufficient planning. Staff throughout the province will benefit from clear and ongoing direction as to Best practices throughout the planning process.

Scientific evidence is very valuable to staff in the field of addictions in determining which programs and strategies are most effective. However, relying solely on an evidence-based model for Best practices has its limitations. Such an approach may lack consideration of the diversity of target groups, and may rely too heavily on published literature and randomized control experiments. Results of controlled scientific experiments may not be easily generalized to reflect the needs and resources of all communities and cultural groups. Also, this approach fails to acknowledge the valuable experience of professionals in the field of addictions. The input of these skilled and experienced practitioners can ensure that scientifically-proven approaches are also practical and feasible. The expert-consensus model (Health Canada, 2001a) proposes that expert opinions should be used to supplement the information provided by evidence-based research. An approach which combines the scientific rigor of controlled experiments with the practical knowledge of professionals in the field of addictions provides the most comprehensive method of determining which programs and strategies should be considered Best Practices.

■ **Comprehensive and Multi-Modal Approach**

The literature reflects a consensus that many factors, both internal and external to the individual, contribute to substance use and abuse decisions and behaviors (Stead, Hastings, & Tudor-Smith, 1996; Botvin & Botvin, 1992; Hawkins, Catalano, & Miller, 1992). Based on this position, there is agreement that a comprehensive, multi-modal approach has the best chance of being effective (Tobler, 1992; Health Canada, 2001b). In order to successfully address the full range of factors which may contribute to harmful involvement with substances and/or gambling, initiatives must be varied but well coordinated (Health Canada, 2001b). That is, programs and services must address all factors ranging from public policy to education, with all strategies informed by the same guiding philosophies and designed to complement one another.

Programming in Addiction Services is designed to act on various aspects of the lives and experiences of Nova Scotians simultaneously, rather than limiting the focus to any single issue or modality. Multiple strategies are directed at all levels – individuals, families, communities, sectors or systems, and society – and are designed to minimize the gaps between services and reinforce positive messages and behaviours throughout the community.

Collaborative Relationships

It is essential that effective communication and collaboration exist between programs and organizations that share responsibility for promoting or maintaining health. At one level, this means that staff in all program areas within each of the DHA's work on thinking holistically about providing the most comprehensive health promotion, prevention, and early intervention efforts. The benefits of effective collaborations and partnerships include:

- Improved staff effectiveness;
- Improved accessibility for clients;
- Reduced fragmentation of services; and
- Elimination of duplication of services. (Addiction Research Foundation, 1995)

A partnership exists when two or more health care or social service providers cooperate to address common problems, exchange resources, and build coalitions (Addiction Research Foundation, 1995). Using a collaborative approach to health promotion, a horizontal rather than hierarchical approach to managing health issues is encouraged. Agencies and organizations may need to take supportive rather than leadership roles in some instances as community members become active. At both a district and a provincial level, it is important that various sectors and organizations function in a collaborative way to provide comprehensive attention to the prevention of substance abuse. Clear, reciprocal understanding of programs, services, and procedures between services in the community, and the Departments of Education, Health, and Justice could improve overall service. This may translate into more effective prevention, in that any underlying risk factors may be dealt with more efficiently among the organizations. Collaboration is supported by effective communication and information sharing systems among the various organizations and departments. In many ways, collaboration is universal in nature, although to the extent that it enhances early intervention with specific high-risk populations or individuals, it could be either selected or indicated.

One caution to be considered is that building and maintaining collaboration of this nature is extremely time consuming and labour intensive. This process, therefore, has implications for the human resources required. It is also crucial that long-term partnerships be established on an organizational level, to ensure that these collaborations will be sustainable regardless of staff turnover and reassignment.

Volunteers - Description and Background

Addiction Services has a cooperative relationship with volunteers from the community. Many of the volunteers participate on Local Committees on Drug Awareness, which have operated autonomously in the community and function in an advisory capacity to Addiction Services. The Local Committees are made up of community members who are committed to the promotion of less harmful involvement with alcohol, other drugs, and gambling. When these committees conduct projects in the community, they rely on the credibility afforded them by their association with Addiction Services. A more formalized relationship between these

volunteers and the agency is becoming essential to protect the volunteers, the client, and the organization in light of the complex issues that arise within the topic of substance use and gambling.

A second category of volunteers associated with Addiction Services is comprised of community members who serve on Advisory Committees. These volunteers may be members of the general public, former clients of Addiction Services, or representatives of other community agencies (e.g., school boards). The committees serve as a body for citizen participation in the ongoing process of quality monitoring and improvement for Addiction Services. These committees operate on a regional basis, and may be referred to as Community Advisory Committees or Service Review Committees (CAC/SRC). Committee members are selected to represent the diversity of the population in terms of age, interest, and expertise.

The CAC/SRC members participate in efforts to ensure the comprehensiveness and quality of programs and services available in the community. Members may advocate for adequate prevention and treatment services, assist in evaluation of existing services, and communicate community concerns to Addiction Services. They may also act as resource personnel for the general public – disseminating health information and increasing awareness of available programs and services.

Evaluation of volunteer contributions and effectiveness of volunteer-run programs/ activities may help to further define and improve upon the important role that volunteers play in Addiction Services.

GLOSSARY

Best Practices

The set or sets of continually evolving actions and associated attitudes which are most likely to achieve health promotion goals in a given situation, and which are consistent with the values of health promotion (Kahan & Goodstadt, as cited in Centre for Health Promotion, 1999).

Determinants of health

The range of social, economic and environmental factors which determine the health status of individuals or populations (WHO, 1998).

Equity in health

Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being (WHO, 1998).

Enabling

In health promotion, enabling means taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health (WHO, 1998).

Goal

Program goals are descriptive, global statements of what a program is intended to achieve or produce. (Dignam, MB & Carr, PA. (1987) Program Planning for Health Education & Health Promotion. Philadelphia: Lea & Febiger.

Health outcomes

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status (WHO, 1998).

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve their health (WHO, 1998).

Health sector

The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related non-government organizations and community groups, and professional associations (WHO, 1998).

Intersectoral collaboration

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone (WHO, 1998).

Objective

A statement describing specific, measurable changes. An objective establishes a performance standard (Cottrell, Girvan, & McKenzie, 2002).

Partnership for health promotion

A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes (WHO, 1998).

Risk factor

Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (WHO, 1998).

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DRIVING WHILE IMPAIRED (DWI) PROGRAMS

The DWI Programs are provided for all persons suspended for, and/or convicted of, impaired driving offenses. In partnership with the Registry of Motor Vehicles (RMV), Service Nova Scotia and Municipal Relations, drivers requesting reinstatement must complete this program. An enhanced assessment is conducted to ensure clients are matched to the appropriate DWI Program.

Enhanced Assessment Standard Measurement

100% of clients entering the DWI Programs will have an enhanced assessment completed and attached to their file prior to program assignment.

■ **DWI BRIEF EDUCATION/INTERVENTION PROGRAM**

The DWI Brief Education/Intervention Program is designed for first offenders assessed as not having a problem with substance use.

■ **Objectives**

- 1 To provide education on safe driving and the effect(s) of alcohol/other drugs.
- 2 To provide education on the administrative and legislative consequences of impaired driving.
- 3 To provide an opportunity for clients to examine their alcohol/drug use and driving behaviour.
- 4 To assist clients in the development of a plan/strategy for avoiding problems associated with substance use, including driving while impaired.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of the DWI Brief Education/ Intervention Program who meet the admission criteria as indicated by:

100% of clients are able to access the program in their district of residence.

90% of clients are contacted within one business day to complete the intake process and initiate appropriate referral.

95% of clients are able to complete an enhanced assessment and program within 60 business days from the date of initial intake.

2 Retention and Connection to Continuum of Care

Addiction Services clients successfully complete the DWI Brief Education/ Intervention Program and are connected to other Addiction Services as indicated by:

85% of clients provide collateral information to Addiction Services as outlined in the Best Practices document.

100% of clients assessed as requiring addiction treatment services are referred to addiction treatment services.

98% of clients complete the program.

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of the program.

75% of clients report improved knowledge and skills as measured by a post-test upon completion of the program.

90% of clients do not re-offend within one year of license reinstatement as measured by RMV database.

80% of clients do not re-offend within two years of license reinstatement as measured by RMV database.

■ LEVEL I INTERVENTION PROGRAM (SHORT-TERM)

Level I Intervention Program (short-term) is designed for those assessed as (a) being in the early stages of substance abuse, (b) having a history of problems with substance use that is now under control*, or (c) having a problem with substance use and who have demonstrated a stable recovery process for at least the previous six months. (*Control means no indication of any negative consequences related to substance use over the previous six months.)

■ Objectives

- 1 To provide education about the roles of Addiction Services in relation to RMV and the applicable laws and regulations in Nova Scotia and Canada.
- 2 To provide education on safe driving and the effect(s) of substance use.
- 3 To provide education on the harms associated with substance use.
- 4 To review factors involved in impaired driving and determine the influence these factors have on the decisions to drive while impaired.
- 5 To provide an opportunity for clients to examine their substance use and driving behaviour.
- 6 To assist clients in the development of a plan/strategy for avoiding problems associated with substance use such as, driving while impaired.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of Level I Intervention Program (short-term) to clients who meet the admission criteria as indicated by:

100% of clients are able to access the program in their district of residence.

90% of clients are contacted within one business day to complete the intake process and initiate appropriate referral.

95% of clients complete the assessment and program within 60 business days from the date of initial intake.

2 Retention and Connection to Continuum of Care

Addiction Services clients successfully complete the Level I Intervention Program (short- term) and are connected to other Addiction Services as indicated by:

85% of clients provide collateral information to Addiction Services as outlined in the Best Practices document.

100% of clients assessed as requiring additional addiction treatment services at completion of the program are referred to Addiction Services.

98% of clients complete the program.

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey at the conclusion of the program.

75% of clients report improved knowledge and skills as measured by a post-test upon completion of the program.

85% of clients do not re-offend within one year of license reinstatement as measured by RMV database.

75% of clients do not re-offend within two years of license reinstatement as measured by RMV database.

■ LEVEL II INTERVENTION PROGRAM

The Level II Intervention Program is designed for those clients who, because of the severity of their problem, require services additional to those provided through the Level I Program. The Level II program has a focus on treatment and rehabilitation. The client continues the treatment process until the Level II goals, objectives, and treatment standards are met.

■ Objectives

- 1 To meet the objectives of the Level I Intervention Program.
- 2 To create awareness of the progressive nature of addiction and the recovery process.
- 3 To reduce the harm associated with substance use.
- 4 To improve the health of clients by promoting healthier lifestyles.
- 5 To motivate the clients' to continue in the recovery process by increasing the clients' knowledge of addiction recovery and support for a personal treatment plan.
- 6 To provide common group experiences for clients facing similar recovery issues.
- 7 To promote a proactive link between the Level II Program and Community-Based (Outpatient) Services and other resources in the community that enhance recovery options.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of the Level II Intervention Program to clients who meet the admission criteria as indicated by:

100% of clients are able to access the program in their district of residence.

90% of clients are contacted within one business day to complete the intake process and initiate appropriate referral.

95% of clients are able to complete the assessment and actively engage in a treatment program within 60 business days from the date of initial intake.

2 Retention and Connection to Continuum of Care

Addiction Services clients successfully complete the Level II Intervention Program and are connected to other Addiction Services as indicated by:

85% of clients provide collateral information to Addiction Services as outlined in the Best Practices document.

98% of clients complete the program.

3 Positive Impact

Addiction Services clients identify a positive impact on their lives as indicated by:

90% of clients report satisfaction with the service as indicated by a standardized client satisfaction survey.

75% of clients report improved knowledge and skills as measured by a post-test.

75% of clients will report a reduction in use and harms associated with their substance use 12-months after intake based on an anonymous standard self report survey.

75% of clients will report an improvement in health determinants 12 months after intake based on an anonymous standard self-report survey.

80% of clients do not re-offend within one year of license reinstatement as measured by RMV database.

70% of clients do not re-offend within two years of license reinstatement as measured by RMV database.

OUTCOME MONITORING

Outcome Monitoring System (OMS) is a common process to provide evaluation and accountability to specific groups including clients, staff, programs, services, district(s), provincial and federal governments, and the general public. The purpose is to maintain and enhance the quality of programs, provide data for future improvement, and evidence to support resource allocation.

■ Objectives

- 1 To provide a common provincial accountability process and content for service delivery as a key element in evaluation.
- 2 To provide reports that include a discussion of the findings for the shared service areas and the province.

■ Standard Measurements

- 1 100% of registered clients are asked to participate in OMS upon registration.
- 2 85% of clients who have been asked to participate give consent for OMS.
- 3 60% of clients who give consent complete the process.
- 4 Annual reports are published.

OUTCOME MONITORING

DESCRIPTION

The Outcome Monitoring System (OMS) is a common process to provide evaluation and accountability to specific groups including clients, staff, services, district(s), provincial and federal governments, and the general public. The purpose is to maintain and enhance the quality of programs, provide data for future improvement, and evidence to support resource allocation. The OMS also provides an opportunity for clients to reflect on their recovery experiences.

GENERAL GUIDING PRINCIPLES

OMS is designed to facilitate an internal/external audit of results, as required. OMS processes must be documented such that the steps are clearly defined, the population and non-response are determinable and the survey is replicable.

Addiction Services initiates the provincial OMS based on the completion of a Client Information Form (CIF) for all new registered clients accessing services for the first time within the district or shared service area. Data collection is continuous. The OMS is introduced to new registered clients during the completion of the CIF.

All eligible clients will be required to specify their agreement or refusal to participate in the 12-month follow-up process by completing and signing the Provincial OMS Client Consent Form. Treatment staff must witness the consent/refusal and write their unique client Statistical Information System (StatIS) ID number on the form. Any time during the treatment process, a client may refuse to participate.

OVERVIEW OF STANDARDS

Objectives

- 1 To provide a common provincial accountability process and content for service delivery as a key element in evaluation.
- 2 To provide reports that include a discussion of the findings for the shared service areas and the province.

Standard Measurements

- 1 100% of registered clients are asked to participate in OMS upon registration.
- 2 85% of clients who have been asked to participate give consent for OMS.
- 3 60% of clients who give consent complete the process.
- 4 Annual reports are published.

■ SPECIFIC GUIDING PRINCIPLES

■ Staffing

The OMS Facilitator is responsible for the general supervision and monitoring of all activities related to outcome monitoring.

■ Target Group

All new registered clients accessing services for the first time within the district or shared service area.

■ Specific Content

Treatment Staff

Treatment Staff are responsible for the following activities, which may be done on an individual basis or in groups.

The treatment staff will:

- Introduce the OMS to every eligible client.
- Provide a brief overview of the purpose of OMS (outlined on the Client Consent Form).
- Stress the importance of client feedback for future Addiction Services program delivery.
- Assure and explain confidentiality. In addressing confidentiality, staff will explain that to enable follow-up the surveys are not anonymous. However, the information clients provide will remain confidential and will be used only to determine aggregate results. Staff will not have access to individual results.
- Explain that the results will not be added to the client file.
- Ensure each client understands and signs the Client Consent Form outlining consent/refusal to participate in the system.
- For Community-based Services, the form must be completed by the end of the first visit (or when the CIF is completed). For inpatient services, it must be completed during the registration process.
- Stress the importance of completing the lower portion of the Client Consent Form so they can be located for follow-up (including a change of address if the client is planning to move prior to follow-up).
- Describe the context for the 12 month follow-up (e.g., short 5 to 10 minute interview by phone to complete the survey) and that a non-clinical staff person will be conducting the survey.
- If necessary, provide the client with the name of a staff person (or more specifically, the OMS Facilitator) so that they have a contact after signing the consent should they have any questions/concerns regarding follow-up.
- Respond to client questions/concerns (seek answers from Onsite OMS Facilitator or OMS Facilitator if they do not know the correct response).
- Ensure confidentiality of all eligible participants and their information by keeping them in a locked cabinet or area.
- Ensure the legible completion of the client contact information.
- Verify all sections of the consent form are completed.
- Sign the consent form, date it, and include staff ID.

Onsite OMS Facilitator

At each treatment site, one person may be designated as the Onsite OMS Facilitator for each program. Depending upon available resources, this may be either a designated Treatment or Administrative Support Staff person.

The Onsite OMS Facilitator will:

- Maintain supplies of Client Consent Form, Monthly Form Control Sheet, District or shared service area specific Client Data Form and Best Practices OMS document.
- Receive completed OMS forms from Treatment Staff.
- Screen for multiple consents and establish client eligibility.
- Review Client Consent Forms (and district or shared service area specific questions, if applicable) for accuracy and completeness. Report problems to staff for correction as necessary.
- Maintain appropriate sections on the Monthly Form Control Sheet.
- Maintain counts of numbers of consent/refusal/incomplete forms and submit to OMS Facilitator monthly.
- Maintain the district process for linking CIF data (and district or shared service area specific questions, if applicable) with the OMS. For example, depending on the district, the Onsite OMS Facilitator may either photocopy the CIF and staple it to the Client Consent Form or staple the Client Consent Form to the yellow data capture copy of the CIF. In the case of the latter, the CIF will go to data capture first, then, those with Client Consent Forms attached will be streamed to continue on to the OMS process (i.e., to OMS Facilitator or delegate).
- Act as liaison between Treatment Staff and OMS Facilitator.

OMS Facilitator

The OMS Facilitator has responsibility for the general supervision and monitoring of the OMS project.

The OMS Facilitator will:

- Introduce the implementation of the OMS process to all staff involved.
- Receive Client Consent Forms and any other related client documentation (depending on the district or shared service area) from the Onsite OMS Facilitator for storage and retrieval at appropriate 12 month bring forward (BF) dates.
- Send the required documentation monthly to the Survey Administrator at the appropriate BF date to begin 12-month follow-up.
- Collect the monthly statistics from the designated Onsite OMS Facilitators.
- Produce and report compliance statistics initially, quarterly and annually.
- Receive completed 12 Month Follow-up Questionnaires monthly from the Survey Administrator.
- Arrange or may perform data entry.
- Store all completed Documentation (12 Month Follow-up Questionnaires, Client Tracking Forms, Monthly Form Control Sheets, district specific information) in a secure location respecting provincial Department of Health retention schedule.
- Order, distribute and monitor OMS form supplies.
- Participate in District/Shared Service Area OMS Committee to review results of OMS and discuss future plans/implementation.
- Participate in the Provincial OMS Committee.

Administrative Staff - 12 Month Follow-up Process

This individual will be responsible for administering the telephone follow-up survey 12 months following the client's consent.

The Administrative Staff will:

- On a monthly basis, receive Client Consent Forms to be followed-up from OMS Facilitator.
- Conduct telephone survey for clients successfully contacted. Adhere to the survey protocol Telephone Tips.
- Record every attempt to contact a client and result on the Client Contact Tracking Form.
 - Make at least 6 attempts over the BF month; varying the time and day of the week.
 - After 3 unsuccessful attempts to call the client at the telephone number and times of day identified on the Client Consent Form, call alternates listed on the Client Consent Form.
 - Record completion status on the Monthly Form Control Sheet enabling maintenance of monthly statistics including number of contact attempts, number of completed surveys (including number of successful follow-ups resulting in a completed questionnaire and unsuccessful follow-ups, such as refusal/unable to contact).
- Read the 12 Month Follow-up Survey and ask all relevant questions on the script as provided. Adhere strictly to the written content of the questions and answers. If a client seeks clarification, use examples provided.
- Follow directions as printed in Telephone Tips.
- Submit completed follow-up questionnaires to the OMS Facilitator at the end of every month along with the client tracking form.
- Refer problems or urgent matters arising from the survey to OMS Facilitator.
- Perform data entry.

Note: Based on previous findings, clients react positively to any follow-up contact.

Calculating Refusal and Response Rates

In calculating refusal and response rates, the OMS Facilitator should follow the Professional Marketing Research Society's (PMRS) guidelines for calculating refusal and response rates (Response Rate Committee, 2003).

Definitions for Calculating Refusal and Response Rates:

- ➔ Refusal rate = Refusals ÷ Total Asked
- ➔ Response Rate = Cooperative Contacts ÷ Total Eligible Numbers
- ➔ Refusals = Household refusal + Respondent refusal + Qualified Respondent Break Off
- ➔ Cooperative Contacts = Disqualified + Completed Interviews

■ SUPPORTING DOCUMENTS AND FORMS

- Provincial OMS Client Consent Form
- Monthly Form Control Sheet
- Client Data Form
- 12 Month Follow-up Questionnaire
- Directions to Survey Taker
- Telephone Tips
- Client Contact Tracking Form
- PMRS Standard Record of Contact Format for Telephone Surveys
- Skill Building/Training Program – Participant Survey

OUTCOME MONITORING SYSTEM CLIENT CONSENT FORM

District

Facility #

Case #

Date:
Day Month Year

Would you be willing to help us by taking part in a follow-up survey?

Your input will allow us to evaluate our services and to make improvements where needed.

If you agree to help, we would like you to:

- allow us to contact you by telephone for a 10 minute interview, approximately 12 months from now; and
- give us the names of at least two people who may be able to help us reach you in case we can't find you in 12 months.

Participation is voluntary. All information you provide is confidential and is collected under the authority of the **Nova Scotia Health Act**. Grouped results can be made available upon request. No information that discloses your identity will be released or published. It is important to note that the original signed consent, and your responses to the questions, will not be included in your treatment record.

- I am willing to participate and to be contacted in the manner noted below
(you may change your mind at any time and discontinue participation)
- I do not wish to participate

Full Name: (Please print): _____
First Name Middle Last

Signature: _____

Staff/Witness Signature: _____ Staff/StatIS ID #: _____

Contact Information

To be completed for clients who are willing to participate. Staff are to cross out and initial all sections for which the client wishes not to provide information.

Home Phone: (_____) - _____ - _____ Work Phone: (_____) - _____ - _____

Best Time: morning afternoon evening

If we cannot contact you, is it ok to leave a message about this: (please respond to both below)

On an answering machine yes no no response
With another person yes no no response

If we are unable to contact you in 12 months from now,
please list some other contacts who can help us reach you (please print)

Name: _____ Phone: _____

Name: _____ Phone: _____

OUTCOME MONITORING SYSTEM TREATMENT MONTHLY FORM CONTROL SHEET

District Facility # Date: Month Year

Date sent to OMS Facilitator: Day Month Year

Service Type: _____ Forms issued to: _____

Onsite OMS Facilitator Section

OMS #	Client Name	Case #	Consent / Refusal	Date
1	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
2	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
3	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
4	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
5	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
6	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
7	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
8	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____

Totals _____ yes _____ no

Interviewer Section

# Follow-up Attempts	Follow-up Achieved?	Interviewer's Initials
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____

Totals _____ yes _____ no

OUTCOME MONITORING SYSTEM TREATMENT CLIENT DATA FORM

District Facility # Case #

Date of Birth: Current Age: _____
Day Month Year

Sex: male female

Referral Source

- Self
- Legal
- Mental Health
- Other Addiction Services
- Vocational
- D.W.I.
- Community Services
- Family
- Other Health Sector
- Other

Specify: _____

Employment

- Employed Full Time
- Employed Part Time
- Employed Seasonally
- Homemaker
- Student
- Disabled
- Retired
- Unemployed

OMS FOLLOW-UP SURVEY DIRECTIONS TO SURVEY TAKER

- 1 Insert all previously obtained relevant data in the required fields prior to proceeding with the Survey.
- 2 Throughout the Survey, guidelines and directions to the Survey Taker are presented in type similar to this.
- 3 The Survey contains a 'script', that is, a conversational way of leading the respondent through the various sections and questions. The script is presented in bold font and is set apart with quotation marks (see example below). The Survey Taker should read the script exactly.

For example:

“This part of the Survey deals with various aspects of your health. By health we mean not only the absence of disease or injury, but also physical, mental and social well being.”

- 4 The Survey Taker must ask/present all the Survey questions exactly as they are written. The Survey Taker must not interpret or explain the questions if not understood by the respondent. If the respondent does not understand the question, the Survey Taker can offer to re-state the question.

For example, the Survey Taker may say:

“I can't try to explain the question to you, but I can read it again slowly. You can answer in terms of what it means to you, or you don't have to answer.”

OUTCOME MONITORING SYSTEM - TREATMENT SERVICES FOLLOW-UP SURVEY

District

Facility #

Case #

Date:
Day Month Year

Before making call > Complete all relevant sections where information is required from previous data.
Check on consent form to see if you are allowed to leave a message.

“ Hello, may I speak with _____ ? ”

If not available > “ When would be a convenient time to call back ?”

Do not identify purpose of call
if the client has previously stated
not to leave a message.

If respondent

answers / takes call > “ Hello, my name is _____ and
I work with addiction services. When you came to our serv-
ices last year, you agreed to take part in a follow-up survey
to allow us to evaluate our services. I would like to remind
you that your participation is completely voluntary and any
information that you provide will be strictly confidential. No
information that you provide will be added to your file. The
survey will take approximately 10 minutes.
Can we begin the survey now?”

If the person indicates that

this is not a convenient time > Arrange a callback Call back time: _____

If the person refuses to take part > Thank them for their time and terminate the call.

Refused:

1 Reasons for accessing services

Take this information from the **client intake form**.

- your own use of alcohol, other drugs, gambling or other addiction issue
- the effects of someone else's addiction on you > **go directly to section 3 – treatment process**
- nicotine program
- driving while impaired program
- adolescents

2 Addiction Specific Outcomes

Take information from the **CI form** and **complete question 2A before making call** > ask questions **2B, 2C, 2D**.

2A	2B	2C	2D
When you came to addiction services last year, you indicated that you were using ...	Did you receive treatment for ...	What was your goal in coming to addiction services regarding your use of ... ? Was it to ...	Compared to when you first came to our services, would you say your current use of (or level of problems with) is...
Alcohol <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no > go to Section C	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all
Drugs / Other Drugs <input type="checkbox"/> yes <input type="checkbox"/> no <small>If Alcohol is checked, then say "Other Drugs" otherwise say "Drugs".</small>	<input type="checkbox"/> yes <input type="checkbox"/> no > go to Section C	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all
Nicotine <input type="checkbox"/> yes <input type="checkbox"/> no <small>If Nicotine is not the only category checked, say "I also see indicated that you used nicotine. Did you receive treatment for that as well?" > If no, check No Goal.</small>	<input type="checkbox"/> yes <input type="checkbox"/> no > go to Section C	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all
Gambling <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no > go to Section C	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all
Other Addiction <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes > specify _____ _____ <input type="checkbox"/> no	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all

2E

Were you having difficulties or problems with any other substances or gambling besides those we just talked about when you first came to addiction services?

yes > record substance / activity in 2E1, then go to 2E2 and 2E3 and 2E4

no > go to Part 3

2E1	2E2	2E3	2E4
Record substance	Did you receive treatment for ...	What was your goal in coming to addiction services regarding your use of ... ? Was it to ...	Compared to when you first came to our services, would you say your current use of (or level of problems with) is...
_____	<input type="checkbox"/> yes <input type="checkbox"/> no > go to Section C	<input type="checkbox"/> quit <input type="checkbox"/> reduce use <input type="checkbox"/> reduce problems caused by use <input type="checkbox"/> No Goal > <input type="checkbox"/> N/A <input type="checkbox"/> Mandatory	<input type="checkbox"/> more <input type="checkbox"/> less <input type="checkbox"/> same <input type="checkbox"/> no use at all

3 Treatment process

“The next few questions are about the services that you received from addiction services.”

- A Did our services help you identify issues or problems in your life? yes no
- B Did our services help you set goals? yes no
- C Did our services help you understand all of the treatment options available to you? (i.e. Nicotine replacement therapy, detox, a 3 or 5 day education program, core program, outpatient counseling, structured treatment) yes no
- D Did our services help you identify ways to deal with issues or problems? yes no
- E Did our services help you in attaining the support from individuals or community agencies or groups? (i.e. AA, NA, GA) yes no

4 Health outcomes and life functioning

Record **Score at Intake** sections from **Baseline Questions** before making call/asking questions.

“This part of the survey deals with various aspects of your health. By health, we mean not only the absence of disease or injury, but also personal health practices, mental and social well being.”

A Replace <Life Area> with the appropriate life area listed below. Do not give the client their ‘score at intake’.

Overall, how would you rate your current <Life Area> ? Would you say that it is poor, fair, good, very good, or excellent.

B After recording current response score for all areas proceed to ask benefit question.

On a scale from 1 to five, where 1 is not at all and 5 is very much, how much did you benefit from the help received at addiction services in the area of <Life Area> ?

Repeat this sequence for each life area.

Life Area	Score at intake	A - Current score	B - Benefit
Income and social status That is, your financial situation.	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Not at all 2 3 4 5 Very Much 99 DK/NA
Support Networks That is, your relationships with family.	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Not at all 2 3 4 5 Very Much 99 DK/NA
Personal Health Practices That is, eating a proper diet, getting exercise, managing stress.	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent 99 DK/NA	1 Not at all 2 3 4 5 Very Much 99 DK/NA

A Overall, how would you rate your current <Life Area> ? Would you say that it is poor, fair, good, very good, or excellent.

B On a scale from 1 to five, where 1 is not at all and 5 is very much, how much did you benefit from the help received at addiction services in the area of <Life Area> ?

Life Area	Score at intake	A - Current score	B - Benefit
Housing and General Living Conditions	1 Poor	1 Poor	1 Not at all
	2 Fair	2 Fair	2
	3 Good	3 Good	3
	4 Very Good	4 Very Good	4
	5 Excellent	5 Excellent	5 Very Much
	99 DK/NA	99 DK/NA	99 DK/NA
Employment That is, keeping a job or getting a better job.	1 Poor	1 Poor	1 Not at all
	2 Fair	2 Fair	2
	3 Good	3 Good	3
	4 Very Good	4 Very Good	4
	5 Excellent	5 Excellent	5 Very Much
	99 DK/NA	99 DK/NA	99 DK/NA
Education That is, continuing with or starting new.	1 Poor	1 Poor	1 Not at all
	2 Fair	2 Fair	2
	3 Good	3 Good	3
	4 Very Good	4 Very Good	4
	5 Excellent	5 Excellent	5 Very Much
	99 DK/NA	99 DK/NA	99 DK/NA
Self Esteem That is, how you feel about yourself.	1 Poor	1 Poor	1 Not at all
	2 Fair	2 Fair	2
	3 Good	3 Good	3
	4 Very Good	4 Very Good	4
	5 Excellent	5 Excellent	5 Very Much
	99 DK/NA	99 DK/NA	99 DK/NA

5 Employment

“Moving on, the next few questions deal with your employment situation.”

- 5A** Were you working for at least minimum wage when you first came to our services 12 months ago?
- yes > **go to 5B**
 no > **go to 5C**
 other / not in workforce > **go to 6**

Other/not in workforce would include those who are retired, homemakers or anyone who is not actively seeking employment.

- 5B** Did our services help you to keep your employment?
- yes > **go to 6**
 no > **go to 5C**
 other / not in workforce
-

- 5C** Are you currently working for at least minimum wage?
- yes > **go to 5E**
 no > **go to 5D**
 other / not in workforce
-

- 5D** At any time during the past 12 months, did you work for at least minimum wage?
- yes
 no > **go to 6**
 other / not in workforce

Note: this could mean even just one day.

- 5E** Did our services help you to find employment?
- yes
 no
 other / not in workforce
-

6 Satisfaction with Service

“These last few questions deal with how satisfied you were with the services provided by addiction services.”

6A Overall, were you satisfied with the services you have received?

yes

no > Why were you not satisfied with the services you received? Comments:

6B Would you recommend our services to another person who needed help?

yes

no > Why would you not recommend our services? Comments:

6C If you needed help again, would you come back?

yes

no > Why would you not come back if you needed help? Comments:

6D When you decided to seek help, was help easily available?

yes

no > Why was the help not easily available? Comments:

TELEPHONE TIPS

There are a variety of strategies that can be used to increase the success of follow-up by telephone.

- Use the information on the Client Consent Form, which indicates a preferred time for contact, but do not be restricted by this information.
- The interviewer should block the caller ID function on their phone prior to dialling the client.
- Make at least 6 attempts over the BF month varying the time of day. Do not call before 8 am or call after 9 pm unless the client indicated otherwise on the consent form.
- Before leaving a message, check the consent form to ensure that the client agreed to have a message left. If an answering machine is reached at a phone number provided by the client, leave a discrete message indicating your name and that you are calling from the District Health Authority regarding a survey. Do not indicate the purpose of the survey in a message. State your phone number and the best time to return your call.
- If someone other than the client answers the phone, ask to speak with the client. If the client is not available, ask when would be a good time to call back. Only leave a message if the client has indicated to do so on the Client Consent Form.
- Once the client is contacted, remind them that they had previously agreed to take part in the survey, that their participation is completely voluntary and that any information provided will be confidential. If the client indicates that it is not a good time to complete the survey, arrange a callback.
- Should a client indicate that they no longer wish to participate in the survey, thank them for their time and end the call.
- If issues related to treatment arise during the interview, the client should be referred to treatment staff immediately.
- After 6 unsuccessful attempts to call the client at the telephone number and times of day identified on the Client Consent Form, call alternates listed. Where possible, leave messages with friends, relatives, employers or other individuals specified on the Client Contact Form; this message should indicate that the District Health Authority is conducting a survey. State your name and work number for a return call during the hours that you work. Do not provide any information about the content of the survey to the alternate contact.

OUTCOME MONITORING SYSTEM TREATMENT CLIENT CONTACT TRACKING FORM

District Facility # Case #

12 Month Follow-up Date:
 Day Month Year

Call Attempts

	Date	Day	Time	Phone # Notes	Staff Initials
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____

Alternate Contact Call Attempts

	Date	Day	Time	Phone # Notes	Staff Initials
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____

TELEPHONE SURVEYS

PMRS Standard Record of Contact Format for Telephone Surveys

DISPOSITION OF LAST ATTEMPT		EXPLANATORY NOTES
Total Numbers Attempted	_____	Total of lines 1 to 14
Not in Service	_____	Include list errors
Fax/Modem	_____	
Business/Residential	_____	"Business" if consumer survey and vice versa
Total Eligible Numbers	_____	Total of lines 4 to 14
Busy	_____	
Answering Machine	_____	
No Answer	_____	
Language	_____	
Illness, Incapable	_____	
Selected/Eligible Resp. Not Avail.	_____	Includes outstanding call backs/appointments
Total Asked	_____	Total of lines 10 to 14
Household Refusal	_____	Before respondent selected
Respondent Refusal	_____	Before answering all qualifying questions
Qualified Respondent Break Off	_____	Any termination after qualifying
Co-operative Contacts	_____	Total of lines 13 and 14
Disqualified	_____	Any disqualification of household or respondent during screening process. Includes quota filled if identified during screening. Does not include quota filled based on sample data.
Completed Interview	_____	Include any qualified completes that are rejected in post-edit. Where needed add sub-categories for rejects and in-tab sample
Refusal Rate = (10 + 11 + 12) / C	_____	Total refused divided by total asked.
Response rate = D / B	_____	Willing respondents divided by total eligible numbers

■ GLOSSARY

■ Forms

Provincial OMS Client Consent Form

Indicates whether or not a client will participate in the OMS. This form also includes basic contact and identifying information that must be completed to assist with the 12-month follow-up. As well, the reverse may contain District or shared services specific questions, which must be completed at time of consent.

Monthly Form Control Log

This district or shared services area specific sheet is a monitoring mechanism used to track the distribution, utilization and status of OMS documentation. Sections are to be completed by the Onsite OMS Facilitator and the designated Administrative Staff. The Monthly Form Control Log will be submitted at the end of every month, along with the Client Consent Forms and district or shared services specific questions to the OMS Facilitator or designate. The OMS Facilitator will maintain these monthly forms throughout the project. The Administrative Staff member will refer to these sheets when making 12-month follow-up calls.

Client Data Form

This district or shared services area specific form provides an alternate form for summarized client information that may be used for group results.

Client Information Form (CIF)

This is the registration form for the Addiction Services' statistical information system (StatIS). It is used to collect mainly demographic information and includes client identification, client characteristics and background, referral source, treatment issues and substance use and/or gambling problems.

12 Month Follow-up Questionnaire

This survey collects information about: Reasons for Accessing Service, Addiction Specific Outcomes, Service Quality, Health Outcomes and Life Functioning, Employment and Education, Satisfaction with Service, and, if applicable, district or shared services specific questions.

Client Contact Tracking Form

At 12 months post consent, this sheet is used to record the total number of call attempts to the client or alternates by the Administrative Staff. Also included on this sheet are the date(s) of contact or attempted contact(s), times, telephone numbers used and comments as appropriate.

Other

Accountability

It demonstrates the quality and efficacy of Addiction Treatment Services to stakeholders including Department of Health, District Health Authorities, internal and inter-sectoral partners, staff, clients and the general public.

Accreditation

A process that helps organizations evaluate services against national standards and facilitates continuous quality improvement efforts.

ADTR Program

The Alcohol Drug Treatment and Rehabilitation Program is a federal cost-sharing program that funds provinces and territories to increase and expand innovative treatment and rehabilitation programs related to alcohol and other drugs. Youth and women are the prime target groups for services funded under this Program. The federal government reimburses 50 percent of the eligible costs incurred by participating provinces and territories in providing alcohol and drug treatment and rehabilitation services.

Determinants of Health

The broad range of social, economic and environmental factors that determine the health status of individuals or populations (Health Canada, 2001). Key health determinants include: income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender, and culture.

EAPD

Employment Assistance for People with Disabilities is a federal-provincial agreement that provides federal funding to a range of provincial programs designed to enhance workforce participation of working age adults with disabilities by helping them to prepare for, attain, and maintain employment.

Quality Improvement

A management approach and system that seeks to meet clients' needs and expectations by using a structured process that identifies areas to improve and improves all aspects of the organization's services, including the outcomes of services to clients (CCHSA, 2002).

■ REFERENCES

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ADOLESCENT SERVICES STANDARDS

DESCRIPTION

A comprehensive array of age-appropriate programs and services are designed to target and meet the unique substance-use and gambling-related needs of adolescents (ages 13-19) across the health-risk continuum. Programs are intended to recognize the distinctness of adolescents in terms of psychological, physical, and social development. These services include specialized community and school-based health promotion, prevention, early intervention, and treatment, as well as a specialized provincial program. This also includes distinct practices applied within traditionally adult-oriented program components. (See also Prevention and Community Education Service Standards and Prevention and Community Education Best Practices.)

OBJECTIVES

- 1 To identify and address the unique needs of adolescents through the provision of health promotion, prevention, early intervention and treatment which are appropriate (e.g., gender, age, culture, sexual identity/orientation, ability, and race) for them, their families, and their communities.
- 2 To foster collaborative relationships and coordinate appropriate external services and supports for adolescent programs.
- 3 To provide the least intrusive interventions necessary to meet the needs of adolescent clients, and to refer to more intrusive interventions only as required.
- 4 To make appropriate services accessible (by addressing barriers such as scheduling, location, and transportation) for adolescents.
- 5 To enhance community capacity to address the needs of adolescents (addressed in more detail in the Service Standards for Prevention and Community Education and Best Practices for Prevention and Community Education).

STANDARD MEASUREMENTS

Accessibility

Addiction Services ensures the timely provision of services to adolescents as indicated by:

- 90% of adolescents requesting treatment services (or referral sources requesting services for an adolescent) are contacted within one working day to engage in the intake process.
- 90% of all potential clients, who consent to participate, have a phone intake completed within one working day, or a face-to-face intake appointment available within three working days.

Retention and connection to the continuum of care

Adolescent clients are successfully connected to Addiction Services as indicated by:

- 70% of adolescent clients give consent to involve adult family members, care-givers, or similar alternate support people.
- Less than 30% no-show/cancellations for in-person clinical sessions.
- For 90% of adolescent clients where consent to involve family members or care-givers is obtained, those identified support people will be involved in the case (e.g. telephone contact to provide or receive information, directly involved in counselling sessions and/or sent general information by mail).
- 90% of internal referrals (i.e. clients referred between components of Addiction Services, including district referrals to CHOICES) will receive a face-to-face interview or intake session within 10 business days.

Positive Impact

Adolescent clients of Addiction Services and/or their adult family members or care-givers identify a positive impact on the lives of the adolescent as indicated by:

- In 75% of cases, the client will report a reduction in the harms associated with his/her substance use and/or problem gambling.
- In 75% of cases, the client will report satisfaction with the service.
- In 75% of cases, the client's parents or caregivers report a reduction in the harms associated with the client's substance use and/or problem gambling.
- In 75% of cases, the client's parents or caregivers report satisfaction with the service.

ADOLESCENT SERVICES BEST PRACTICES

DESCRIPTION

A comprehensive array of age-appropriate programs and services are designed to target and meet the unique substance-use and gambling-related needs of adolescents (ages 13-19) across the health-risk continuum. Programs are intended to recognize the distinctness of adolescents in terms of psychological, physical, and social development. These services include specialized community and school-based health promotion, prevention, early intervention, and treatment, as well as a specialized provincial program. This also includes distinct practices applied within traditionally adult-oriented program components. (See also Prevention and Community Education Service Standards and Prevention and Community Education Best Practices.)

GUIDING PRINCIPLES

- 1 The development needs of adolescents are different from those of adults, and problem gambling- and substance-related programs should meet their unique needs.
- 2 A range of services should address the needs of adolescents along the health risk continuum.
- 3 The least intrusive sufficient treatment method should be used.
- 4 Appropriate involvement of family and other support is encouraged in the programs for adolescents.
- 5 The principles of harm reduction are appropriate for adolescent programs.
- 6 A strengths-oriented approach, which focuses on the resiliency of youth, should be used with adolescents.

OVERVIEW OF STANDARDS

Objectives

- 1 To identify and address the unique needs of adolescents through the provision of health promotion, prevention, early intervention and treatment which are appropriate (e.g., gender, age, culture, sexual identity/orientation, ability, and race) for them, their families, and their communities.
- 2 To foster collaborative relationships and coordinate appropriate external services and supports for adolescent programs.

- 3 To provide the least intrusive interventions necessary to meet the needs of adolescent clients, and to refer to more intrusive interventions only as required.
- 4 To make appropriate services accessible (by addressing barriers such as scheduling, location, and transportation) for adolescents.
- 5 To enhance community capacity to address the needs of adolescents (addressed in more detail in the Service Standards for Prevention and Community Education and Best Practices for Prevention and Community Education).

Standard Measurements

Accessibility

Addiction Services ensures the timely provision of services to adolescents as indicated by:

- 90% of adolescents requesting treatment services (or referral sources requesting services for an adolescent) are contacted within one working day to engage in the intake process.
- 90% of all potential clients, who consent to participate, have a phone intake completed within one working day, or a face-to-face intake appointment available within three working days.

Retention and connection to the continuum of care

Adolescent clients are successfully connected to Addiction Services as indicated by:

- 70% of adolescent clients, consent to involve adult family members, care-givers, or similar alternate support people.
- Less than 30% no-show/cancellations for in-person clinical sessions.
- For 90% of adolescent clients where consent to involve family members or care-givers is obtained, those identified support people will be involved in the case (e.g. telephone contact to provide or receive information, directly involved in counseling sessions and/or sent general information by mail).
- 90% of internal referrals (i.e. clients referred between components of Addiction Services, including district referrals to CHOICES) will receive a face-to-face interview or intake session within 10 business days.

Positive Impact

Adolescent clients of Addiction Services and/or their adult family members or caregivers identify a positive impact on the lives of the adolescent as indicated by:

- In 75% of cases, the client will report a reduction in the harms associated with his/her substance use and/or problem gambling.
- In 75% of cases, the client will report satisfaction with the service.
- In 75% of cases, the clients' parents or caregivers report a reduction in the harms associated with the clients' substance use and/or problem gambling.
- In 75% of cases, the clients' parents or caregivers report satisfaction with the service.

SPECIFIC GUIDING PRINCIPLES

Staffing

Each program will ensure that the staff complement for Adolescent Services includes an appropriate combination of skills, knowledge and experience required to meet goals and objectives of the program. Recognizing the importance and value of a multi-disciplinary team approach, staff should understand addiction issues and mental health issues, understand adolescent development and be able to work effectively with families. They should have practical experience in helping adolescents work toward positive change. Minimum qualifications for adolescent treatment positions (all new hires) include:

- Minimum 2 years post-secondary education with training in counselling preferably with a focus in adolescents and/or addictions.
- No child abuse-related convictions, as demonstrated by a Child Abuse Registry Check and/or a Criminal Record check.

Addiction Services will make every effort to ensure that staff providing services to adolescents receive ongoing education and training.

Target Group

Adolescent Services are intended for those from 13 to 19 years of age, and their families and care-givers. Appropriateness of specific services or levels of program may vary depending on the needs of individual clients and their families/care-givers.

■ Admission Criteria

Withdrawal Management

With the adult population, it is often preferable (and sometimes mandatory) that the client make direct contact him/herself to make appointments or arrange for admission. However, in the case of adolescents, greater flexibility needs to be afforded in this regard. For adolescent clients, who rarely self-refer, primary involvement and input from parents/care-givers in the referral and admission processes is appropriate and often desirable. Such involvement provides the opportunity to engage an adolescent who otherwise might not enter the addiction treatment system, and provides greater opportunity to involve the parents/care-givers in the treatment process.

Structured Treatment (including CHOICES)

Based on the principles of least intrusiveness and community-based programming, adolescent clients should be admitted to CHOICES' day program or other structured treatment programs based on an enhanced assessment and other treatment attempts which clearly indicate the need to move to this level of intervention.

■ Planned Discharge

Withdrawal Management

When an adolescent is admitted to a Withdrawal Management Unit, it is essential that the discharge planning begin immediately and be proactive in ensuring linkage with community-based services. Adolescent clients are less likely to engage in such planning or initiate such contact on their own. To help with this linkage, and with further client engagement, the following practices are encouraged:

- Whenever an adolescent client is admitted to a Withdrawal Management Unit, staff will contact the adolescent counselling/treatment staff member for that area to inform him/her of the admission. This contact will be made prior to or on the same day that the client is brought onto the Unit.
- The adolescent counselling/treatment staff person will respond with a brief face-to-face visit whenever possible, or, in exceptional circumstances, telephone contact with the client before his/her scheduled or expected discharge from the Withdrawal Management Unit. This meeting is intended to introduce the adolescent client to the idea of continuing to work on addiction-related issues on an outpatient basis, to set an appointment, and to thereby increase the likelihood of engagement after discharge.
- For purposes of engagement and relationship building, this face-to-face meeting or telephone contact should ideally be conducted by the adolescent treatment staff who will be seeing the client. In cases where this is not possible, the adolescent worker will arrange for an alternate community-based staff member to attend or call on his/her behalf.

Admission to Withdrawal Management and/or Structured Treatment is based on the best practices for these programs.

Structured Treatment

As part of the discharge from Structured Treatment, a formal link will be made between the Structured Treatment staff and the community-based adolescent treatment staff in the client's home community. This will include:

- A phone call to the community-based staff person in advance of the client's program completion to inform him/her of the planned discharge, to briefly discuss the client's progress and ongoing treatment needs, and where possible, to arrange a follow-up appointment.
- A discharge summary sent within five working days after discharge, which includes the following information:
 - the primary treatment issues/goals addressed in the program
 - the client's progress on those primary treatment issues/goals
 - difficulties or problems experienced in addressing those issues/goals
 - identified client strengths, talents, assets, skills and interests
 - treatment/follow-up recommendations.

It is important to note that this type of information sharing/case conferencing between structured treatment programs and community-based treatment staff in Addiction Services throughout the districts is not considered a breach of confidentiality. As various parts of the continuum of service with Addiction Services, this is appropriate communication between co-workers working collaboratively in the best interest of the client's care.

UNPLANNED DISCHARGE AND RE-ENGAGEMENT IN STRUCTURED TREATMENT

Alternating periods of engagement, disengagement and re-engagement with adult support systems, whether initiated by the adolescent or the staff involved, are characteristic of healthy adolescent development. This means that termination work with adolescents should include more encouragement for the client to return to treatment at a later time than is common in adult treatment. This encouragement should include efforts to keep the therapeutic relationships intact.

Program completion and early dismissal are two among many strategies available to treatment staff as part of an ongoing clinical process. Usually, they are well considered clinical decisions that are based on a specific set of circumstances. Recognizing and naming of these milestones in the client's movement toward, or away from, treatment goals are ways of enhancing the client's self-awareness and the related capacity for self-change.

The decision to declare the client's current phase of treatment complete indicates either that the treatment goals that have been established with the client have been achieved or that the clinical team believes the client has come as far in the direction of meeting these goals as (s)he is apt to come during the present period of engagement.

The decision to dismiss a client early from a program should primarily be a specific clinical decision based on client behaviour. Examples of behaviour that might lead to early dismissal are:

- violence or serious verbal threats or threatening behaviour toward staff or other clients
- suicidal behaviours or mental health issues such that the client would be more appropriately served in a mental health facility
- behaviour that constitutes a serious and/or repeated disruption to the treatment process and/or the progress or well-being of other clients.

The decision to dismiss a client early should always be a well-considered clinical decision, making use of as many safeguards as possible against clinical error and unfairness of any kind. The client will be informed of a pending discharge and the reasons for the discharge. The details of the discharge, including the reasons for the discharge, as well as any recommendations for further treatment, will be documented. If the client's health and safety is at risk at the time of discharge, a designated next of kin, contact person, or appropriate person will be notified.

COMPONENTS OF CONTINUUM OF SERVICES

Components of Continuum of Services

Adolescent Services should include a continuum of programs including:

- connection to prevention, health promotion and community education
- early intervention counselling (brief, education-based)
- intensive individual and family therapy services
- withdrawal management
- structured treatment (e.g. CHOICES).

Involvement of Parents and Other Care-givers

Where possible and appropriate, it is considered important to involve an adolescent's parents and/or other care-givers in the treatment process. That involvement may range from the exchange of information to full participation in family therapy. Given that there is no legal age of consent for health services in Nova Scotia, and that the client therefore has a legal right to confidentiality, in most cases staff are not free to arrange such involvement directly without the client's consent. However, in the interest of best clinical practice, Addiction Services staff are expected to work with the client toward that end. Where appropriate, staff must make every effort, in their clinical and motivational process, to move each adolescent client toward a recognition of the value of such parental/caregiver involvement, and toward a decision to allow it.

Whether or not an adolescent chooses to become a client, services will be provided independently to parents, care-givers and other support people upon request. This is provided to help that support person be a catalyst in moving the adolescent toward improved health or engagement in appropriate treatment, as well as to assist the support person to understand the impact of addiction on their own life.

■ **Case Management**

Case Management is an essential component of adolescent services. Many adolescents accessing addiction services are involved with multiple agencies. Because many systems and agencies may work in isolation, they may have an incomplete view of the adolescent. The adolescent, due to his/her stage of development and level of motivation, may have a limited capacity to advocate on their own behalf or negotiate these systems to their advantage. A proactive case management approach will enable agencies to work collaboratively, to view the adolescent holistically and to foster resilience.

Case management should involve, but is not limited to:

- collaboration with other organizations
- case planning
- initiation and participation in case conferences
- advocacy
- consultation
- referral

■ **Recreation and Experiential Learning**

It is recognized that adolescents often learn emotional competence through active pursuits. Therefore, where possible, meaningful activities should be integrated with treatment to aid in motivation, engagement, and the development of a therapeutic relationship.

■ **School Policy**

Most adolescents spend a considerable amount of time in school. School policies that clearly articulate the roles and responsibilities of school personnel and community-based agencies such as Addiction Services in addressing student substance use and/or gambling can facilitate a healthy school environment that is responsive to the needs of the entire student population. Addiction Services can enhance on-going services for adolescents in schools by participating in the development of school drug policy and/or memorandum of understanding which support healthy outcomes for adolescents and their families.

■ **Public Policy**

There is substantial evidence that various public policy initiatives can greatly reduce substance use and/or gambling and/or their related harms among adolescents (e.g. decreasing availability or increasing price of tobacco or alcohol). Advocating for such actions should therefore be a fundamental part of the role of Addiction Services.

Idealism and Culture

Idealism, criticism of existing authority, and the attempt to find meaning in their experiences are some of the ways through which young people accomplish some of the key developmental tasks of adolescence, including identity formation. Best practices in adolescent treatment are those which accept adolescent idealism, have good tolerance for a wide range of appropriate challenges to authority, and encourage young people to explore questions of meaning experientially as well as intellectually. Such practices are inevitably limited by the resources and focus of the treatment context, but examples of this approach might include opportunities to participate in wilderness programs, to explore personal creativity and to participate directly, or as an observer, in the artistic and cultural life of the community, to observe and/or participate in the practice of one's own or another's culture, and volunteerism.

Motivation

It is recognized that adolescents may not be motivated by the same things as adults, and such motivators may change more frequently than in adults. As a result, an approach which supports client involvement in goal setting and treatment planning is especially important in adolescent treatment. Such processes should be dynamic and responsive to ongoing changes in the client's motivation.

Education, Vocation and Employability

The acquisition of an appropriate education and the exploration of initial vocational goals are essential to the lives of well functioning adolescents in this culture. Best practices in adolescent treatment encourage these activities by co-operating with education and training programs to support the efforts of adolescents in obtaining and maintaining education and/or employment. Adolescents should be encouraged to expand their awareness of educational and employment options, and explore these in the context of their developing identity.

Community Consultation

Prevention and treatment of adolescent substance abuse and gambling are specialized services. Many other service providers and care-givers, such as teachers, probation workers and children's aid workers, may not have an in-depth knowledge of issues relating to adolescent substance and gambling abuse, but often find themselves having to work with these issues on a daily basis. It is therefore important to provide the various stakeholders with information and support. This can be provided in the form of informal case consultation (with non-identifying information), formal case conferencing (with informed and signed consent by the client) and in-service training on adolescent substance abuse and gambling treatment issues.

This issue is addressed in more detail in the Service Standards for Prevention and Community Education and Best Practices for Prevention and Community Education.

■ Culture, Identity and Cultural Competency

Nova Scotia has a diverse population including First Nation, African Nova Scotians, and new Canadians representing a broad range of cultural and ethnic groups. Consequently, the population of youth seeking substance abuse and/or gambling treatment is increasingly diverse. Since adolescent identity does not form in a vacuum but is embedded in ethnicity and culture, it is essential to provide a therapeutic experience that is culturally relevant and sensitive. This is true for youth who strongly identify with their culture, as well as for those youth who have yet to determine the value of their culture as it relates to their identity.

An environment that demonstrates an understanding and appreciation of different cultures is important. This ranges from displaying multi-cultural posters and art to creating policies with zero tolerance for discrimination and racism to the development of cultural competence among all staff. Cultural competence “is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations” (J. Fortier, et al, 2000).

Cultural competence should exist along the continuum of adolescent services. All youth, at every level of intervention, should feel safe in expressing their individuality and, in fact, whenever possible, should be encouraged to celebrate who they are culturally as well as who they are individually. In addition, there needs to be an ongoing monitoring of the extent to which various cultural groups are reflected among the youth served, and the staff that provide treatment interventions. Each adolescent service should undertake organizational self-assessment of cultural competence to determine areas of strength and areas requiring improvement.

■ Concurrent Disorders

While many young people who are harmfully involved with substance use and/or gambling may also be thought of as suffering from concurrent psychiatric or mental health disorders, it is best to exercise caution in providing, or arranging for, adolescents to be given a psychiatric diagnosis and/or psychopharmacological treatment. This is because the diagnostic categories provided by, for example, the DSM IV are inadequate to describe the many and changing kinds of relationships adolescents have with mood and perception altering substances. It is also influenced by the limited usefulness of diagnostic assessment with a population whose physical, emotional and social characteristics are so often in flux, both from moment to moment and as the overall process of adolescent development unfolds. Finally, in part because of the link between psychiatry and physical medicine, a psychiatric diagnosis can take on an air of objective reality that does not belong to it by nature and may unfairly bias the ways in which clients are viewed and treated in future, both by professionals responsible for their care and more generally.

This having been said, it is important that indications of psychopathology in harmfully involved adolescents be identified early and that adolescents who manifest a significant number and/or intensity of these symptoms be promptly referred for mental health treatment that is concurrent with their treatment for

substance use and/or gambling. It is also important that treatment for harmful involvement with substance use and/or gambling be well coordinated with any mental health treatment that is arranged and that services in both areas - 'mental health' and 'addictions' - be provided by staff who specialize in one of these areas but are knowledgeable in both.

■ BEST PRACTICES REFERENCE LIST

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LONG TERM RECOVERY HOME SERVICES

■ DESCRIPTION

Long Term Recovery Home Services are living facilities designed to provide a supportive environment and the recovery supports for persons who have accessed addiction treatment and require a safe, secure and supportive environment for an extended period of time to stabilize their recovery. Services include an array of community living activities, employability experiences, connection to self help and a link to treatment at Addiction Services.

■ OBJECTIVES

- 1 To provide a safe and healthy, long-term residence for individuals who have been harmfully involved with alcohol, drugs and/or gambling.
- 2 To provide the residents with an opportunity to learn and apply coping strategies for problems associated with substance abuse and/or gambling.
- 3 To provide the residents with an opportunity to learn and apply social skills.
- 4 To foster employability through:
 - structured activities and/or
 - pursuit of employable activities.
- 5 To assist residents to locate a suitable residence.
- 6 To motivate and encourage residents to set up linkages to community resources.

STANDARD MEASUREMENTS

Accessibility

Long Term Recovery Home Services ensure a timely provision of services to individuals who meet admission criteria^a as indicated by:

- 80% of potential residents are offered admission within 60 working days of a completed Admission Assessment^b.

RETENTION AND CONNECTION TO THE CONTINUUM OF CARE

Long Term Recovery Home Services ensure support for recovery as indicated by:

- 90% of residents will attend the required number of in-house groups^a while residents of the service.
- 90% of the residents will be assessed by an Addiction Services treatment staff within thirty (30) working days of becoming a resident.
- 90% of the residents will follow the treatment plan developed in consultation with house staff and the Addiction Services case manager.
- 90% of all discharged residents have a Discharge Plan that includes a recommendation to continue treatment with Addiction Services.

Residents of Recovery Home Services successfully complete this service as indicated by:

- 90% of clients admitted are discharged with consent^c.

MEDICAL HEALTH AND SAFETY

Long Term Recovery Home Services ensure that basic medical and health services are provided to all residents as indicated by:

- 95% of the residents are seen by a physician and/or nurse for a medical examination within 14 working days of taking up residency in the facility. Documentation is placed on their chart/record.
- 95% of the residents receive a complete review of all their reported prescription and over-the-counter medications by a pharmacist, nurse or physician 14 days after taking up residency in the facility, which is documented on their chart/record.
- 0% Building and Fire Code violations.
- 0% incident rate of physical or sexual abuse amongst residents and/or staff.

POSITIVE IMPACT

Residents of Long Term Recovery Home Services identify a positive impact on their lives as indicated by:

- 90% of residents discharged report satisfaction with the programming and services.
- 90% of the residents discharged with consent have a suitable place of residence upon discharge as recorded on their chart/record.
- 25% of residents discharged with consent have not been harmfully involved with alcohol, drugs and/or gambling one year after discharge.

NOTES

- a** As prescribed by the facility.
- b** Admission criteria are defined in the organization's Policy and Procedures Manual.
- c** Discharged with consent as defined in the organization's Policy and Procedures Manual.

RECOVERY HOME SERVICES

DESCRIPTION

Recovery Home Services are transitional living facilities designed to provide a supportive environment and recovery supports for persons who have accessed addiction treatment services and require a safe, secure and supportive environment to stabilize their recovery. Services include an array of community living activities, employability experiences, connection to self help and a link to treatment at Addiction Services.

OBJECTIVES

- 1 To provide a safe and healthy residence for individuals who have been harmfully involved with alcohol, drugs and/or gambling.
- 2 To provide the residents with an opportunity to learn and apply coping strategies for problems associated with substance abuse and/or gambling.
- 3 To provide the residents with an opportunity to learn and apply social skills.
- 4 To foster employability through:
 - upgrading education or training and/or
 - pursuit of career/employment opportunities.
- 5 To assist residents to locate a suitable residence.
- 6 To provide the residents and their significant others with support and contact information concerning community resources.

STANDARD MEASUREMENTS

Accessibility

Recovery Home Services ensure a timely provision of recovery services to individuals who meet admission criteria as indicated by:

- 90% of potential residents are offered recovery home services within 30 working days of a completed Admission Assessment^a.

■ Retention and connection to the continuum of care

Recovery Home Services ensure support for recovery as indicated by:

- 90% of residents will attend the required number of in-house groups^b while a resident.
- 90% of the residents will attend an Orientation Session with an Addiction Services treatment staff within ten (10) working days of taking up residency.
- 90% of the residents will follow the treatment plan developed in consultation with their Addiction Services treatment staff/Recovery Home staff.
- 90% of all discharged residents have a Discharge Plan that includes a recommendation to continue treatment with Addiction Services.

Residents of Recovery Home Services successfully complete this service as indicated by:

- 30% of clients admitted are discharged with consent.

■ Medical Health and Safety

Recovery Home Services ensure that medical health and safety services are provided to the residents as indicated by:

- 95% of the residents are seen by a physician and/or nurse for a medical examination within 14 days of being admitted. Documentation is placed on their chart/record.
- 95% of the residents receive a complete review of all their reported prescription and over-the-counter medications by a pharmacist, nurse or physician within 14 days of being admitted. Documentation is placed on their chart/record.
- 0% physical or sexual abuse among residents and/or staff.
- 0% Building Code and Fire Code violations.

■ Positive Impact

Residents of Recovery Home Services identify a positive impact on their lives as indicated by:

- 30% of clients meeting admission criteria are discharged with consent.
- 25% of residents discharged with consent report not being harmfully involved with alcohol, drugs and/or gambling one year after discharge.
- 50% of residents discharged with consent are employed (i.e. part time, full time, casual, seasonal) one year after discharge.
- 90% of the residents discharged have a suitable place of residence upon discharge.
- 90% of the residents discharged with consent report satisfaction with the service as indicated by a standardized satisfaction survey at discharge.
- 90% of clients discharged with consent will have attended at least one outside self help/support group, and indicated on their chart.

■ NOTES

- a** Admission criteria are defined in the organization's Policy and Procedures Manual.
- b** Numbers of groups and sessions are detailed in the organization's Policy and Procedures Manual.
- c** Discharged with consent as defined in the organization's Policy and Procedures Manual.

METHADONE MAINTENANCE TREATMENT SERVICES STANDARDS

DESCRIPTION

Opioid Replacement Therapy involves the replacement or substitution of a long-acting opioid drug (typically in an oral formulation) for the opioid(s) that the person is administering intravenously. Opioids refer to all drugs, either natural or synthetic, with morphine-like actions. Methadone, Buprenorphine and levo-alpha-acetylmethadol (LAAM) are examples of long-acting opioids that have been used to substitute for intravenously administered heroin or prescription opioids. Currently in Nova Scotia, hydromorphone (Dilaudid®) or morphine (MS Contin®) are the prescription opioids that individuals are injecting (cocaine hydrochloride is also an illicit drug that is being injected).

OBJECTIVES

- 1 To ensure the accessibility of a comprehensive range of interventions and continuum of care approach including, but not limited to:
 - education and awareness
 - advocacy
 - social supports
 - health care services
 - health promotion
 - pharmacotherapies
 - alternative therapies
 - continuous assessment
 - crisis intervention/response
 - cognitive-behavioural therapy
 - relapse prevention for opioid-dependent individuals.

- 2 To enhance the health of clients by reducing the harms associated with the abuse of opiates including:
 - the use of other opioids
 - the use of other substances, e.g. cocaine, alcohol
 - drug-related criminal activity
 - mortality and morbidity
 - injection drug-related risk behaviours
 - other risk behaviours for transmission of HIV, HCV and other blood borne pathogens and STDs

- 3 To coordinate and link with the Colleges of Physicians and Surgeons, Pharmacists and Nurses in delivering an integrated treatment approach.
- 4 To ensure that any client receiving Methadone Maintenance Treatment Services has an individualized treatment plan established.
- 5 To coordinate the continuity of Methadone Maintenance Treatment Services for clients who move between community and institutions (e.g. correctional facilities, acute care facilities).

STANDARD MEASUREMENTS

Safety

Addiction Services ensures the safety of clients involved in Methadone Maintenance Treatment Services as indicated by:

- 95% of clients have a urine sample collected and tested as part of:
 - the assessment process
 - the admission process.
- 95% of clients undergo random and/or fixed urinalysis throughout their participation in Methadone Maintenance Treatment Services.
- 95% of clients participating in Methadone Maintenance Treatment Services will have access to primary medical care and services.
- 0% mortality rate.

Accessibility

Addiction Services ensures a timely provision of services as indicated by:

- 80% of clients who contact and request Methadone Maintenance Treatment Services have an intake completed in one working day.
- 80% of clients who consent to participate have an assessment completed and attached to file within three treatment-related contacts.
- 90% of clients have Methadone Maintenance Treatment Services made available within 5 working days following a completed assessment.

■ Retention and connection to the continuum of care

Addiction Services clients are successfully connected to services as indicated by:

- 85% of clients have an initial plan as required developed by the end of a completed assessment, which will include, but not be limited to:
 - medical care
 - other substance use treatment
 - counselling and support
 - mental health services
 - health promotion, disease prevention and education
 - other community-based services and supports
 - outreach and advocacy services.
- 20% of clients continue to participate in the Methadone Maintenance Treatment Service for at least one year.

■ Positive Impact

Addiction Services clients participating in Methadone Maintenance Treatment Services identify a positive impact on their lives as indicated by:

- 30% of clients report a reduction in opiate use at 12-month follow-up.
- 30% of clients report a decrease in the use of other psychoactive drugs at 12-month follow-up.
- 30% of clients report a decrease in the use of needles at 12-month follow-up.
- 90% of pregnant, substance-abusing women in the Methadone Maintenance Treatment Services are linked to the appropriate antenatal care.
- 50% of clients report a decrease in drug-related criminal activity at 12-month follow-up.
 - 90% of clients report positive lifestyle improvements in:
 - employability
 - family relationships
 - strengthened social networks
- 90% of clients report satisfaction with the service at the conclusion of the in-patient phase.

METHADONE MAINTENANCE TREATMENT BEST PRACTICES

DESCRIPTION

Opioid Replacement Therapy involves the replacement or substitution of a long-acting opioid drug (typically in an oral formulation) for the opioid(s) that the person is administering intravenously. Opioids refer to all drugs, either natural or synthetic, with morphine-like actions. Methadone, Buprenorphine and levo-alpha-acetylmethadol (LAAM) are examples of long-acting opioids that have been used to substitute for intravenously administered heroin or prescription opioids. Currently in Nova Scotia, hydromorphone (Dilaudid®) or morphine (MS Contin®) are the prescription opioids that individuals are injecting (cocaine hydrochloride is also an illicit drug that is being injected).

GUIDING PRINCIPLES

- Methadone Maintenance Treatment Services are recognized as an effective treatment option for opioid-dependent individuals.
- Health Canada's Best Practices: Methadone Maintenance Treatment Manual and Addiction Prevention and Treatment Services Methadone Maintenance Treatment Services Program Manual (draft) should form the basis of program development.
- Access to Methadone Maintenance Treatment Services should be available in each of the three shared service areas and the Capital District.
- Provincial coordination ensures a seamless continuum of care.
- Methadone Maintenance Treatment Services should incorporate a community development model and partnership.
- Methadone Maintenance Treatment is guided and based upon provincial Addiction Services philosophies, visions and goals.
- Methadone substitution alone does not constitute effective treatment for opioid dependency.
- A harm reduction, client centred approach will be utilized.

OVERVIEW OF STANDARDS

Objectives

- 1 To ensure the accessibility of a comprehensive range of interventions and continuum of care approach including, but not limited to:
 - education and awareness
 - advocacy
 - social supports
 - health care services
 - health promotion
 - pharmacotherapies
 - alternative therapies
 - continuous assessment
 - crisis intervention/response
 - cognitive-behavioural therapy
 - relapse prevention for opioid-dependent individuals.

- 2 To enhance the health of clients by reducing the harms associated with the abuse of opiates including:
 - the use of other opioids
 - the use of other substances, e.g. cocaine, alcohol
 - drug-related criminal activity
 - mortality and morbidity
 - injection drug-related risk behaviours
 - other risk behaviours for transmission of HIV, HCV and other blood borne pathogens and STDs

- 3 To coordinate and link with the Colleges of Physicians and Surgeons, Pharmacists and Nurses in delivering an integrated treatment approach.

- 4 To ensure that any client receiving Methadone Maintenance Treatment Services has an individualized treatment plan established.

- 5 To coordinate the continuity of Methadone Maintenance Treatment Services for clients who move between community and institutions (e.g. correctional facilities, acute care facilities).

Standard Measurements

Safety

Addiction Services ensures the safety of clients involved in Methadone Maintenance Treatment Services as indicated by:

- 95% of clients have a urine sample collected and tested as part of:
 - the assessment process
 - the admission process.
- 95% of clients undergo random and/or fixed urinalysis throughout their participation in Methadone Maintenance Treatment Services.
- 95% of clients participating in Methadone Maintenance Treatment Services will have access to primary medical care and services.
- 0% mortality rate.

Accessibility

Addiction Services ensures a timely provision of services as indicated by:

- 80% of clients who contact and request Methadone Maintenance Treatment Services have an intake completed in one working day.
- 80% of clients who consent to participate have an assessment completed and attached to file within three treatment-related contacts.
- 90% of clients have Methadone Maintenance Treatment Services made available within 5 working days following a completed assessment.

Retention and connection to the continuum of care

Addiction Services clients are successfully connected to services as indicated by:

- 85% of clients have an initial plan as required to be developed by the end of a completed assessment, which will include, but not be limited to:
 - medical care
 - other substance use treatment
 - counselling and support
 - mental health services
 - health promotion, disease prevention and education
 - other community-based services and supports
 - outreach and advocacy services.
- 20% of clients continue to participate in the Methadone Maintenance Treatment Service for at least one year.

Positive Impact

Addiction Services clients participating in Methadone Maintenance Treatment Services identify a positive impact on their lives as indicated by:

- 30% of clients report a reduction in opiate use at 12-month follow-up.
- 30% of clients report a decrease in the use of other psychoactive drugs at 12-month follow-up.
- 30% of clients report a decrease in the use of needles at 12-month follow-up.
- 90% of pregnant, substance-abusing women in the Methadone Maintenance Treatment Services are linked to the appropriate antenatal care.
- 50% of clients report a decrease in drug-related criminal activity at 12-month follow-up.
- 90% of clients report positive lifestyle improvements in:
 - employability
 - family relationships
 - strengthened social networks
- 90% of clients report satisfaction with the service at the conclusion of the in-patient phase.

SPECIFIC GUIDING PRINCIPLES

Staffing

Target Population

Admission Criteria

■ **COMMON PROVINCIAL PRACTICES**

■ **Methodone Stabilization Protocol**

■ **SUPPORTING DOCUMENTS AND FORMS**

■ **GLOSSARY**

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NICOTINE TREATMENT SERVICE STANDARDS

DESCRIPTION

Nicotine Treatment provides educational and/or therapeutic interventions to support those who wish to reduce or stop the use of nicotine. It is available to individuals and groups within the community and to Addiction Services clients. Nicotine treatment is based on client needs, strengths and readiness to change.

OBJECTIVES

- 1 To enhance health and reduce/minimize the harms associated with the use of tobacco products.
- 2 To provide a range of cost effective interventions using a continuum of care.

STANDARD MEASUREMENTS

Accessibility

Addiction Services ensures a timely provision of nicotine treatment to clients who require services as indicated by:

- 100% of clients who seek nicotine treatment will be offered nicotine services.
- 90% of clients will have nicotine treatment services offered within 15 working days following intake.
- 90% of clients will report that help was readily available when they decided to seek help.

■ Retention and Connection to Continuum of Care

Addiction Services clients are successfully connected to services as indicated by:

- 90% of clients will receive information on the range of available nicotine prevention and treatment services as documented on their client file.
- 90% of clients who consent to participate will have an assessment and Fagerstrom Test for Nicotine Dependence completed within three treatment contacts as documented on their client file.
- 90% of clients receiving nicotine treatment services will be informed of other treatment services as documented on their client file.
- 90% of clients receiving nicotine treatment, who self-identify as requiring additional services, will be referred to the appropriate service(s) as documented on their client file.

■ Positive Impact

Addiction Services clients participating in Outcome Monitoring System (OMS) identify a positive impact on their lives as indicated by:

- 30% of clients report a reduction in nicotine use at 12-month follow-up.
- 5% of clients who participate in an assessment only will not be using tobacco products at 12-month follow-up.
- 10% of clients who complete nicotine treatment during the course of their treatment for other substances and/or gambling will not be using tobacco products at 12-month follow-up.
- 15% of clients who are involved exclusively in nicotine treatment will not be using tobacco products at 12-month follow-up.
- 90% of clients will report satisfaction with nicotine treatment.

NICOTINE TREATMENT BEST PRACTICES

DESCRIPTION

Nicotine Treatment provides educational and/or therapeutic interventions to support those who wish to reduce or stop the use of nicotine. It is available to individuals and groups within the community and to Addiction Services clients. Nicotine treatment is based on client needs, strengths and readiness to change.

GUIDING PRINCIPLES

- 1 Nicotine treatment is efficient and clinically effective when tailored to an individual's readiness to change (Krejci and Foulds, 2003).
- 2 Social and physical environments impact on motivating and supporting an individual's reduction of tobacco use and should be considered in the development of all intervention strategies (Farkas et al., 1999; Krejci and Foulds, 2003).
- 3 Individuals respond best when offered a variety of treatment modalities.
- 4 Some individuals may require multiple interventions to reach their goal.
- 5 Behavioural approaches to preventing relapse/return to use are an integral component of the treatment (Fiore et al., 2000).
- 6 Nicotine Replacement Therapies (NRT) are a safe and effective adjunct to treatment for those dependent on nicotine (Henningfield, 1995; Ontario Medical Association, 1999).

OVERVIEW OF STANDARDS

Objectives

- 1 To enhance health and reduce/minimize the harms associated with the use of tobacco products.
- 2 To provide a range of cost effective interventions using a continuum of care.

■ Standard Measurements

1 Accessibility

Addiction Services ensures a timely provision of nicotine treatment to clients who require services as indicated by:

- 100% of clients who seek nicotine treatment will be offered nicotine services.
- 90% of clients will have nicotine treatment services offered within 15 working days following intake.
- 90% of clients will report that help was readily available when they decided to seek help.

2 Retention and Connection to Continuum of Care

Addiction Services clients are successfully connected to services as indicated by:

- 90% of clients will receive information on the range of available nicotine prevention and treatment services as documented on their client file.
- 90% of clients who consent to participate will have an assessment and Fagerstrom Test for Nicotine Dependence completed within three treatment contacts as documented on their client file.
- 90% of clients receiving nicotine treatment services will be informed of other treatment services as documented on their client file.
- 90% of clients receiving nicotine treatment, who self-identify as requiring additional services, will be referred to the appropriate service(s) as documented on their client file.

3 Positive Impact

Addiction Services clients participating in Outcome Monitoring System (OMS) identify a positive impact on their lives as indicated by:

- 30% of clients report a reduction in nicotine use at 12-month follow-up.
- 5% of clients who participate in an assessment only will not be using tobacco products at 12-month follow-up.
- 10% of clients who complete nicotine treatment during the course of their treatment for other substances and/or gambling will not be using tobacco products at 12-month follow-up.
- 15% of clients who are involved exclusively in nicotine treatment will not be using tobacco products at 12-month follow-up.
- 90% of clients will report satisfaction with nicotine treatment.

SPECIFIC GUIDING PRINCIPLES

Staffing

Nicotine treatment staff are responsible for coordinating, delivering and evaluating a range of interventions to support people who wish to reduce or stop the use of nicotine.

- Each Addiction Services Shared Service Area will have dedicated nicotine staff who should have a minimum of 2 years post-secondary education and training related to addiction and counselling.
- Staff from across the organization will be trained and supported to provide a range of cost effective interventions using a continuum of care approach.
- Staff training and continuing education will be provided on an ongoing basis to ensure services are aligned with current best practices.
- Nicotine treatment staff should participate in ongoing tracking and outcome monitoring.
- Nicotine treatment staff should facilitate the development and implementation of smoke-free policies.
- Nicotine treatment staff should collaborate with key stakeholders such as Public Health Services to reduce the cost burden associated with tobacco use.

Program Content

Nicotine Treatment provides a range of treatment modalities tailored to meet the individual's readiness to change. Treatment should incorporate four equally important areas having significant impact on outcomes. The four components of optimal tobacco treatment are illustrated in the Figure below:

1 Client Outreach and Engagement

The focus on this component is on engaging tobacco users along the continuum of nicotine dependency. Strategies include, but are not limited to:

- Develop, support and advocate for smoke free policies which prompt individuals into stop attempts.
- Advocate for workplace programming in combination with smoke free policy to effectively engage tobacco users.
- Develop written materials with a positive focus, i.e. immediate health benefits of stopping, money saved, and not 'fear arousal' or negative health messaging.
- Explore innovative approaches to engagement, within a setting.

- Tailor engagement activities to meet the readiness to change.
- Support activities that de-normalize tobacco use.

It should be recognized that broad media campaigns designed to engage clients might not be cost effective.

2 Treatment

Focus should be placed on the positives of benefits and outcomes of stopping. Nicotine replacement therapy (NRT) should be offered to all individuals dependent on nicotine, as assessed by the Fagerstrom Test for Nicotine Dependence, and who demonstrate a desire to stop. Ongoing assessment of treatment strategies should include:

- Level of nicotine dependence
- Level of motivation
- Personal and family relationships
- Relationships to other tobacco users; and
- Co-morbidity factors

3 Return to Use

Return to use prevention is designed not only to reward continued stopping but also to prompt new stop attempts. It involves a variety of strategies including, but not limited to:

- Telephone support
- Letter to self
- Communication campaigns
- Emails

Return to use prevention measures should be implemented at 30 days, 60 days, 90 days, 180 days and a year post-treatment.

4 Evaluation and Outcomes

Interventions must be shown to be clinically effective and to meet the needs of the clients. There are a variety of mechanisms that can be utilized to do this:

- Provincial outcome monitoring practices
- District-specific research
- Client satisfaction
- Program evaluation
- Quit rates

■ Special Populations

Nicotine treatment is designed for individuals affected by the use of nicotine. Interventions may be tailored to meet the needs and assets of the following populations:

1 Other Substance Use and/or Gambling Problems

Tobacco-related illness is the leading cause of premature death in individuals accessing addiction services (Hurt et al., 1996). Sixty-five percent (65%) of regular video lottery players are tobacco users (Nova Scotia Department of Health, 1998). Treatment for problems associated with substance use and/or gambling provides a unique opportunity to address nicotine dependence, build motivation to change and present treatment options. Individuals can address tobacco and other dependencies simultaneously and be successful in achieving their goals (Fogg and Borody, 2002; Sullivan and Covey, 2002).

All clients accessing Addiction Services should be offered minimal intervention for tobacco use employing the 5As (Ask, Advise, Assess, Assist, Arrange).

2 Mental Health Consumers

Mental Health consumers should be supported in their attempts to quit smoking. This includes, but is not limited to, staff training, policy development, programming and prevention initiatives.

3 Women who are Pregnant

A variety of treatment modalities should be offered. NRTs can be considered as a treatment modality (Fiore et al., 2000; Hegaard et al., 2003). Special emphasis should be given to postpartum return to use.

4 Youth

All youth using tobacco should be offered minimal intervention using the 5As. Treatment approaches should be youth-focused (web, print, resources, group, etc.). Education should include a focus on de-normalizing tobacco use, how tobacco is marketed, tobacco company strategies and short-term health benefits of stopping. NRTs should not be excluded as a treatment modality because they are less harmful than smoking.

5 Settings

Taking nicotine treatment to an individual's work, community or place of leisure removes barriers to treatment and may engage more tobacco users in programs and increase quit rates (Nova Scotia Department of Health, Moher et al., 2004).

a Work Sites

Addiction Services should support work sites to develop and implement a 100% smoke free policy. Treatment services should be delivered in work sites that have or are developing a 100% smoke free policy.

b Health Care Settings

Every effort should be made to partner with other health care providers to ensure that at least minimal intervention (5 As) is provided. For hospitalized patients, high intensity behavioural interventions, that include at least one month of follow-up, should be provided (Rigotti et al., 2002).

COMMON PROVINCIAL PRACTICES

Pharmacotherapies

Nicotine replacement therapy (NRT) medications include:

- Nicotine Gum
- Nicotine Transdermal Patch
- Nicotine Nasal Spray (not currently available in Canada)
- Nicotine Inhaler

1 Nicotine Gum

- Nicorette® (2 mg of nicotine)
- Nicorette Plus® (4 mg of nicotine)

Nicotine is absorbed through the buccal mucous membranes. The gum is kept between the gum and cheek and slowly turned over for 30 minutes, then discarded. It should not be chewed. Maintaining a steady state plasma level of nicotine is very important. Therefore, individuals should use one piece of gum per hour for the first day. Clients should wait 15 minutes after food or drink before using nicotine gum. Nicotine gum is available in doses of 2 mg and 4 mg. The 4 mg dose is more effective in highly dependent individuals. The gum has the potential advantage that in acute, high stress situations, an individual can make an active coping response that delivers a dose of nicotine. The use of nicotine gum as a stand-alone treatment without any concurrent counselling has low rates of success.

Dose

Before using the gum, an individual's level of physical dependence to nicotine can be facilitated using the Fagerstrom Tolerance Scale. For scores of 6 or less, Nicorette 2 mg is recommended; for scores of 7 or greater, Nicorette Plus 4 mg is recommended.

How to Use the Gum

- Bite the gum once or twice
- Park the gum between the gum and cheek to promote buccal absorption
- "Bite, bite, park."
- Use the gum for a 30 minute period of time.
- Slow down if feeling uncomfortable.
- Do not chew more than one piece of gum at any one time.
- Do not exceed 1 piece of gum per hour.
- Do not chew more than 25 pieces of gum per day.

Factors Effecting Nicotine Absorption

Avoid the following acidic beverages at least 30 minutes before using the gum as they prevent absorption of nicotine:

- Coffee
- Tea
- Soft drinks
- Alcohol
- Citrus juices

2 Nicotine Transdermal Patch

Nicotine Transdermal patch systems include:

- Habitrol®
- Nicoderm®

Nicotine patches deliver doses of nicotine in a steady fashion for the period of time they are worn. The patch has been reported to have advantages over the gum that include:

- Compliance problems with the gum.
- Patients often experience difficulty in using the gum properly.

Dose

For individuals smoking 10 or more cigarettes/day, start with the 21 mg/day Nicotine Patch. For individuals smoking less than 10 cigarettes/day, start with the 14 mg/day Nicotine Patch. Use of the nicotine patch consists of selection of the initial dosage strength, a maintenance period at this dosage followed by two weaning periods of decreasing amounts of nicotine.

Contraindications

- Non-smokers or occasional smokers
- Post-myocardial infarction patients
- Hypersensitivity or allergy to nicotine
- Patients with generalized skin disorders
- Pregnant or nursing mothers

Side Effects

- Headaches
- Insomnia
- Palpitations
- Rash, acne (especially with the patch)

3 Nicotine Nasal Spray (Not currently available in Canada)

The Nicotine Nasal Spray is not currently available in Canada. Each spray delivers 0.6 mg of nicotine. Typical doses are 1-2 puffs per hours. Peak plasma levels of nicotine are reached in 10 minutes. This system delivers nicotine more rapidly than nicotine gum or the Transdermal patch but less rapidly than from cigarettes. There does not appear to be an abuse liability associated with this delivery system.

Side Effects

- Nasal and throat irritation
- Inflammation of the nostrils
- Sneezing
- Coughing
- Watery eyes

4 Nicotine Inhaler

The Nicotine Inhaler is currently available in Nova Scotia. The Nicotine Inhaler is comprised of a plastic rod with a nicotine plug that provides a nicotine vapour. The vapour does not deliver the nicotine through the lungs but through buccal absorption in the mouth. The kinetics of the nicotine mimics the Nicotine Gum. The external resemblance of the inhaler to a cigarette does not appear to increase its abuse liability.

Side Effects

- Throat irritation
- Coughing

5 Bupropion (Zyban®)

Bupropion is chemically unrelated to nicotine. It was originally developed and marketed under the trade name Wellbutrin® to treat depression. The mechanism by which Bupropion helps people to stop smoking is currently unknown. It is presumed that Bupropion exerts its effects by mediating Noradrenaline and/or dopamine. Bupropion is a weak inhibitor of the reuptake of Norepinephrine, Serotonin, and Dopamine. Treatment with Zyban® typically starts one week before the person's quit date at a dose of 150 mg once a day. After the first week, the dose is changed to 150mg bid for 8-12 weeks.

Contraindications

- History of seizures
- Heavy alcohol users
- Head trauma
- Anorexia

Research in the area of NRTs has shown that:

- Nicotine replacement therapies are a safe effective adjunct for the treatment of nicotine dependence.
- Any tobacco user may consider the use of nicotine replacement therapy. This is safer than using tobacco.
- Nicotine replacement therapies should be provided at no charge to program participants.
- Nicotine replacement therapies are most effective when used in conjunction with a complete stop smoking program that addresses the emotional, social and psychological aspects of tobacco use.

Assessment & Intake

The Fagerstrom Test for Nicotine Dependence is the accepted means of assessing nicotine dependence. The Hooked on Nicotine Checklist is an accepted means of determining youth dependence on nicotine.

A complete assessment should include, but is not limited to, the following:

- Score on Fagerstrom Test for Nicotine Dependence
- Years of tobacco use
- Motivation level
- Other tobacco users in the home
- Family relationships
- History of withdrawal severity
- Greatest amount of time spent tobacco free since starting tobacco use
- Amount smoked/day over the last 6 months
- Co-morbidity factors (i.e. cancer, other health conditions)
- Number of serious quit attempts
- Past use of Nicotine Replacement Therapies

Telephone Counselling

Telephone help lines can assist individuals in stopping smoking. The Canadian Cancer Society operates the NS Smokers Helpline. The Smokers Helpline is telephone based information and support services for smokers and the people who care about them. Trained quit specialists can help individuals develop a structured "Quit Plan," answer questions about quitting and refer to services in the community.

The Helpline recognizes that individuals have different reasons for smoking and different reasons for wanting to quit. Through the Helpline, individuals can discuss:

- Withdrawal symptoms
- Quitting methods
- Dealing with slips and relapses
- Managing stress
- Dealing with cravings
- Asking for support

The service is free and can be accessed by calling 1-877-513-5333. Its hours of operation are from Monday to Thursday from 9 a.m. - 9 p.m. and Friday from 9 a.m. to 5 p.m. The Smokers Helpline also refers individuals to Addiction Services.

School-Based Programs

Effective tobacco reduction programs at the school level combine smoke-free policy, smoking prevention activities including effective curriculum supplements, and support to help students stop smoking (smoking cessation).

1 Policy

Under the Smoke-Free Places Act, smoking is not permitted in school buildings or on school grounds. To assist schools in developing and implementing effective school-based policy, the NS School Smoking Prevention Coalition developed and promoted to all Nova Scotia schools the resource entitled, Making It Work: Guidelines for Effective School-Based Smoke-Free Policy.

Making It Work provides a framework to guide schools through the steps necessary to create or revise school-based smoke-free policy and highlights effective smoking prevention curricula and youth cessation resources. Specifically, the guide provides:

- Steps/process to policy development
- Recommendations for policy at elementary, junior high and high school levels
- Suggested consequences for students who violate smoking policy
- Information on stop smoking (cessation) groups for youth
- Information on smoking prevention curriculum for grades primary - nine

Information in the resource is based on the most recent research available about youth smoking prevention and reflects the results of consultations with students, parents, teachers and administrators from across the province, as well as the Nova Scotia School Boards Association. The resource can be accessed through www.gov.ns.ca/health/tcu (click on schools).

2 Curriculum Supplement

Smoke Free for Life is a tobacco prevention curriculum supplement learning resource for grades primary to nine. The learning resource was developed by the Nova Scotia Department of Health in 1996 and was updated in 2001. The resource meets the criteria for effective school smoking prevention programming.

The resource is promoted through Public Health Services. Teachers in grades primary - nine should be encouraged to use Smoke Free for Life.

3 Smoking Cessation

No More Butts! (2002) is a peer-led stop smoking program for high school-aged students who smoke daily, and want to quit smoking. The program provides individual and peer group support, as well as incentives to attract people to the program and acknowledge their ongoing participation and effort. Program participants are asked to find and bring a friend who does not smoke (a buddy) to support them, during the meetings and beyond the school day.

No More Butts! was created based upon a review of the published literature related to tobacco-use reduction programs for teens and adults, and focus groups with program participants, peer leaders, staff advisors and high school principals, conducted by Public Health Services, Capital Health in 2001.

Web-based Interventions

These are quit smoking sites.

1 Adults

Health Canada: www.hc-sc.gc.ca/hecs-sesc/tobacco/quitting/index.html
QuitNet (Boston University School of Public Health): www.quitnet.com

2 Youth

Health Canada: www.hc-sc.gc.ca/hecs-sesc/tobacco/youth/quit/quit.html
I Quit (US Centers for Disease Control and Prevention): www.cdc.gov/tobacco/educational_materials/iquit.htm
TeenNet (University of Toronto): www.cyberisle.org/access/buspass.php

SUPPORTING DOCUMENTS AND FORMS

Nicotine Withdrawal Protocol

Nicotine Withdrawal Protocol is published separately.

No More Butts! Program

The No More Butts! program was piloted in 22 high schools from across Nova Scotia in 2002. The following is a summary of the results from the pilot:

28-day continuous abstinence rate

- 20.9%

Self-Efficacy

- 62% of participants smoke-free at the end of the program were confident they would stay smoke-free.
- 79% of participants who cut down the amount smoked were confident they would not increase the amount they smoke.
- 83% of participants (regardless of their change in smoking behaviour) were confident that the information and skills in No More Butts!, if used, would help them try to quit smoking or cut down in the future.

Student Recruitment and Retention

The student recruitment (6.5%) and participation (5%) results for those students estimated to be smokers within the pilot high schools is similar to the most successful results reported in the published literature (6% recruitment).

Relationship Between Meeting Attendance and Reduced Consumption

As the level of success increased in quitting, or cutting down the amount smoked, so did attendance at meetings. Half the participants who were smoke-free for 4 weeks attended all 15 meetings.

School Enrollment and Retention

- 56% of the 18 schools that started to implement the program were able to complete it as designed.
- 45% of schools that had expressed an interest in offering the program were able to complete it as designed.

Participant Assessment of the Value of the Program

Approximately two-thirds of participants rated No More Butts! in the two highest of five categories, as "a program to help high school-aged people to stop smoking."

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PROBLEM GAMBLING SERVICE STANDARDS

DESCRIPTION

Problem gambling services provides public awareness, health promotion, prevention, early intervention, and treatment for problem gamblers and their families. It also develops and supports research pertaining to problem gambling.

OBJECTIVES

- 1 To increase public awareness and knowledge of problem gambling, through evidence-based, target-specific programs and strategies.
- 2 To develop and implement target-specific health promotion, prevention and education programs.
- 3 To develop and implement target-specific early intervention programs for at-risk and problem gamblers, their families and service providers.
- 4 To provide community-based outpatient and telephone counselling, and short-term residential treatment services for problem gamblers and their families.
- 5 To conduct problem gambling research.

STANDARD MEASUREMENTS

Services for problem gamblers and their families and communities are governed by Addiction Services Standards. Additional problem gambling service standards follow.

Accessibility

Addiction Services ensures the timely provision of problem gambling information, including self-help manuals, will be available for:

- 95% of all visitors to the Problem Gambling Web-Site will have immediate access to the website.
- 90% of all callers who request information from the Problem Gambling Helpline (PGHL) will receive information within 20 minutes verbally.
- 80% of all clients who call and request mail-outs from Addiction Services offices will receive the materials within 5 working days.

- Telephone counselling will be available for problem gamblers and their families, as indicated by: 95% of all problem gamblers and members of their families, who request help, will have access to telephone counselling within 30 minutes.

Community groups identifying to Addiction Services, a facilitation of learning need related to problem gambling, will receive services based on the Prevention and Community Education Service Standards.

Retention and connection to the continuum of care

Clients are successfully connected to Addiction Services as indicated by:

- 60% of all problem gamblers, and members of their families, who call the PGHL and agree to participate in the counselling process, will have 3 clinical counselling sessions recorded within one year.

Positive Impact

Program reach volumes will be reported, based on Service Standards for Prevention and Community Education. Self-help materials for allied helping professionals will be evaluated, utilizing the Service Standards for Prevention and Community Education.

Clients will identify a positive impact on their lives as indicated by:

- 60% of all gamblers who access self-help materials, and who agree to a 12-month followup, will report increased knowledge of problem gambling and decreased time and money spent on gambling.
- 90% of clients report satisfaction with the service by the session with the PGHL based on a standard self report measure.

PROBLEM GAMBLING BEST PRACTICES

■ DESCRIPTION

Problem gamblers are individuals who persist in continuing destructive patterns of gambling despite irrefutable evidence that their behaviours are creating serious financial, family, employment, social, psychological, physical and spiritual problems for themselves, their families, their employers and their communities. Services for problem gamblers and their families include public awareness, health promotion, prevention, early intervention, treatment and research programs.

■ GUIDING PRINCIPLES

- 1 Services will be based upon evidence-based best practices.
- 2 All gambling projects and interventions will have evaluation plans.
- 3 Services will be based upon the needs of problem gamblers, their families and communities.
- 4 Programs and services addressing problem gambling can only be achieved as part of a concerted effort among a range of stakeholders, including problem gamblers and their families, health and social service providers, policy makers, financial institutions, the gaming industry and communities.
- 5 Problem gambling services will be provided along the health continuum from the optimum health to risk of premature death. Addiction Services is committed to a coordinated team approach among all District Health Authorities and the Problem Gambling Help Line.

OVERVIEW OF STANDARDS

Objectives

- 1 To increase public awareness and knowledge of problem gambling, through evidence-based, target-specific programs and strategies.
- 2 To develop and implement target-specific health promotion, prevention and education programs.
- 3 To develop and implement target-specific early intervention programs for at-risk and problem gamblers, their families and service providers.
- 4 To provide community-based outpatient and telephonic counselling, and short-term residential treatment services for problem gamblers and their families.
- 5 To conduct applied problem gambling research.

Standard Measurements

1 Accessibility

Addiction Services ensures the timely provision of problem gambling information, including self-help manuals, will be available for:

- 95% of all visitors to the Problem Gambling Web-Site will have immediate access to the website.
- 90% of all callers who request information from the Problem Gambling Helpline (PGHL) will receive information within 20 minutes verbally.
- 80% of all clients who call and request mail-outs from Addiction Services offices will receive the materials within 5 working days.
- Telephone counselling will be available for problem gamblers and their families, as indicated by: 95% of all problem gamblers and members of their families, who request help, will have access to telephone counselling within 30 minutes.

Community groups identifying to Addiction Services a Facilitation of Learning need related to problem gambling, will receive services based on the Prevention and Community Education Service Standards.

2 Retention and connection to the continuum of care

Clients are successfully connected to Addiction Services as indicated by:

- 60% of all problem gamblers, and members of their families, who call the PGHL and agree to participate in the counselling process, will have 3 clinical counselling sessions recorded within one year.

3 Positive Impact

Program reach volumes will be reported based on Service Standards for Prevention and Community Education. Self-help materials for allied helping professionals will be evaluated utilizing the Service Standards for Prevention and Community Education.

Clients will identify a positive impact on their lives as indicated by:

- 60% of all gamblers who access self-help materials, and who agree to a 12-month followup, will report increased knowledge of problem gambling and decreased time and money spent on gambling.
- 90% of clients report satisfaction with the service by the session with the PGHL based on a standard self report measure.

SPECIFIC GUIDING PRINCIPLES

Staffing

All Addiction Services Treatment and Prevention staff are expected to have a general knowledge concerning problem gambling. Designated problem gambling staff are expected to provide leadership for problem gambling services and act as a lead problem gambling consultant to other staff. Designate Problem Gambling staff must have knowledge of the unique characteristics of problem gambling and its relationship to other substance abuse. Addiction Services will provide ongoing training and staff development on research and trends of problem gambling prevention and treatment.

Target Group

Individual families, community groups, and others affected by problem gambling.

■ COMMON PROVINCIAL PRACTICES

■ Theoretical Context

Common Provincial Practices must have a theoretical context; they must be supported by the most up-to-date research and clinical experience. In the absence of recognized theories about the nature of problem gambling, an up-to-date body of scientific literature, and logical models to address its risks and consequences, Common Provincial Practices have little validity. Without these critical elements, Common Provincial Practices are likely to be based upon conjecture, policy preferences and past practice. As the field develops, common provincial practices will evolve and be added to Best Practices.

All Addiction Services staff, who work with problem gamblers in any capacity, need to be conversant with the main theories of problem gambling. They must exercise caution and discretion in explaining the nature and apparent causes of problem gambling to problem gamblers, their families, health and social service providers and the public. Training materials and information, and best advice will be developed to make the complex task of disseminating information about problem gambling as effective as possible.

WOMEN SERVICE STANDARDS

DESCRIPTION

Addiction Services for women are services to address women's specific experiences, issues and realities. The focus of services for women is to encourage the empowerment of women to choose and direct their own lifestyle changes and to participate in the development of services based on their actual needs, rather than their needs as perceived by others.

Addressing interrelated health issues and the impact of the determinants of health is key to the delivery of services for women. Addiction Services for women embraces (a) a gender-sensitive and culturally appropriate approach, (b) client education, (c) a relational model of treatment, (d) practical skill-building, (e) family issues, (f) a harm reduction approach, and (g) a realistic view of return-to-use prevention and management. Women's services also serve as a resource for adolescent programs with young women.

OBJECTIVES

- 1 To increase opportunities for women to engage and continue in the recovery process.
- 2 To increase accessibility by reducing barriers such as transportation, elder/child care needs, etc.
- 3 To provide a menu of options including individual counselling, shared group experiences, women-specific groups, etc.
- 4 To coordinate care for women needing Addiction Services using a case management approach through the continuum of treatment options.
- 5 To advocate broadly for services and public policy on the behalf of women in the community.

■ **STANDARD MEASUREMENTS**

Services for women are governed by Addiction Service Standards.

■ **Accessibility**

Addiction Services ensures a timely provision of services to women who require services as indicated by:

- 100% who self-identify as pregnant will be offered appropriate services within three working days. [To be added to Intake Service Standards.]

WOMEN BEST PRACTICES

■ DESCRIPTION

Addiction Services for women are services to address women's specific experiences, issues and realities. The focus of services for women is to encourage the empowerment of women to choose and direct their own lifestyle changes and to participate in the development of services based on their actual needs, rather than their needs as perceived by others.

Addressing interrelated health issues and the impact of the determinants of health is key to the delivery of services for women. Addiction Services for women embraces (a) a gender-sensitive and culturally appropriate approach, (b) client education, (c) a relational model of treatment, (d) practical skill-building, (e) family issues, (f) a harm reduction approach, and (g) a realistic view of return-to-use prevention and management. Women's services also serve as a resource for adolescent programs with young women.

■ GUIDING PRINCIPLES

- 1 The focus of women's specific Addiction Services is to encourage the empowerment of women to choose and direct their own wellness.
- 2 For many women, the experience of trauma and addictions are interrelated and should be addressed together in the continuum of care.
- 3 Women experience gender-specific socioeconomic barriers, which should be addressed in the continuum of care provided by Addiction Services.
- 4 Women's Addiction Services must reflect the most current knowledge and research.

OVERVIEW OF STANDARDS

Objectives

- 1 To increase opportunities for women to engage and continue in the recovery process.
- 2 To increase accessibility by reducing barriers such as transportation, elder/child care needs, etc.
- 3 To provide a menu of options including individual counselling, shared group experiences, women-specific groups, etc.
- 4 To coordinate care for women needing Addiction Services using a case management approach through the continuum of treatment options.
- 5 To advocate broadly for services and public policy on the behalf of women in the community.

Standard Measurements

Services for women are governed by Addiction Services Standards

Accessibility

Addiction Services ensures a timely provision of services to women who require services as indicated by:

- 100% who self-identify as pregnant will be offered appropriate services within three working days. [To be added to Intake Service Standards.]

SPECIFIC GUIDING PRINCIPLES

Staffing

Addiction Services will:

- Hire staff who are knowledgeable of and sensitive to women's issues.
- Provide ongoing training and staff development regarding trends and research related to women's addictions (e.g., trauma and addictions).
- Support a collaborative team approach to service delivery.
- Collaborate with staff, clients, and volunteers in the delivery of women-specific services and in the development of operational policies related to women's services.
- Ensure that women have the option of choosing a female counsellor.
- Whenever possible, female staff should be available during a woman's treatment experience.

■ **Target Group**

Women affected by their own, or others' substance use and/or gambling problems.

■ **Admission Criteria**

Admission criteria are specified in Best Practices for Withdrawal Management, Addiction Education Program, Structured Treatment, and Community-Based Outpatient Services.

■ **Discharge/Dismissal**

Discharge planning should address women's bio-psycho-social needs, understanding the need for respect and safety in any discharge or dismissal situation.

■ **COMMON PROVINCIAL PRACTICES**

■ **Key Approaches and Strategies**

Addiction Services acknowledges that:

- Women are more likely to have a history of victimization (e.g., Smith, 1992; Copeland & Hall, 1992; Thom, 1986).
- Women respond differently than men to treatment settings (Health Canada, 2001).
- Women's treatment/recovery needs differ from men (Health Canada, 2001).
- Women's patterns or preferences in obtaining services for addictions are unique (Health Canada, 2001).
- Women experience their reality in relationship to others (Covington, 1998).
- Treating women effectively can have a positive impact on their children (Finklestein, 1993).
- Services should address women's health in the context of women's lives understanding the need for respect and safety (Mattson & Allen, as cited in Waltman, 1995).

Addiction Services supports:

- Harm reduction approach.
- Women-centred approach.
- Groups as an effective form of treatment for most women.
- Systems approach to working with clients, with particular emphasis on family involvement.
- Women-specific day- and in-patient treatment.
- Culturally sensitive approaches.
- Services should be offered as close as possible to where clients live. Use of educational resources in women's addiction education, prevention and treatment programs (e.g., videos, books, and other publications) that are current and reflective of women's realities in Canada.
- Giving pregnant women priority access to services in an attempt to prevent the irreversible effects of alcohol and other drugs, thus reducing the incidence of Fetal Alcohol Spectrum Disorder (FASD).

Groups

Many women experience isolation in their relationships, as a result of trauma, and substance use and/or gambling problems. Therefore, groups are a preferred and common practice in the treatment and rehabilitation of many women (Health Canada, 2001). Groups do not replace the need for individual counselling (therapy) and often they are offered concurrently, based on the woman's evolving needs.

The key benefits of women-only group work are:

- Empowerment (Health Canada, 2001; Kasl, 1995).
- Reduced isolation (Health Canada, 2001).
- Healthy relationships and support networks.
- Validation and mutuality and reciprocity.
- Motivates women to make changes in their lives.

Community Outreach, Contact, and Engagement

Community outreach is an essential component of Addiction Services. Research shows that clients in contact with community outreach workers are more likely to enter treatment than others (Booth et. al. 1992 in Health Canada Best Practices). (See also Prevention & Community Education Service Standards and Prevention & Community Education Best Practices.)

The following practices enhance outreach, contact, and engagement of women:

- Flexibility of programming, menu of choices, and range of service options (Health Canada, 2001).
- Consistent presence in the community (e.g., regularly scheduled programs (Health Canada, 2001).
- Direct outreach to high-risk populations (e.g., Women's Centres, Parent/Family Resource Centres, Cultural Centres, Youth Health Centres, Needle Exchange, Transition Houses) (Health Canada, 2001).
- Culturally appropriate services (e.g., Health Canada, 2001; Ja & Aoki, 1993).
- Staff designated to provide outreach services (Health Canada, 2001).
- Women-friendly policies within treatment settings (Health Canada, 2001).

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